The Achilles’ heel of scale service design in social security administration: The case of the United Kingdom’s Universal Credit

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Abstract This article takes a critical view of the United Kingdom government’s design for the delivery of the Universal Credit (UC) benefit reforms. It is argued that the UC is destined to fail because of the policy’s extension into specifying the means (“digital by default”) of delivery for such services. The authors argue that an unseen but ubiquitous set of “scale” management assumptions has been allowed to infiltrate the means by which the government intends to enact its headline policy objective to “make work pay”. Following Seddon’s “Vanguard Method”, a practical example of how a better service was designed in a local authority housing benefits service is then examined. Results from this service include being able to deal with up to 50 per cent more demand, with fewer resources, in half the official target time. Finally, the article will conclude with a call for more evidence-based policy.

Keywords social security administration, management, client oriented approach, universal benefit scheme, United Kingdom

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Introduction: The flaws of scale assumptions

Locally designed services are human, receptive, engaging and productive. Counter-intuitively, they are also high quality and low cost. British local authorities that have rejected the United Kingdom government’s “best practice” guidance on how to manage housing benefits now deliver a service that puts official targets in the shade and cuts costs into the bargain. East Devon and Stroud councils, to cite just two, process benefits in less than half the official target time, in a period when the number of claimants has increased (Middleton, 2010). East Devon serviced 33 per cent more demand and Stroud 50 per cent more, in both cases using less resources. Blaenau Gwent leapt from the bottom of the Welsh league table to the top; the improvement in housing benefits service cut the number of “benefits” calls to the service centre by 50 per cent and face-to-face visits to solve problems by 57 per cent (Zokaei et al., 2010). These were improvements and savings that would never have been put in a central government “plan”.

However, there is a difficulty. Unfortunately, the idea of locally designed, human-scale service runs against the grain of successive United Kingdom governments’ policies for public sector reform – in particular, the present Conservative-Liberal Democrat coalition government’s plan to reform the social security benefits system by the introduction of the new Universal Credit (DWP, 2010). The authors support the government’s stated intention to redesign social security benefits in order to “make work pay” (Kirkup, 2011b). However, ministers have also stipulated policy which dictates how the Universal Credit must be delivered. The government wishes to use the welfare changes to further its intention to make all public services “digital by default” (Cabinet Office, 2010). Claimants will be pushed towards an online delivery channel and, if that fails to meet their needs, a centralized call centre. As a corollary, the government intends to close down locally-based housing benefits offices.

Examination of what actually happens in IT-dominated industrial designs such as the one proposed for Universal Credit reveals massive disruptions to the service flow, for the customer service is anything but smooth. There is huge waste in the shape of handoffs, rework, duplication of effort, and a focus on meeting activity targets and service levels. All of these “system conditions” lengthen service delivery times and consequently create failure demand: “demand caused by a failure to do something or do something right for the customer” (Seddon, 2003, p. 26). In other words, the service gets worse and costs go up. On all counts such industrial “scale” designs fail miserably.

Before investigating the design flaws of these proposed welfare reforms in greater detail, the next section briefly outlines why industrialized, alienating service designs for the delivery of social security programmes have continued to...
prove so appealing to politicians. The history of designing work operations to achieve economies of scale is a long one which has strongly influenced managers and politicians alike.

**Scale thinking: The milestones in operations management history**

Economy of scale, in common with many modern management principles, derives from economics. When more units of a good or service can be produced on a larger scale, with (on average) lower input costs, economies of scale are said to be achieved. The development of the idea can be traced back to the father of modern economics, Adam Smith. On the back of a Bank of England 20 pound note there is a picture of Smith and the words:

The division of labour in pin manufacturing: (and the great increase in the quantity of work that results)

In his most famous work, *The Wealth of Nations* (Smith, 1998), Smith explained how while one worker could make 20 pins a day, ten workers dividing the 18 pin-making steps between them could produce 48,000. He identified the division of labour and specialization as the two key means to achieve this huge increase in productivity. Through these techniques, he believed that employees would not only be able to concentrate on a specific task, but with time improve the skills necessary to perform their jobs, which could then be carried out even better and faster. Hence, through such efficiency, time and money could be saved while production levels increased: the idea that economy could be achieved through “scale” production had been established. It is pertinent to note that Smith’s innovation also relied on mechanization, something peculiar to manufacturing systems.

The next boost to scale thinking came with the early 20th century pioneers Frederick Winslow Taylor and Henry Ford, who devoted their efforts to boosting productivity through the specialization and standardization of work. F. W. Taylor developed what became known as “scientific management” (Taylor, 1998). He brought the notion of “method” to management (he called it the search for “the one best way” of completing a task), and this spawned “organization and methods” departments in every large organization. “Method” was established as belonging in the province of supervision: managers saw it as their job to decide the best way to carry out a task and it was the workers’ job to follow the specified method.

Perhaps the single most important contribution to the dominance of scale in management thinking, however, was Henry Ford’s mass production system (Ford, 2003). In the early 20th century, his black “Model T” cars flowed out of a factory that worked like a grand machine, with men and materials in harmonious flow.
His innovation enabled him to halve the costs of production and double the workers’ wages. It caught the world’s attention; the mass-production factory had brought efficiency, and efficiency meant the ability to compete. Ford’s plants were envied throughout the world for their scale and efficiency (Krafcik, 1988). Mass production, at scale, became the norm. Inevitably, Ford’s methods were copied by other companies, and management writers began to detail the application of Taylor and Ford’s approaches in other organizations: "factory management" was born (Lockyer, 1962). The field was gradually extended to become “operations management” in the 1970s, expanding until it encompassed service operations as well as manufacturing (Johnston, 2005).

**Scale thinking and the move towards industrialized, standardized service**

In 1972, Ted Levitt wrote a seminal Harvard Business Review (HBR) article entitled “Production-line approach to service”. In it, Levitt urged managers to pay the same attention to improving the efficiency and design of services as they did to manufacturing operations:

> In sum, to improve the quality and efficiency of service, companies must apply the kind of technocratic thinking which in other fields has replaced the high-cost and erratic elegance of the artisan with the low-cost, predictable munificence of the manufacturer (Levitt, 1972, pp. 43-44).

Levitt used the example of fast-food production and service in McDonald’s as an example of how factory methods could be profitably employed in a service. The method by which McDonald’s achieved its market domination was through mastery of a “system” which was “engineered and executed according to a tight technological discipline that ensures fast, clean, reliable service in an atmosphere that gives the modestly paid employees a sense of pride and dignity”. Levitt believed that McDonald’s had successfully applied “a manufacturing style of thinking to a people-intensive service situation” (Levitt, 1972, p. 45), reinforcing the argument that service design should employ the manufacturing approaches of standardization and specialization.

The next important step in service industrialization was taken by Richard Chase, who in another HBR article proposed that service operations should be organized in separate “front” and “back” offices (Chase, 1978). In essence, his argument for a separate back office was that since it has no contact with the customer, it offers greater potential to operate at peak efficiency. Chase argued that service systems with high customer contact were more difficult to control and rationalize than low contact systems; so decoupling front from back enabled what he saw
as the “technical core” to operate as a factory, isolated from outside influences, following a resource-oriented schedule and optimizing efficiency through batch scheduling, forecasting, inventory control and work measurement, just as in manufacturing.

These ideas continue to form the conceptual foundations for the way services are designed and managed today. As the American economist-turned-management-guru Michael Porter puts it:

Scale economies can be present in nearly every function of a business, including manufacturing, purchasing, research and development, marketing, service network, sales force utilization, and distribution (Porter, 1980, p. 7).

The “scale” archetype for service design

The “scale” archetype for service design has thus emerged from several generations of conventional management theory. Many of the underlying assumptions are so deeply pervasive in management literature and practice that they have become invisible – hidden in plain view. The “scale” design archetype commonly features:

* Standardization and specialization.
* Separated and “optimized” front and back offices.
* Access channel management (pushing customers to transact with the organization through cheaper channels such as by phone or online).

Following this archetype, management is primarily concerned with managing activity on the assumption that activity represents cost. To that end, “command and control” management is focused on what Seddon describes as the “core management paradigm” (Seddon, 2008, p. 51):

* How much work is coming in?
* How many people do I have?
* How long do people take to do things?

However, studying service organizations reveals that industrialized designs have an unexpected Achilles’ heel: paradoxically, attempts to manage costs create costs.

As a simple illustration, consider what happened when English local authorities were set a target to establish call centres by April 2005. When consultants were hired to help them move “telephone work” from council departments to centralized call centres, call volumes shot up. Why? The increase in call volumes was caused by the phenomenon of “failure demand” (Seddon, 2003, p. 26; see definition above). The assumption that telephone work could be treated as a specialized activity separate from the core service provision was an example of misplaced faith in scale and centralization; as a direct result, call centres were besieged by people wanting to know what had happened to their application or enquiry. Installing
more information technology (IT) in the shape of “customer relationship management” (CRM) systems only served to institutionalize this waste, compounding the error.

Conventional managers have been taught to strive for lower unit costs, which in a service environment leads them to focus on preferred (cheaper) modes of transactions with their customers. Unfortunately, their focus on transaction costs blinds them to the fact that, while transaction costs may indeed be lower, transaction volumes will inexorably rise as the system fails to provide a service that works for the customer. A common reaction to increasing call volumes (as in the local authority call centres described above) is to add more resources – employ more agents to field the calls – which of course mitigates or nullifies any gain from lower transaction costs. Another is to outsource call-handling to lower-wage economies, ignoring the fact that such contracts are commonly priced according to transaction volumes. Being paid by volume, outsource providers have no incentive to tackle and remove failure demand. Indeed, suppliers are effectively incentivised to worsen service to the customer.

In the same pursuit of lower transaction costs, managers focus on “access channel management”, driving customers away from supposedly expensive face-to-face contacts to the telephone; and then from telephones to electronic transactions online. Such scale concepts are aggressively marketed by the major management consultancies which have developed lucrative businesses providing the necessary IT. Government and the consultancies enjoy a close relationship, with many of the top public sector chief information officers having previously worked for these IT suppliers (Ballard, 2012).

But scale fails: The problems revealed when managers study their services as a system

The Vanguard Method was developed to help managers look at their organization as a system and, on the basis of the knowledge gained, redesign their services to improve performance and drive out costs. Studying the organization as a system reveals counter-intuitive truths, the importance of demand, and, in particular, failure demand and its causes, being just one. By studying demand, managers are able to understand the levels of failure demand they are unwittingly creating for themselves and other downstream organizations. Rising failure demand is a signal of a broken system. Revealingly, the “system conditions” (Seddon, 2003, p. 112) which cause failure demand are found to be those listed above as the ingredients for efficiency through scale. One of the exemplars of this scale design is Her Majesty’s Revenue and Customs (HMRC) in the United Kingdom, whose failure to provide a service to many taxpayers is discussed later in this article.
Despite being offered abundant and growing evidence of the costs of scale initiatives, successive United Kingdom governments have continued to be seduced by the potential efficiency gains scale thinking promises.

**United Kingdom government reforms and the growing influence of scale thinking**

In the 1998 Comprehensive Spending Review (CSR), the then Labour government promised to “root out waste and inefficiency” by setting efficiency targets for key public services (HM Treasury, 1998). At the same time, Prime Minister Tony Blair was setting a target for all government services to be accessible online by 2008, later brought forward to 2005 (Cabinet Office, 1999). By 2004 and the next CSR, Sir Peter Gershon was employed to find GBP 21.5 billion of public sector efficiency savings. Among other things, he offered up greater use of IT in benefits payments as an example of “streamlining the delivery of services to the public, cutting transaction costs and reducing paperwork” (HM Treasury, 2004, p. 1). Official “e-efficiency” reports then started to come thick and fast. In 2005, “Transformational Government” (Cabinet Office, 2005) pinpointed the need to “Develop modern channels for citizen and business access to services, and actively manage the shift in channels towards the most efficient and effective”. In 2006, the Varney review asserted that “Technology has enabled a revolution in the way service providers interact with their customers” (HM Treasury, 2006, p. 1) before going on to recommend that:

... this approach could drive out [in]efficiencies by improved performance and coordination of front-line e-services, contact centres and local offices and reducing duplication of business processes through shared use of an identity management system. Over the longer term further efficiencies and service enhancements could be made by reducing the back-office functions that would no longer be required (HM Treasury, 2006, p. 4).

After the formation of the Conservative-Liberal Democrat coalition government in 2010, there was even greater pressure for public sector efficiency gains in light of the government’s stated central aim of reducing the fiscal deficit. The internet entrepreneur Martha Lane Fox was commissioned to write a report reviewing the government’s web-portal service, Directgov. Among her recommendations was that government services should be “digital by default”:

Go digital only: ... shifting to digital-only services has huge cost-saving potential. Directgov should be the default platform for information and transactional services, enabling all government transactions to be carried out via digital channels by
2015. Achieving this will require a radical reallocation of effort and resources within Directgov. The organisation must focus its effort on creating high-quality user-friendly transactions and guidance. It can only do so by scaling back on non-core activities and being given the power to enforce user-centred quality standards across government (Lane Fox, 2010).

Her proposal was enthusiastically endorsed by ministers:

Public services should be delivered online or by other digital means, the Government has announced in response to a report published by Martha Lane Fox today. The report, and the Government’s initial response, argues for a Channel Shift that will increasingly see public services provided digitally “by default” (Cabinet Office, 2010).

Behind the “digital by default” policy is the belief that overall costs can be controlled by reducing the cost per transaction. But if going digital increases the total number of transactions it takes to receive service, the cost advantage will be nullified. Our contention is that “digital by default” will lead to rising failure (and thus overall) demand at a systemic level, substantially increasing costs as a result, although no one in government will be able to see this because of their silo-based lines of sight. Unfortunately, the policy is being pushed most fervently in a service where some of the poorest in society will be worst affected.

**Universal Credit**

In 2011, Secretary of State for Work and Pensions Iain Duncan Smith introduced a Welfare Reform Bill which aimed to overhaul the United Kingdom benefits system. At its centrepiece was a single Universal Credit that would replace several benefits: working tax credit, child tax credit, housing benefit, council tax benefit, income support, income-based jobseeker’s allowance and income-related employment and support allowance (House of Commons, 2011). The stated aim of the Universal Credit was to smooth transition into work by reducing the support a person received at a consistent rate as their earnings increased:

The complexity of the current benefit system makes it slow to react to changes in people’s circumstances, meaning that many are afraid to try work, but also makes it expensive and difficult to administer. This fuels error by administrators and claimants alike and reduces benefit take-up as people do not understand their entitlements. It is central to the purpose of Universal Credit that it is a simpler system than the one it replaces (DWP, 2011).

These principles appear sensible and the authors would wish to see the reforms succeed in their aim of “making work pay” (Kirkup, 2011b). However, the
Universal Credit was chosen as the first major project to be made to fit in with the Cabinet Office’s cross-government “digital by default” policy. With welfare spending being one of the largest and most politically sensitive areas of public expenditure, it was inevitable that a government focused on deficit reduction would seek to cut the cost of benefits administration. According to the Department for Work and Pensions’ (DWP) White Paper:

In delivering Universal Credit, the DWP will adopt the “digital first” principle and meet the growing demand for flexible and comprehensive online services. For people making Universal Credit claims, notifying changes or checking their payments and responsibilities, the digital channel will be the primary contact route . . . The DWP recognizes that there will continue to be a minority of people who cannot use online channels. For these people we will offer alternative access routes, predominantly by phone but also face to face for those who really need it. We expect these alternative access routes to be reserved for the minority who can’t use, or be helped to use, online services and therefore kept to a minimum (DWP, 2010).

Here is the first of two fundamental weaknesses in the plan for delivering Universal Credit: it is dependent on the successful construction of a large-scale computer system. How likely is this to be achieved? In their aptly-titled book, “Dangerous Enthusiasms”, Gauld and Goldfinch show that up to 30 per cent of major IT projects fail completely while a further 60 per cent go far over budget and/or fail to meet specifications (Gauld and Goldfinch, 2006). In the specific case of the United Kingdom, the House of Commons Public Administration Select Committee (2011) noted:

The lack of IT skills in government and over-reliance on contracting out is a fundamental problem which has been described as a “recipe for rip-offs”. IT procurement has too often resulted in late, over-budget IT systems that are not fit for purpose . . . The UK has been described as “a world leader in ineffective IT schemes for government”. There have been a number of high cost IT initiatives which have run late, under-performed or failed over the last 20 years including: the Child Support Agency’s IT system, the IT system that would have underpinned the National ID Card scheme, the Defence Information Infrastructure Programme, the implementation of the Single Payments Scheme by the Rural Payments Agency, and the National Offender Management System (C-Nomis).

By September 2011, the British press was warning that Universal Credit was top of Chancellor George Osborne’s at-risk list of potentially failing projects, with the House of Commons Public Accounts Committee chairman calling the plan “a train crash waiting to happen” (Kirkup, 2011a). Unsurprisingly, concern centred on the IT build-out. The Child Poverty Action Group’s chief executive Alison
Garnham stated: “The DWP is not famous for its success with new IT projects, and I really worry, because everything goes into one system”, adding, “If it fails it will have really serious consequences” (Stevens, 2011).

The DWP has remained confident that it can deliver its side of the Universal Credit system on time (Kirkup, 2011a), pointing out that the IT contractors are carrying out the project using “agile” means. Agile – a technique which supposedly allows for the building of computer systems in an iterative, “live” way – has been described elsewhere as “merely to do the wrong thing faster” (Seddon, 2011). It is not just the United Kingdom that is putting all its eggs in the IT basket. As can be seen from the agenda for the 13th International Conference on Information and Communication Technology in Social Security, the ingrained assumption is that social security services require “complex administrative tools”, “data exchange between agencies”, and hence “data security” and “inter-operability” – all testimony to the scale arguments of the IT companies.

Internationally, there is an almost unquestioned belief that social security administration can only be carried out through a factory-style operation, with pervasive use of IT to deliver both scale and the complexity of benefits that follow. But this is the second and perhaps even more fundamental weakness of current plans. Even if the Universal Credit IT system is built, the service will fail. This is because taxation, credits and benefits are high-variety services that computers are poorly equipped to handle. Using computers to deliver the service depends on codifying in rules the eligibility and entitlements of claimants of every type and condition. Since the rules can never completely specify all the possible variations, the predictable consequence will be poor-quality, hard-to-get services for the most vulnerable in society. The provision will not match the need. The knowledge and awareness of local context that are critical for dealing with claimants’ individual circumstances will be lost as local authority housing benefits offices are slimmed down or closed and claimants are instead pushed through the DWP system (DWP, 2010).

A revealing glimpse into the distressing way the government intends to treat benefit claimants in order to fit their scale designs was provided in September 2012 (Ramesh, 2012). In preparation for the Universal Credit, the government had set the DWP a target that 80 per cent of new claims for unemployment benefit must be made online by September 2013. The DWP, in its determination to force all benefit claimants to use online services, therefore began deliberately putting claimants on hold when they rang DWP call centres, in order for the claimant to listen to injunctions to go online. If the claimant were to hold on in order to eventually speak to a call centre agent, then the agent would make a further attempt to convince the claimant to switch to an online service.

This aggressive treatment of claimants is driven by an obsession with cost. Paradoxically, such behaviour toward claimants will inevitably drive costs up. The assumption is that web-based transactions will be cheaper. However, this is to confuse transaction costs (which will indeed be lower online) with the true costs of service, which are determined by the total number of transactions it takes for citizens to get a service. The failure of the web-based service to resolve individuals’ problems will multiply those transactions, generating massive amounts of failure demand as vulnerable citizens keep returning until their needs are met. It is most unfortunate that what we have called scale thinking has been allowed to impede an initiative with the potential to improve the life-chances of the poorest in society. The political imperative to dictate not just the “what” but also the “how” of policy has meant that the Universal Credit is destined to fail. How best to deliver a policy ought to be treated as an empirical question, not one of managerial ideology. However, decisions about the delivery of the reform have been taken based not on careful learning and experimentation but instead on a set of management nostrums about how best to cut costs.

What do we discover when we study housing benefits as a system?

Failure demand is a systems concept. Absent any understanding of the conceptual foundations behind the idea, the opportunities it provides for radical improvement will be missed. As a “product”, the Universal Credit is obviously different from anything that has gone before. However, we can learn much about how to deliver it from experience in housing benefits. Having analysed their housing benefits service as a system, many British local authorities have delivered radical improvements; similar results could be achieved if the designers of the Universal Credit followed the same procedure.

In the early years of the New Labour government, Gordon Brown, then Chancellor of the Exchequer, famously asserted there would be no investment in public-sector services without reform (The Economist, 2007). The DWP persuaded him to invest GBP 200 million in promulgating a new design for the delivery of housing benefits. It was one of the earliest attempts to impose a separate front/back office design in public services. The front office provides the means of access or front door, while claims are processed at the back, the two being connected by electronic work flow in which documents received at the front are scanned and transmitted electronically to the back. Included in the design were targets for both front (how quickly people should be seen, phones picked up and documents scanned and sent to the back office) and back offices (how quickly correspondence should be responded to and claims processed, and how many work activities carried out).
When housing benefits services are studied as systems, the flaws in this design become quickly apparent. Analysing demand reveals that, unsurprisingly, very few people present with all the documentation needed to establish eligibility and entitlement to hand. But to conform to front office targets and service standards, whatever is brought in is processed and sent to the back office. This leads to mounting backlogs as back office workers struggle to find and bring together the various electronic “work objects” belonging to each case into a single “work object” that can be used to do the “value” work (establish eligibility and entitlement). Since floating work objects are frequently lost, people find themselves being asked to bring in documents again that they had already produced before. It is not uncommon to find that 20 per cent of objects in the electronic system are duplicates. Meanwhile, to meet their activity targets, back office workers send out letters and forms requesting more information rather than attempting to resolve the claim. Because there is no continuity or case ownership, each new piece of information requires the case to be started all over again, so the worker has to ask: does this complete the picture, generating still more information requests. The back office becomes a repository of electronic “work objects” and the job of the workers is to process a number of work objects each day. Much of this work is “re-work”, adding no value. As the work accumulates in the back office, it creates increasing volumes of failure demand in the front office too.

One consequence is that claimants return to the front office repeatedly to get their problems solved, increasing tension and lowering staff morale (hence the posters in many offices threatening dire consequences in the case of aggressive...
behaviour towards staff). Another is that, to tackle massive back office backlogs generated by compliance with the DWP design, local authorities have not only been encouraged to spend tens of millions of pounds employing private-sector “backlog-busters” to search for lost information (i.e. to solve the wrong problem); they have also been exhorted by DWP, the Audit Commission and the 2004 Gershon review to share and/or outsource back office housing benefits services (Audit Commission, 2008). Reflecting the government’s unshakeable belief in economies of scale, sharing back offices makes matters worse, adding to already high costs and poor service. Indeed, having a back office itself is a design mistake (Seddon, 2010 and 2011).

The first step in understanding the system is to look at demand from the claimant’s point of view. There are two types of demand: “value demand” – “demand we want”, i.e. that the service is set up to provide for – and “failure demand”. In the case of housing benefits there are only two value demands: “Can I make a claim?” and “I have had a change in my circumstances”.

Failure demand includes progress chasing (“What has happened to my claim?”, “I don’t understand how to fill in your form”), having to bring in duplicate documents, making repeat visits – all of which create demands on the system, and therefore more work, caused by a failure of the service to work from the claimant’s point of view. We find that failure demand typically accounts for as much as 70 per cent of the total demand into housing benefits services – all of which are in full compliance with the DWP’s directives.

When they analyse demand, managers are invariably shocked to discover that despite meeting all their targets, service quality from the claimant’s point of view is appalling. The end-to-end time for claimants to receive a service typically averages 50 days and can rise to six months. A queue at a benefits front office will often contain people who are turning up for the fifth, sixth and up to tenth time. Making employees work harder is no solution – it is the design that is the cause of poor performance, and at the heart of the design is management by targets. There is a paradox here. Working to targets actually makes performance worse. But meeting targets is the way to win approval from government inspectors.

The second step in the Vanguard Method is to design the service against demand. The idea is simple but profound: the service should be designed to make it easy for the customer to “pull value” (get what they want) from the system. Knowing the type and frequency of demand – why citizens make demands on the housing benefits service from their point of view – puts people in a position where they can design a service that works.

As we have noted, there are only two value demands in a housing benefits service: “I want to make a claim”, and, “my circumstances have changed”. We shall use the former – “I want to make a claim” – to illustrate the approach. The
claimant demand dictates the value work – the things that need to be done to satisfy that demand. In this case the value work consists of:

- Obtaining “clean” information (a complete picture of the claimant’s circumstances).
- Making a decision.
- Notifying the claimant.
- Paying the claimant (if entitled).

Knowing the type and frequency of demands for claims, it makes practical sense to equip the people at the first point of contact with the necessary expertise to respond to high-frequency predictable demands – demands which the organization knows it can expect. That is to say, it makes no sense to train everybody in everything; but it does make sense to train people to handle the bulk of the predictable work. When more unusual demands hit the system, people working at the point of contact “pull” expertise from others equipped to handle such cases. This design principle keeps the ownership with the person providing the service and, consequently, speeds up their rate of learning – as they meet more “less frequent” demands they develop the skills and knowledge required to deal with them.²

In practice, many benefits claims are tied up with claimants’ council tax obligations. It follows that the expertise required to deal with the council tax implications should be designed into the roles of those who work at the point of transaction with the claimant (which also happens to be something that the current design for the Universal Credit will be unable to do, having been designed to be administered by different government agencies to those responsible for council tax benefit (Adam and Browne, 2012).

Finally, to understand how well a service is working it is necessary to measure achievement of purpose from the claimant’s point of view. This means precise calculation of end-to-end times, from when claimants first present to the point where they receive the correct money or are told they do not qualify. Taking the Vanguard approach, an authority will typically process all benefits within three to six days, a result so far beyond the government benchmark of 28 days that no one would dream of setting it as a target.

². Systems designs challenge the current norm of “dumbing-down” service (hire cheap people, give them scripts and computer-based diagnostics). Traditionally workers are trained against procedures, subjects and rules. This is why, despite the time it takes, conventional training often leaves people both poorly equipped to answer calls and understandably nervous. Every one of us has had experience of talking to call-centre workers who are unable to solve our problem. Instead, people who deliver services need the expertise required to identify and deal with the complexity and variety of customer demands. If they have been trained against demand, staff know exactly how to get help for calls for which they are not trained. Training against demand engages the workers in solving the problems that benefits claimants present with, ensuring that there is continuous improvement. However, the consequence of such “smartening up” is a fall in costs – the organization learns to do the “value work” and only that, driving waste out of the system.
Unfortunately, councils following this approach have found themselves in trouble with government bodies. The inspectors inspect against the specifications, and in these designs, however successful in performance and cost terms, they cannot “tick” their boxes (target-monitoring, plans for sharing services, etc). All too often inspection coerces managers to do the things inspectors have been sent to monitor, not the things that meet customer demand; to fail inspection did not look good in the then Labour government’s “targets and terror” regime (Hood, 2006).

It is salutary to contrast the performance of these authorities with that of the departments which have followed the various scale-based reform edicts of government. As noted above, HMRC’s operations represent the most egregious example of the failure of command and control, scale-based thinking. HMRC’s amalgamation by then-Chancellor Gordon Brown was in itself an example of official obsession with scale and centralization. In a classic case of service industrialization based on the belief that taxation service can be mass-produced like a manufactured product, HMRC has gone “lean” and gone wrong (Seddon, 2012). Their work has been standardized and specialized. The management’s focus is on activity, not achievement of purpose. In a misguided attempt to create a performance culture, workers are set to solving management’s wrong problem – “why didn’t we meet our targets yesterday?”

While HMRC managers assure parliamentary select committees that lower transaction costs will bring improvement, the evidence is of mounting failure demand (House of Commons Treasury Committee, 2011; BBC, 2010, Warwick-Ching, 2011). Accountants have built websites to complain about the number of transactions it takes to get a service. Even when callers to HMRC’s call centres can get through they are left uncertain about the advice they have received (Barrow, 2011). AdviceUK, the umbrella for welfare advice organizations, has established that it is costing member organizations across the country at least GBP 500 million per year to mop up failure demand downstream from HMRC and the equally dysfunctional DWP (AdviceUK, 2008).

HMRC exemplifies the fallacy of scale thinking: the belief that improved efficiency can be achieved through lower transaction costs, staff specialization and work standardization, using an IT “solution” as the means. It fails because it mistakenly assumes that the fact that some channels are inherently cheaper than others is more important than the design of the system. Unfortunately, the lower cost of transactions is more than wiped out by rising failure demand, which means that the total number of transactions it takes customers to get a service goes up. Based on the central idea that costs are associated with activity, service managers bear down on exactly the wrong lever and drive their costs up.

Despite the evidence from “flagship” programmes such as HMRC, however, scale assumptions remain all pervasive. A telling example is a recent National Audit
Office (NAO) report detailing the failure of United Kingdom scale-based shared service ventures, which then manages to draw all the wrong conclusions (NAO, 2012). Replete with compelling evidence of the cost of failure, the report concludes (where have we heard this before?) that the problem is implementation and that the answer is to do it better. In particular shared services have failed, according to the report, because providers have mistakenly “customized” services for clients instead of forcing them to standardize in the cause of both economy and, even more alarmingly, the requirements of the IT platforms – a remarkable example of reversing the proper position of cart and horse. Ignoring its own evidence, the report concludes that Cabinet Office pressure on departments to share services, combined with stronger governance and project management, will ensure the failures are avoided in the future (Best, 2012). This is a good example of “doing the wrong thing righter”, as Russell Ackoff put it, which actually makes things “wronger” (Stern, 2009).

**Service is not the same as manufacturing**

As we have noted above, many of the attempts to industrialize service come from a misguided attempt to reproduce the scale economies of Adam Smith’s pin factory and Henry Ford’s car plants. Manufacturing can survive command and control management (albeit at a cost) because products are standard; there are economies of compliance. But service differs in crucial respects from manufacturing. Aside from the obvious lack of physical manufacture, a service is co-produced by the customer and the service agent. Variety of demand is inherently greater. Instead of thinking of the system as one that pulls physical parts together to manufacture at the rate of customer demand, as in manufacturing plants modelled on the Toyota Production System (Ohno, 1988), the system must be conceived as one that brings (largely) intangible expertise together in response to the variety of customer demands. A different purpose requires different methods, since there are different problems to solve. Solving these problems shows how to design services from which customers can “pull value” (i.e. get what they want).

When applied to service organizations, the traditional command and control scale design responds to the variety of customer demands by establishing procedures, standard forms, functions, levels, specialized “factories” and the like to deal with it. The consequence is enormous amounts of waste. To eliminate the waste it is necessary to dismantle the functional structures and “put variety in the line”.

Conventionally-schooled managers believe that this will take time. This is partly because of how they think about change. It is also because of what it implies for their past identity and effort. In the name of “service” many of our organizations have been built as mass-production factories subjected to detailed programmes of activity directed by managers. Often this represents a significant investment in
human and financial resources. To undo or redirect this effort represents a considerable psychological as well as intellectual challenge.

Maximizing the ability to handle variety is central to improving service and reducing costs. The systems approach employs the ingenuity of workers in managing and improving the system. It is intelligent use of intelligent people; it is adaptability designed in, enabling the organization to respond effectively to customer demands. Workers are connected with customers in self-organizing relationships. In managing flow the work itself is the information, and this in turn comprises the information required to direct operations in the work.

People are good at handling variety. Computers are not. As managers develop the systems approach, they learn to use computers for the things they are good at and *a contrario* avoid using computers for things that people are good at. The consequences are fewer computer systems and more control. The value of IT lies in supporting those who deliver service; in scale designs, IT systems dominate and hinder the delivery of good service. Computers have become the cement for command and control management, reflecting the unquestioned assumption that managers should set targets and then create control systems – incentives, performance appraisals, budget reporting and computers to keep track of them. On the contrary, to make service organizations work better, it is necessary to take these things out.

**Evidence-based policy**

The redesigned benefits service examples demonstrate better service to claimants, at much lower cost, as well as better relationships with people who need support. There are further positive unintended consequences: benefits staff have learned to see their job as helping people to solve their problems (e.g. with housing services, other related benefits such as free school meals, health services), not just administering benefits – a perspective it would be impossible to take in a fragmented scale design (Middleton, 2010). In addition there is clear evidence that fraud detection is far more effective in these local designs than in the nationally-organized framework.

Returning to the “core paradigm” embedded in the proposals for the Universal Credit, we contend that it contains three major flaws:

- It treats all demand as “work to be done” ignoring, *inter alia*, the importance of understanding failure demand.
- It assumes that individuals should be held accountable for their work. In fact, as W. Edwards Deming taught, 95 per cent of individual performance variation can be shown to be attributable to the way the work is designed and managed – the system – and is thus the responsibility of management (Deming, cited in Scholtes, 1998, p. 296). Holding individuals “accountable” results in sweatshop...
conditions – DWP call centres are described as “living hell” by staff who carried out a two-day strike (Davies, 2011) –, while HMRC is disfigured by a long-running dispute on performance measurement (Gall, 2008) and disastrous staff relations.

- It fails to absorb the variety of service demand. By ignoring the nature of demand and measuring and managing activity, as above, it ensures that costs will rise and services worsen. In both HMRC and DWP, work has been standardized on the assumption that standardization leads to lower costs; in fact, along with specialization, it is a primary cause of failure demand and thus raises costs.

Under government proposals, full implementation of the Universal Credit will take seven years and a massive investment in IT. This is a hopeless formula for absorbing variety and will generate – as it always does – enormous amounts of failure demand, citizen dissatisfaction and cost. By contrast, if what constitutes the Universal Credit could be defined today, housing benefits offices redesigned along the lines described above could provide it quickly and efficiently in a matter of weeks. In fact, to ensure that the Credit is fit for purpose, these offices should be used to develop the rules, taking risk out of the solution.

The essence of the better design is i) to provide the necessary expertise at the first point of contact to satisfy all of the predictable “value” demand (a claim or a change of circumstances); ii) to allow agents to “pull” expertise for the less predictable demand, using measures that relate to the purpose (the right money to the right people as quickly as possible); and iii) to switch management’s focus from managing activity to managing the whole system’s achievement of purpose. Using these joined-up principles, housing benefit offices have subsequently learned another lesson. People’s needs and problems come in a variety of interlocking forms and guises; solving them all at first point of contact offers huge potential (if usually invisible) cost savings since it reduces knock-on demand on other services. In contrast with factory designs such as HMRC and DWP, morale in public services designed on these lines is invariably high because people are intrinsically motivated, illustrating Herzberg’s dictum that the best way to get people to do a good job is to give them a good job to do (Herzberg, 1987).

However, despite the growing evidence of both failure of scale (e.g. in Western Australia,3 the United Kingdom’s Research Councils4 or the United Kingdom’s

3. Western Australia’s Department of Treasury and Finance Shared Service Centre promised savings of AUD 56 million, but incurred costs of AUD 401 million (Western Australia Economic Regulation Authority, 2011).
4. A National Audit Office report said that the Research Councils’ project was due to be completed by December 2009 at a cost of GBP 79 million. But, in reality, it was not completed until March 2011, at a cost of GBP 130 million (NAO, 2011).
Department of Transport\textsuperscript{5} shared service disasters) and success (Vanguard Method designs have been successful and documented in the United Kingdom, New Zealand (Middleton, 2010), Netherlands and Sweden), policy-makers stick to plausible but wrong ideas. Unfortunately – and this is the deep sadness of our political system – politicians do not “do” evidence. Politicians do narrative; they worry more about how to handle fierce television interviewers than whether their initiatives will work. As Alex Stevens (2011) has shown, Whitehall\textsuperscript{6} is a policy-making machine that prefers certainty to accuracy, action to contradiction, and only accepts “evidence” that fits the story already being told. Policy is based on systematic distortion of evidence. Hence the continued promotion of “scale” ideas despite overwhelming evidence of failure. The costs associated with failure, massive at any time, are even more glaring in a period of austerity. But never mind the evidence of previous IT-based scale failures, “digital by default” fits the government narrative. Politicians argue for the need to hold local public services to account, but in this context accountability is reduced to little more than compliance with centrally-promulgated ideas. As the Finnish educator Pasi Sahlberg puts it, “Accountability is something that is left when responsibility has been subtracted” (Partanen, 2011).

What we have learned from working with public services in various countries is that the structure of government (whether devolved or centralized) is not the critical factor. What does make a difference, however, is the amount and nature of control exercised through specifications – with which services must comply – and inspection, the means for ensuring compliance. Where any agency mandates matters of method and measures, the inevitable problems ensue. The ability to mandate method and measures has to be removed from all agencies and made the responsibility of managers who deliver the service. This change to the locus of control is an essential prerequisite for innovation.

One element of control is the requirement for “improvement” to be planned, resulting in massive investment in bureaucracies of interpretation, planning, project management, administration, report-writing and self-publicity, all of which are a huge stumbling block to innovation. As all the pioneers described here have learned through experience, change is an emergent property, so that having a plan for it is a contradiction in terms. The priority for management is to study

\begin{itemize}
\item \textsuperscript{5} The Department for Transport’s Shared Services, initially forecast to save GBP 57 million, is now estimated to have cost the British taxpayer around GBP 170 million, a failure in management that the House of Commons Public Accounts Committee described as a display of “stupendous incompetence”. The most recent evidence of the higher cost was documented in a House of Commons Transport Select Committee report (2010).
\item \textsuperscript{6} Whitehall is recognized as the centre of Her Majesty’s Government. The street is lined with government departments and ministries; the name “Whitehall” is thus also frequently used as a metonym for overall British governmental administration, as well as being a geographic name for the surrounding area.
\end{itemize}
their systems, to get knowledge; to understand how their current work designs sub-optimize performance; to discover the importance of understanding real customer demand; and to learn how to design a system to serve it. En route they discover the counterintuitive truth that economy comes from flow, not scale.

Concluding thoughts

To conclude, this article calls for more evidence-based policy. In public services all over the world, there is a ferment of activity in which small groups of dedicated people are enthusiastically demonstrating that better economics follow from delivering services that are truly local. Many examples of success have been published (Middleton, 2010; Pell, 2012) and more are to come in books and case studies. This is real evidence, but the concern is that it is so much against the grain of opinion and current political narrative that it seems impossible for many minds to comprehend. Many governments, with their ingrained command and control, top-down perspectives, cannot or are unable to accept this evidence. Whilst this article has focused on the flaws of the particular social security reforms planned for the United Kingdom, what is crucial is that governments internationally recognize that the centre must be able to support innovation where it happens locally, rather than crushing it through specifying methods for delivery. Our hope would be for governments to declare a single policy initiative: henceforth responsibility, the prerequisite for innovation in the delivery of services, will be placed firmly where it belongs, with local service leaders.

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The Achilles' heel of scale service design in social security administration


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Gaps in social protection for health care and long-term care in Europe: Are the elderly faced with financial ruin?

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Abstract

While public expenditure on health care and long-term care (LTC) has been monitored for many years in European countries, far less attention has been paid to the financial consequences for older people of private out-of-pocket (OOP) expenditure necessary to access such care. Employing representative cross-sectional data on the elderly populations of 11 European countries in 2004 from the Survey of Health, Ageing and Retirement in Europe (SHARE), we find that OOP payments for health care and LTC are very common among the elderly across European countries and such expenditures impact significantly on disposable income: up to 95 per cent of the elderly make OOP payments for health care and 5 per cent for LTC, resulting in income reductions of between 5 and 10 per cent, respectively. Failure to prevent financial ruin, as a consequence of excessive OOP payments, is evident in 0.7 per cent of elderly households utilizing health care and 0.5 per cent of elderly households utilizing LTC. Those particularly concerned are the poor, women and the very old.

Keywords

long term care, consumption of health care, older people, poverty, Europe

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Introduction

In many countries, access to health care and long-term care (LTC) requires co-payments, user fees and other private expenditure – despite individuals having coverage under social protection systems such as National Health Systems or social health and long-term care insurances (ILO, 2008). Catastrophic health expenditure – defined as expenditure exceeding 40 per cent of subsistence income – might force the most vulnerable into debts and poverty (Xu et al., 2007). Although most studies to date have focussed on the effects of out-of-pocket (OOP) expenditure in developing countries (Bredenkamp, Mendola and Gragnolati, 2011; Van Doorslaer et al., 2007), recent research (Xu et al., 2007) has reported that catastrophic health expenditure is a source of impoverishment for 0.6 per cent of households in developed countries – including in Europe, the focus of this article. If needed health care and LTC services are affordable only for the better off, social protection systems might aggravate rather than mitigate inequality. Further, the negative effects of such catastrophic health expenditure combined with the public budget restraints created by the current eurozone debt crisis might weaken the ability of European social protection systems to achieve their goals.

The elderly population’s double burden of having to meet expenditure on health care and LTC is not a new phenomenon. However, while the levels of public expenditure on health care and LTC constitute a major concern for European governments and key international organizations (European Commission, 2009; OECD, 2011a, 2011b), the financial impacts of private OOP expenditure encountered by the elderly have attracted less attention in public debates.

The situation of elderly persons such as Talia S., an 81 year-old woman living on a small Greek island, is representative: having worked all her life as a contributing family worker on her husband’s farm, Talia S. is now living on a farmer widow’s pension of EUR 400 per month. Despite being covered by a special social health protection scheme for agricultural workers, cost sharing regulations result in her spending more than 5 per cent of her income, out of pocket, on co-payments for needed health care and pharmaceuticals. In turn, another severe financial burden that consumes 10 per cent of her income is the cost of nursing care needed to perform basic living activities such as washing and dressing. Given additional expenditure (for example, for housing, food, insurance payments, and for transportation to medical facilities, etc.), her monthly expenditure exceeds the income from her small widow’s pension: Talia S. cannot afford the payments for nursing and health care without becoming a financial burden on her two sons and their families.
Given the process of demographic ageing across European populations, the widening gap in financial protection for health care and LTC for the frail elderly has become an issue for more and more people – often for people that are already challenged by economic vulnerability. This issue is included in a broader debate on the consequences of demographic change for social security systems (Bloom and McKinnon, 2010). Among those most concerned are members of the population cohort aged 85 or older (85+). Between 1994 and 2010, the average growth rate of this population cohort grew nine times faster than the rest of the European population (Figure 1).

Against this background, this article examines the financial impacts on the elderly of private OOP expenditure on health care and LTC in selected European countries. In particular, we seek to address the following key questions: What is the financial impact on the frail elderly of direct private expenditure on health care and LTC? As a consequence of European welfare states providing inadequate levels of social protection coverage for necessary care, which thus necessitates OOP expenditures, how common is individual financial ruin? Among the frail elderly, who are the most vulnerable in having to shoulder these costs?

We define the “elderly” population as those aged 50 or older (50+). Where possible, we further distinguish between households with members that are aged 50+, 65+ or 85+.

After presenting a brief overview of social protection systems for health care and LTC, key factors characterizing the burden of OOP expenditure on the elderly across countries and within specific groups are analysed. We identify the frequency and impact on households’ income of OOP expenditure for health care and LTC. This allows us to evaluate the extent to which social health protection systems offer adequate protection to the elderly. Moreover, we present the characteristics of those who are the most vulnerable among the frail elderly in having to shoulder the costs of living longer.

We employ nationally-representative data from the Survey of Health, Ageing and Retirement in Europe (SHARE 2004) on the elderly population in eleven European countries for the year 2004, which was released at the end of 2009 (SHARE, release 2.3.0). The sample is representative for the elderly population in Austria, Belgium, Denmark, France, Germany, Greece, Italy, the Netherlands, Spain, Sweden and Switzerland. The database includes micro data on health,

1. This article is largely based on the broader study by Scheil-Adlung and Bonan (2012).
2. SHARE release 2.3.0, 13 November 2009. SHARE data collection in 2004–2007 was primarily funded by the European Commission through its 5th and 6th framework programmes (project numbers QLK6-CT-2001-00360; RII-CT-2006-062193; CIT5-CT-2005-028857). Additional funding by the United States’ National Institute on Aging (grant numbers U01 AG09740-13S2; P01 AG005842; P01 AG08291; P30 AG12815; Y1-A-AG-4553-01; OGRA 04-064; R21 AG025169) as well as by various national sources is gratefully acknowledged <http://www.share-project.org>.
socio-economic status, and social and family networks of individuals aged 50+ from 19,411 households (28,357 individuals). Point averages are provided, thus the results may be imprecise estimates of population averages. Calibrated cross-sectional weights are employed to minimize the potential selectivity bias.

Figure 1. Average population growth rate 1994–2010 (percentage), by major cohorts, across European countries

Note: EU 27 = All of the above countries, except Andorra, Iceland, Liechtenstein, Norway and Switzerland. Source: Authors’ calculations based on EUROSTAT.
generated by non-respondent households and individuals (Klevmarken, Swensson and Hesselius, 2005, pp. 28-69).3

**Social protection for health care and LTC in Europe:**

**Key characteristics**

Nearly-universal population coverage for health care could be achieved by the two predominant health financing mechanisms in Europe: National Health Services funded by taxes; and social insurance schemes based on payroll contributions. In many countries, however, we see a mix of components taken from both models. A third financing mechanism – OOP payments – is found to a varying extent in almost all countries and is linked to the utilization of services (Scheil-Adlung and Bonnet, 2011).

Many countries with National Health Services, such as Italy and the United Kingdom, have adopted the same financing mechanism for LTC (Table 1). These systems are sometimes means-tested and thus provide coverage to the poorest sections of the population only. Countries operating social insurance health care schemes often establish social assistance tax-funded LTC schemes; Germany, however, has introduced a separate mandatory social insurance scheme for LTC.

In Europe, the scope of medical health benefits is broadly comparable and largely complies with the International Labour Organization’s Social Security (Minimum Standards) Convention, 1952 (No. 102). LTC benefits, however, show a large variation across countries. They are provided either in cash (as in Belgium), in kind (as in France), or as a combination of cash and in kind (as in Austria, Germany, the Netherlands and the United Kingdom) (Scheil-Adlung and Kuhl, 2011).

LTC benefits include a wide range of non-medical support services provided over a prolonged period. Eligibility is frequently based on the presence of chronic conditions or disabilities defined as the inability to perform basic “activities of daily living” (ADL). Limitations in dressing, walking, washing, eating and using the toilet autonomously, for instance, might be taken into account when evaluating the degree of disability that will define the level of benefits to be paid. Typical in-kind LTC benefits consist of services provided at home or in nursing homes, as is the case in the Nordic countries (Denmark and Sweden). These may be supplied by either the public or the private sector. Cash LTC benefits consist of allowances to finance the provision of LTC. Such benefits may be used to purchase services directly from LTC providers, to cover private expenditure, or to provide income for

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3. For further description of the survey, methodologies, sampling and weights, see Klevmarken, Swensson, and Hesselius (2005).
informal carers. Cash benefits might be means-tested (Spain and the United Kingdom), or flat-rate (Italy), or their value may depend on the severity of the assessed incapacity or inability to perform basic ADL (Austria, Germany and Spain). A common situation is that benefit amounts are often insufficient to cover the total cost of LTC occurring to the elderly, thus making additional private expenditure necessary.

Besides issues of the affordability, effective access to health care and LTC services is linked to the availability of related services – for instance, services requiring a sufficient number of professional health and nursing care staff or the existence of infrastructure, especially in rural areas. Particularly as regards LTC,

### Table 1. Key financing mechanisms for health care and LTC, selected countries

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<th>Countries using social health insurance</th>
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Sources: SSA and ISSA (various years) and ILO databases.
there is an important shortage in the formal nursing workforce: estimates suggest that formal LTC workers constitute a significantly smaller share of total caregivers than informal workers, and the proportion of foreign-born workers in home care exceeds that of local workers in most European countries (Fujisawa and Colombo, 2009). Thus, all too frequently, those in need have to rely on informal carers – such as family members or skilled or unskilled workers from abroad, who might be legally or illegally contracted by private households. As a result, informal care plays a crucial role in filling gaps in the availability of services and can be a severe drain on private expenditure.

**Public expenditure on health care and LTC**

Among the initial fifteen Member States of the European Union (EU-15), public health care provision constitutes the second largest public expenditure item for the elderly after pension schemes (Rodrigues and Schmidt, 2010; Huber et al., 2009), ranging from about 5.5 to 8.5 per cent of GDP.

Far less public resources are devoted to LTC expenditure: ranging from under 0.5 per cent of GDP, as in Greece and Spain, to around 3.5 per cent, as in the Netherlands and Sweden. Most commonly, countries employ between 1 to 1.5 per cent of GDP (Figure 2). This very low percentage might point to gaps in financial protection (i.e. the level of LTC benefits is frequently inadequate to cover the costs of services), meaning that paying for the cost of needed care has to be met in part through private resources.

In many countries, the use of public LTC funds is linked strongly to care provided by skilled professionals, particularly in an institutional care setting (Rodrigues and Schmidt, 2010). Thus, country variations in LTC expenditure might reflect differences in salaries, which stem from national preferences for formal versus informal care.

**The burden on the elderly of private expenditure on health care and LTC**

What is the burden on the elderly of private expenditure on health care and LTC? For our purposes, we assess the burden with respect to:

- the utilization of health care and LTC services by the elderly;
- the incidence of OOP expenditure for health care and LTC; and
- the related depth of impact on elderly income.

4. The EU-15 Member States are: Austria, Belgium, Denmark, Finland, France, Germany, Ireland, Italy, Greece, Luxembourg, the Netherlands, Portugal, Spain, Sweden and the United Kingdom.
Further, we seek to identify the common socio-economic characteristics of the most vulnerable groups concerned.

The SHARE database on the elderly population for the year 2004, released at the end of 2009, allows us to evaluate the financial burden on the elderly in 11 European countries: Austria, Belgium, Denmark, France, Germany, Greece, Italy, the Netherlands, Spain, Sweden and Switzerland.

**Utilization of health care and LTC services by the elderly**

The utilization rates of health care and LTC services are important indicators to help understand the elderly population’s financial burden. The more frequently services are utilized the greater the financial impact of OOP expenditure, especially if the design of the social protection system has left gaps in financial protection. Further, equity concerns might be raised if significant differences in utilization rates across income groups occur despite equal needs.

Analysis of the data reveals that:

Figure 2. Public expenditure on health care and LTC (percentage of GDP), selected countries, 2008

Sources: OECD (2011b); OECD Health Care Data 2010 (data for Greece are for 2007); Netherland health care public expenditure for 2008 from World Bank, World Development Indicators <http://data.worldbank.org/data-catalog/world-development-indicators>; LTC data for Italy from Huber et al. (2009).
Between 80 and 90 per cent of the elderly in European countries utilize outpatient health care. The number of persons aged 50+ that reported medical doctors’ visits in the past year ranges from around 80 per cent in Denmark to more than 90 per cent in Belgium and France (Scheil-Adlung and Bonan, 2012).

A significant percentage of the elderly utilize inpatient care. The share of the elderly hospitalized for at least one night varies between 9 per cent in Greece and the Netherlands and 20 per cent in Austria.

Utilization of health care services is generally equitable across income groups in European countries (Van Doorslaer et al., 2000; Van Doorslaer and Masseria, 2004).

Utilization of LTC shows stark variations across countries (Figure 3). The significant variance across countries might be explained by factors such as differences in family size and employment rates of female members that might impact on informal care from family members, the extent of informal labour markets for nursing care, and the affordability and availability of formal services. Across all countries, a high share of the population aged 80+, ranging from 13 per cent (Spain) to 45 per cent (Switzerland), utilizes LTC; the utilization rate of the

Figure 3. LTC users as a share of reference cohort (65+ and 80+), selected countries, most recent available data (2007–2009)

Source: Authors’ calculation based on OECD Health Data 2010.
population aged 65+ varies from around 5 per cent (Spain) to close to 20 per cent (Switzerland).

- Care at home prevails significantly for all age groups, while public expenditure is focused on institutional care (Rodrigues and Schmidt, 2010; OECD, 2011a, 2011b). Thus the funding priorities supported by public policy (institutional care) may not be sufficiently adapted to the elderly population’s preferences for care (at home), resulting in the need for higher private expenditures.

The need for LTC is formally defined in relation to the assessed limitations of a person to perform ADL autonomously. However, utilization rates are likely to reflect additional factors such as:

- Income, which plays a crucial role in privately meeting the costs not covered by social protection systems.
- Constrained availability of services, owing to gaps in the workforce.
- Tight eligibility criteria.
- Limited scope of in-kind and cash benefits, which prevent access to needed services.
- Gaps in financial protection, resulting in co-payments.

While these factors are also important to the utilization of health care, they are more relevant for LTC. This is so because of the limitations of in-kind and cash LTC benefits and the severely constrained nature of the nursing workforce in most countries, even in those with significant numbers of irregular domestic workers from abroad.

In some of the countries observed (Belgium, Denmark, France, the Netherlands, Spain and Sweden) more people in the lowest income quintile suffer from limitations as regards performing ADL than people in the highest income quintile (Scheil-Adlung and Bonan, 2012). This difference is reflected in the higher utilization rate of LTC by the elderly in the lowest income quintile (Figure 4).

However, in some countries (Austria, Germany and Italy) the elderly in higher-income groups utilize more LTC than those in lower-income groups. Possible explanations of these inequities in utilization rates within countries include strict eligibility criteria and assessments of the ability to perform ADL. These might exclude the poor from access to needed care and lead to non-utilization owing, both, to insufficient financial protection of lower-income groups and gaps in the availability of preferred services at home for the poor as compared to the rich.

5. Household income is defined as annual household total gross income, i.e. for all household members, the sum of the individual values of employment income, pensions (all types), LTC insurance and interest payments (all type of investments). Income does not include private transfers e.g. from family members, savings or assets. All nominal amounts are converted into euros.
Incidence of OOP expenditure on health care and LTC and its impact on the income of the elderly

What is the incidence of OOP expenditure among the elderly? What share of the population resort to the use of OOP payments? To what extent does OOP expenditure impact on the income of the concerned households? Key aspects to be tackled in this context relate to the frequency and severity of OOP expenditure.6

The following evaluation across selected countries reports on OOP expenditure for health care and LTC for elderly households as a share of these households’ total gross income. This allows us to compare the effectiveness of social protection systems in terms of financial protection and equity of outcomes, regardless of the cost of services and differences in living costs.

6. We define OOP expenditure for health care as the sum of the costs of inpatient and outpatient care and prescribed medicines paid directly by individuals and not covered by social health protection systems. OOP expenditure for LTC is the sum of expenses for nursing home care, day care and home care not covered by social protection systems.
For the selected countries, the data highlight that between 75 and 95 per cent of elderly households with at least one member aged 50+ incur OOP expenditures for health care; shares of less than 50 per cent are observed only in France, the Netherlands and Spain (Figure 5).

Health-related OOP expenditure reduces the income of the households concerned by 1 to 5 per cent; it amounts on average to 2.5 per cent of the income of the elderly. Such expenditure sits at relatively low levels of less than 2 per cent in Austria, Denmark, France, Germany, the Netherlands and Sweden, but exceeds 5 per cent in Greece (Figure 6). On average, prescribed medication and outpatient care account for 46 and 44 per cent of this OOP expenditure, respectively, and have the most significant impact on households’ income.\(^7\)

\(^7\) The sample does not include households experiencing financial ruin as a consequence of OOP expenditure (defined as OOP higher than 100 per cent of income), therefore averages might be underestimated. The next section of this article addresses this subsample of the population.

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**Figure 5.** Percentage of elderly households with OOP expenditure on health care, selected countries, 2004

Source: Authors’ calculations based on SHARE (2004). Health care expenditure include prescribed drugs, inpatient and outpatient care. The sample includes households with at least one member aged 50+ with positive OOP expenditure on health care.
Comparatively lower shares of the elderly population incur OOP expenditure for LTC than for health care: on average, about 5 per cent of elderly households make OOP payments for LTC. However, the rates across countries range considerably from 1.6 per cent in Italy to close to 12 per cent in Belgium (Figure 7).

However, the impact of LTC on household budgets is much more important than OOP expenditure for health care: on average, the elderly households concerned allocate nearly 10 per cent of their income in the form of OOP expenditure for LTC services. Levels of expenditure equating to more than 10 per cent of income (Denmark, Greece, Italy and Sweden) may be considered severe, while the figure of around 25 per cent of income in Spain is unacceptably high (Figure 8). For the elderly who utilize both health care and LTC, OOP expenditure for LTC has a further deleterious impact on disposable income, given that it will have been already reduced, on average, by 2.5 per cent by OOP expenditure on health care.

**Figure 6.** Health-related OOP expenditure as a percentage of elderly household gross income by different items, selected countries, 2004

Source: Authors’ calculations based on SHARE (2004). Health care expenditure include prescribed drugs, inpatient and outpatient care. The sample includes households with at least one member aged 50+ with positive OOP expenditure on health care; the sample does not include households declaring zero income and positive OOP expenditure on health care and household with OOP > 100 per cent of income; averages are weighted accounting for unit non-response at household level.
How common is financial ruin as a result of OOP expenditure?

When the incidence and/or severity of OOP expenditures exceed a certain limit, the burden associated with such expenses may become unsustainable for the individual or household and create financial problems: financial ruin as a result of catastrophic expenditure refers to instances when OOP payments for either health care or LTC exceed 100 per cent of the household’s income. Reasons for this occurring include very low income and/or very high OOP expenditure on health care or LTC. That OOP expenditure may lead to financial ruin indicates major gaps in social health protection and LTC. This is particularly so as regards financial protection, the more adequate provision of which would obviate the need for current levels of OOP expenditure for health care and LTC.

Intolerably high OOP payments that result in financial ruin, as defined above, are observed in a significant share of the population in all the European countries observed. This is despite the existence of social health protection and

\[ \text{Source: Authors’ calculations based on SHARE (2004). Health care expenditure include prescribed drugs, inpatient and outpatient care. The sample includes households with at least one member aged 50+ with positive OOP expenditure on health care; averages are weighted accounting for unit non-response at household level.} \]
social protection systems covering LTC needs in these countries. On average, 0.7 per cent of elderly households in Europe utilizing health care and 0.5 per cent utilizing LTC experience financial ruin as a result of excessive OOP expenditure (Figure 9).

These figures are significant and alarming. At the country level, they correspond in Greece to 220,000 elderly households facing financial ruin as a result of OOP payments for health care and 170,000 elderly households facing financial ruin as a result of private LTC expenditure. For Italy, the corresponding figures are 50,000 elderly households facing financial ruin as a result of OOP payments for health care and 29,000 elderly households facing financial ruin as a result of private LTC expenditure.

For all countries in the sample, more households are burdened by excessive expenditure for health care than for LTC. However, the number of elderly
households confronted by financial ruin due to OOP expenditure for health care and LTC are not evenly distributed across Europe: this outcome is most common in Greece and Italy, with lower incidence in Denmark and Sweden.

Ruinous OOP expenditure for health care affects 2 per cent of elderly households in Greece, 1.8 per cent in Italy and just over 1 per cent in Austria. The percentage is between 0.1 and 0.4 per cent of elderly households in Denmark, France, Germany, the Netherlands, Sweden and Switzerland.

Ruinous OOP expenditure for LTC affects between 1.0 and 1.4 per cent of elderly households in Austria, Greece and Italy. The percentage is between 0.1 and 0.3 per cent of elderly households in Denmark, France, Germany, the Netherlands and Sweden.

Deficits in population coverage under social health protection systems as well as for systems of LTC can be considered as the root cause for these developments in all countries. Further, the uneven distribution of OOP expenditures across coun-

Figure 9. Percentage of elderly households paying more than 100 per cent of household annual gross income on OOP total health-care or LTC expenditure, selected countries, 2004

Note: The sample includes only household with at least one member aged 50+; the sample includes also households declaring zero income and positive OOP expenditure on health care and LTC; averages are weighted accounting for unit non-response at household level; health care expenditure includes prescribed drugs, inpatient and outpatient care.
Source: Authors’ calculations based on SHARE (2004).
tries also occurs as a result of differences in the generosity of social health protection and LTC systems. This is especially so as regards the financial protection of the frail elderly. No less relevant are insufficient benefit packages for health care and LTC that require additional private expenditure to address needs.

**Who are the most vulnerable?**

What are the socio-economic characteristics of those most at risk of impoverishment and financial ruin as a result of OOP expenditure? Co-factors that might determine high vulnerability include income and gender. The gender dimension seems to be particularly relevant: there are twice as many women as men in the elderly population. Further, women are more likely to be poor than men (Scheil-Adlung and Kuhl, 2011).

How many elderly households are concerned by OOP expenditure in the highest and lowest income quintiles? In these households, what percentage of household income is spent on OOP expenditure for health care and LTC?

In most European countries in our sample, OOP expenditure on health care takes up a higher share of household income from the lowest income quintile than for highest income quintile. Although OOP expenditure for health care is less than 1 per cent in all countries for the highest income quintile, households in the lowest income quintile have to pay as much as 11 per cent in Greece, about 9 per cent in Belgium and Italy, 8 per cent in Spain, and 2 to 3 per cent in Germany and Sweden (Figure 10). Given these results, we can conclude that age, gender and income are key factors affecting inequities in access to services.

Comparatively speaking, OOP expenditure for health care, as opposed to that for LTC, is a more common concern for higher-income elderly households. In contrast, OOP expenditure for LTC is a more common concern for lower-income elderly households (Scheil-Adlung and Bonan, 2012). Further, the impact of OOP expenditure on LTC as a share of household income is greater for the lowest income quintile than for the highest income quintile. For the lowest income quintile, it amounts to more than 10 per cent of income in elderly households in Greece, Italy, the Netherlands, Spain and Sweden. In contrast, the burden for the highest income quintile is below 2 per cent, except in Germany, the Netherlands, Spain and Sweden (Figure 11).

Across the sample of European countries, more elderly women than elderly men are faced with OOP expenditures for LTC (Scheil-Adlung and Bonan, 2012). Further, in most of the countries elderly women have higher OOP expenditures for LTC than do men. In France, elderly women have to spend as much as 6 per cent of household income, as compared to 0.1 per cent for men. Significant gender differences in OOP expenditure also occur in Greece and Italy. Generally, the extent of OOP expenditure to be paid by elderly women ranges from
nearly 13 per cent of household income in Spain to 2 per cent in Switzerland (Figure 12).

Further, there are more than twice as many elderly women living alone compared to men who incur OOP expenditure on LTC (Scheil-Adlung and Bonan, 2012). Thus, despite the importance of informal care delivered by family members in most countries (EC, 2009), women cannot rely on this form of support and are more vulnerable to higher levels of OOP expenditure.

**Summary of the comparative analysis**

The demographic and epidemiological characteristics of the population and their needs for health care and LTC are relatively comparable across the countries observed. However, there are significant differences in the incidence and severity of the impact of OOP expenditures and in the equitable sharing...
Incidence of OOP expenditure and utilization rates. In the countries examined here, public expenditure for LTC is extremely low (when compared to health care) and service delivery is focused on institutional care, which is not the considered preference for the majority of those in need; the preference is for nursing care at home. Institutional care is also more costly than nursing care provided at home (Scheil-Adlung and Bonan, 2012). In all the countries observed, the incidence of OOP expenditure for health care and LTC in elderly households is common. Financing mechanisms for health care and LTC (taxes or contributions) are unable to explain the differences across countries.

Severity of impact. The elderly – who often have low incomes in European countries – are faced by OOP expenditures for health care that range between 1 and 5 per cent of their income, mostly for medicines and outpatient care. In turn, OOP
payments for LTC amount to a minimum of about 5 per cent of income in elderly households. Thus, OOP expenditures for health care and LTC impact significantly on the net income of elderly households in all countries observed, reducing it by an important percentage. It is most likely that those among the elderly who are faced by OOP expenditure for health care will also have OOP expenditure for LTC.

Financial ruin due to excessive OOP expenditure for health care and LTC of more than 100 per cent of income occurs in all countries and concerns up to 2 per cent of the elderly population.

Across all countries, women – particularly those aged 80+ living alone – face the greatest risk of having to meet OOP expenditure for LTC.

**Equity in burden sharing.** Among the elderly, OOP expenditure on health care and LTC is resulting in significant inequities, with the gap in financial protection being more important for poorer households than for the wealthier:
• While wealthier elderly households are more likely to incur OOP expenditure for health care, the amount spent does not exceed a substantial amount of household income. Poorer elderly households, on the contrary, are less likely to incur OOP expenditure for health care – however, the impact on household income is more severe.

• Among poor elderly households, OOP expenditure for LTC is more common than OOP expenditure for health care. The related impact on household income is significantly higher for poorer than for wealthier elderly households.

Conclusions and policy implications

Root causes explaining the above findings relate to significant gaps in national social protection systems for both health care and LTC. Thus, while adequate social protection in health care and LTC is a human right and legislation does exist, such systems are not sufficiently implemented to adequately cover all elderly people in European countries. Gaps in European social protection systems for health care and LTC covering the frail elderly frequently result in high levels of OOP expenditure for the poorest, inequities in access to needed services and, for some of the most vulnerable, financial ruin.

Against this background and with a view to providing equitable access to available and affordable services for the elderly, policy interventions should urgently be centred on reforming social protection systems for health care and LTC. Necessary requirements are for:

• sufficient public funding for social protection systems with a view to minimize OOP expenditure;
• extending coverage and effective access to services by adjusting and implementing legislation;
• increasing the size of the workforce providing health care and LTC services;
• integrating social and health care services to better match the needs of the covered population; and
• improving the monitoring of impacts, for instance, by including gender-sensitive voice.

More specifically, policy considerations should focus on four main areas.

Making services affordable by closing the gaps in financial protection and minimizing OOP expenditure. The use of OOP expenditure for health care and LTC is a widespread financing practice across Europe, but one that should be minimized when aiming at achieving universal and equitable access to services. This might involve extending financial protection in the context of social protection systems with a view to reduce OOP expenditure to an acceptable level, increasing health care and LTC benefit packages, and loosening ADL eligibility and assessment...
criteria. It is particularly important to offer protection to those confronted by catastrophic expenditure and financial ruin.

**Making services available.** A priority must be to close the gaps in the availability of both formal and informal care. This will include providing sufficient funds for the health care and LTC needs of the elderly. Current shortages in the caregiving workforce, which exacerbate the burden placed on the elderly and their families, must be addressed. Policy responses should take into account regional differences, especially between rural and urban areas, as well as the increasing needs arising out of demographic changes. Options that might be useful include linking the financial and human resources for health care and LTC to the share of the elderly in the total population. Further, a close interface between health and social services might be sought in order to fill service gaps and improve service quality.

**Improving equity in financing and access to services.** The requirement for OOP expenditure constitutes a significant barrier to accessible health care and LTC services and impacts regressive on income. Such expenditure is a severe burden for lower-income households and for women and the oldest in particular. Addressing these effects might include linking co-payments, user fees and other forms of OOP payments used in social protection systems – if, indeed, these are to be retained as a financing mechanism – to income, and introducing ceilings for these payments (for example, to limit costs for the most vulnerable, i.e. women aged 80+). This seems to be particularly important for LTC.

**Improving the socio-economic context.** Co-factors contributing to issues of service affordability should be addressed in a comprehensive manner. In particular, such issues include vulnerability deriving from household income levels. Greater affordability of access might be achieved by raising the level of basic care and ensuring access to essential social services provided as part of broader “national floors of social protection”. Such an approach should aim at improving the overall performance of the social protection system with regard to equity impacts and also to its efficiency and effectiveness in achieving objectives. This should take into account old-age and income support programmes in particular, to better protect the most vulnerable. Possibilities include i) the introduction of guaranteed minimum income that would help protect against financial ruin and ii) effective access to needed health and social services.

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Old-age protection for women in the Spanish pension system

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Abstract The example of Spain confirms the common view that contributory pension systems reproduce inequalities between the sexes that result from the nature of labour market structures and the sharing of family responsibilities. In general, women who stay at home are not entitled to their own pensions and are dependent on benefits of lower value such as survivors’ pensions (derived entitlements) or non-contributory pensions. In turn, women who work outside the home accrue lower entitlements than men and, consequently, lower old-age or disability pensions (personal entitlements). The purpose of this article is to examine the figures for pension distribution by sex in Spain, review some of the pension policies that have been implemented since 2000, and propose direct action for progress in the transition from derived entitlements to personal entitlements. These proposals are designed to promote sex equality, defined as the right to equal well-being and financial security in old age.

Keywords social security reform, old age benefit, survivors benefits, equal treatment, women, Spain

Introduction

Spanish women access social security benefits under the same conditions as men; as workers and contributors their entitlement to all of the rights of the pay-as-you-go (PAYG) and occupational social protection system is guaranteed. However, equal conditions of access do not mean equal ease of access.

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1. See Appendix.
Proposals to promote sex equality in the pension system call for action to be taken first on the position of women in the labour market, by increasing the introduction of measures to eliminate gender differences in terms of pay, access to employment and promotion on the job. In turn, it is important that this action should be accompanied by the design of effective work-life balance policies. However, this article focuses on a third line of action: actions on the regulations that determine and quantify pension entitlements in Spain.

The first section of the article presents figures for spending on pensions and pension distribution by sex in Spain, using statistical and budgetary social security data published in 2011 by the Spanish Ministry of Employment and Social Security (MESS – Ministerio de Empleo y Seguridad Social). This is followed by a review of some of the changes made to the Spanish pension system since 2000 and their implications for the old-age protection of women. In large part, these are parametric reforms introducing a higher contribution rate (with effect from 2013), which have been driven by the European Council’s requirement to achieve financial sustainability. These have been made with the consensus of the parliamentary groups who are present in what is known as the “Toledo Pact” (concluded in 1995) and its subsequent reviews (2003 and 2011). The last section presents a range of proposals based on the opinions of a variety of experts on how to achieve a more egalitarian system for providing financial security in old age through a combination of a revised contribution rate and entitlement provided as a right of citizenship. These may serve to guide reforms in Spain and in other countries, including those with defined contribution systems.

Unequal accrual of contributory entitlements: Figures and gender consequences

If an old-age pension is designed as deferred income from paid work and its amount is fixed in relation to the wage that has served as the basis for contributions, then the social security system does not guarantee equal financial security to women who, subject to social conditioning factors and the needs of their families, have spent most of their lives away from the labour market or have combined traditional domestic tasks with temporary or marginal employment. In fact, although the number of pensions paid to men and women in the Spanish system is practically equal, women account for only 39 per cent of pension expenditure.

The existence of a benefit system wherein access is derived through stable employment means that elderly women receive lower benefits than men. In most cases these benefits are derived entitlements stemming from marriage – in old age, the majority of Spanish women receive survivors’ pensions. Yet the increase over
recent decades in the number of women joining the labour force evidences that the nature of employment inequalities between men and women is now shifting to variables that determine the value of pensions: the length of time that contributions have been paid and the contribution bases.

It is not surprising that the average contribution period accrued by women is lower than that of men, given their more common role as care givers, their lower job stability and their greater propensity to be in part-time work. The percentage impact of these variables on the accrued contribution period is clear. For example, according to the Continuous Sample of Working Lives (Muestra Continua de Vidas Laborales – MCVL) published by the MESS in 2006, 41 per cent of women paying social security contributions between the ages of 60 and 65 (i.e. in the years leading up to the legal retirement age of 65) had not accrued the minimum period required to be entitled to a pension (15 years) and only 6 per cent had satisfied the contribution period of 35 years required for entitlement to a full pension. In contrast, for men in the same age cohort, only 6 per cent had not satisfied the minimum contribution period and a third had already satisfied the contribution period of 35 years. In addition, the contribution bases for women are around 79 per cent of those for men (Vicente Merino et al., 2010), this difference being the result of the disparities in pay and the greater presence of women in the contributory schemes for self-employed, domestic and agricultural workers, with average contribution bases that are close to the permitted minimum.

The predominance of survivors’ pensions and the lower entitlements to pensions that women accrue in their own right (old-age and disability), give rise to significant gender disparities (Alonso San Alberto and Pazos Morán, 2010), as illustrated below.

Pension distribution by type of contributory pension

The main pension in the Spanish system is the old-age pension, 64 per cent of which are paid to men and 36 per cent to women. More than three quarters of men receive the old-age pension (Figure 1). However, the pension received by most women is the survivor’s pension, although the increasing numbers of women joining the labour market have reduced its dominance.

2. Women’s rates of employment rose 15 percentage points from 1996–2011 to reach 52.9 per cent. This is still 14.7 points lower than that of men; see <http://www.ine.es>. See also Moreno Raymundo, Cebrián and Gutiérrez (2009).

3. In 2011, 32 per cent of women’s employment contracts were part-time compared with 11.5 per cent of men’s; see <http://www.mtin.es/series>.
Monthly average amounts

The average values of the pensions paid to women are around the minimum for disability and old age as well as for the death of a spouse (Figure 1). Men earn higher disability pensions and considerably higher old-age pensions (a difference of slightly more than EUR 400 per month). Widowers’ pensions are an exception: their average amount is below the minimum because the large majority of men drawing them are not entitled to the supplementary allowance owing to the fact they have sufficient other means.

Correlation between average pensions and age

In general, the highest average old-age pensions are those paid to the youngest pensioners, i.e. those just beginning to collect their pensions. This is because new pensions are adjusted in line with the wages of the last years of work, whereas existing pensions are adjusted according to the Retail Price Index (RPI), which has a lower rate of growth than wages (Figure 2).

The average amount of survivors’ pensions also decreases with age, albeit to a lesser extent, owing to the predominance of minimum pensions that have grown less than wages.
Pensions that are paid below the legal minimum are topped up to this level by a supplementary allowance, provided that the recipient’s income does not exceed a given amount. Women account for 62 per cent of pensioners receiving this allowance.

Overall, 33 per cent of women’s pensions are topped up in this manner, as are 22 per cent of men’s pensions (Figure 3, category 1). When the pensions provided under Spain’s SOVI scheme (Pensiones del Seguro Obligatorio de Vejez e Invalidez; a residual scheme for mandatory old-age and disability insurance paying an amount similar to that of the non-contributory pension) are also taken into account, these percentages rise to 41 per cent and 23 per cent, respectively (Figure 3, category 2).

These figures show the prevalence of minimum pensions in the contributory system, and especially so among women. Figure 4, which presents a breakdown of pensions by amount brackets and sex, provides even more striking results as regards gender disparities: the majority of women’s pensions are concentrated in the EUR 500–633 and EUR 150–500 brackets, i.e. minimum or below-minimum
Old-age protection for women in the Spanish pension system

**Figure 3. Recipients of minimum pensions by category, 2010 (percentage of total for each sex)**

![Graph showing recipients of minimum pensions by category, 2010 (percentage of total for each sex).](image)

Source: Adapted from MESS (2011); see [http://www.seg-social.es/Internet_1/Estadistica/PresupuestosyEstudios47977/Presupuestos/index.htm](http://www.seg-social.es/Internet_1/Estadistica/PresupuestosyEstudios47977/Presupuestos/index.htm).

The pensions men receive are grouped to a greater extent in the EUR 700–1,100 bracket.

**Non-contributory pensions (NCPs)**

The introduction of disability and old-age NCPs (Law 26/1990) universalized the right to receive a pension for people without sufficient means and had an appreciable effect on attenuating situations of poverty, particularly in households headed by women older than age 65 for whom working outside the home had not been customary. Since their introduction, there has been a downward trend in the proportion of women receiving NCPs, although the non-contributory side of the system still has a heavy female bias. Women were the recipients of 71 per cent of NCPs in 2010, which offer a maximum amount equal to 58 per cent of the minimum contributory pension.

Taking into consideration the total figures for beneficiaries who receive minimum pensions (i.e. contributory or SOVI pensions with the supplementary allowance, or non-contributory pensions), an estimated 35 per cent of pensioners in 2010 received minimum amounts (Figure 3, category 3). These figures explain the high proportion of poor elderly people, most of whom are women, who receive pension amounts that are below the poverty threshold (Ayala Cañón and Sastre
Moreover, to these figures should be added the women who, although they have no income of their own, are not entitled to a pension because their income exceeds the income threshold – because their spouse’s income is taken into account.

**Policies on old-age pensions and sex inequality**

This section lists and discusses some of the measures adopted and the changes made to the Spanish pension system concerning, more or less explicitly, provisions for women in old age. Particular reference is given to the pension system reform that was implemented on 1 January 2013 (Law 27/2011)⁴ and to the changes made to survivors’ pensions (Table 1.).

**Minimum amounts**

In the majority of cases, it is women who receive minimum pensions. During the period 2004–2010 – but particularly from 2005, which marked the start of a

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vigorous policy to raise minimum benefits – the policy to increase minimum pensions above the rate of inflation had a very positive impact. In 2011 and 2012, the awarded increase was 1 per cent, which is below the rate of inflation.

In addition, Law 27/2011 sets a ceiling on the value of the supplementary allowance payable with contributory pensions, so that it cannot exceed the amount of the non-contributory pension. Although this measure brings coherence to the system, it transfers the inadequacy of the non-contributory system to the contributory system, with a possible negative gender impact, given the higher proportion of women receiving a pension with the supplementary allowance.

**Review of the contribution rate**

Although there have been no noteworthy developments in terms of positive action to improve equality, mention should be made of some of the parametric reforms introduced by Law 27/2011 and their implications, specifically: the increase in the period for calculating the regulatory base (from 15 to 25 years), the reduced amount to be used when calculating compensation for gaps in the insured’s contribution history (from 100 per cent to 50 per cent of the minimum contribution base), the raising of the retirement age (from age 65 to 67), and the increase in the number of years of contributions necessary for entitlement to the maximum pension (from 35 to 37 years).

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**Table 1. Measures on old-age pensions and parametric reforms, Law 27/2011**

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<tr>
<th>General provisions</th>
<th>Specific provisions</th>
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<tbody>
<tr>
<td><strong>Review of contribution rate</strong></td>
<td>Increase in period for calculating regulatory base: from 15 to 25 years (starting 2013) Reduced compensation for contribution gaps (2013) Extension of minimum contribution period required to 15 effective years (16.7 per cent) (2007) Commitment to improve calculation of contribution periods in part-time or intermittent contracts Raising of retirement age: from age 65 to 67 (starting 2013) Increase in the number of years of contributions for entitlement to 100 per cent pension: from 35 to 37 years (starting 2013)</td>
</tr>
<tr>
<td><strong>Rationalization of protection</strong></td>
<td>Unification of protection under the General Scheme (employed persons) and Self-Employed Scheme (2008 and 2012)</td>
</tr>
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With regard to the increase in the period for calculating the regulatory base, the findings of Muñoz de Bustillo et al. (2011) estimate a drop in the average old-age pension of one percentage point for each year of increase. The authors indicate that this will have a greater adverse effect on higher income groups and, to the extent that women receive lower average pensions, the detrimental effect will be somewhat more noticeable for men than for women. Regardless, a slight reduction in gender disparity should not be considered an achievement if the resultant reduction in the pensions of lower income groups, even if slight, has a negative impact on these groups. Notwithstanding that the overall reduction in pensions affects women to a lesser extent, it reduces their pensions and raises the number of those receiving minimum pensions.

Besides, the increase in the period for calculating the regulatory base is actually going to be greater than that taken into account in the above-mentioned research (from 15 to 25 years, as opposed to 15 to 20 years). Thus the findings of Muñoz de Bustillo et al. underestimate the negative impact for people who have irregular occupations or careers, particularly women, because of the increased likelihood of the calculation period including more episodes of part-time or zero contributions. These episodes previously remained outside the calculation period, or the period taken into consideration, but now will be included either on the basis of very low contribution bases or by applying the new more restrictive rule for calculating compensation for gaps in the insured’s contribution history. The increase in the number of years required for entitlement to a full pension will have a similar impact, since women accrue shorter periods of contributions.

These adverse effects are in addition to the toughening of the requirements for entitlement to an old-age pension with a 16.7 per cent increase in the minimum contribution period, which now requires 15 years of effective contributions (Law 40/2007), signifying longer contribution periods for people in insecure jobs, particularly women. Carrillo Márquez (2009) considers this measure to be indirect discrimination and believes that, by proving statistically that it affects women in particular, it could be deemed unconstitutional. Consequently, an additional number of women could be excluded from the system if they do not satisfy the contribution period, while those who do meet the minimum legal requirements for entitlement will, in general terms, obtain smaller or minimum pensions.

Nevertheless Law 27/2011 includes measures that in principle may improve sex equality. One of them is the inclusion in the General Scheme of some workers covered by the special schemes for domestic and agricultural workers – schemes with a high proportion of female members. To be meaningful, however, such a change must offer an extension of access to benefits and, importantly, the greater contribution requirements that this involves must not encourage an increase in clandestine employment.
In addition, this Law allows contribution gaps during the first six years after the birth or fostering of a child to be recognized as periods of insurance coverage, up to a maximum of 112 days per child (to be increased gradually to nine months in 2019). This change, however, does not apply to the calculation of the minimum contribution period. Law 27/2011 also includes an undertaking to improve the calculation of the contribution period for workers with part-time or permanent intermittent employment contracts.

It is very difficult to predict overall results in connection with all these measures, although it is probable that they will have a negative impact on women (CES, 2011). This is so since they are mainly targeted at ensuring the financial stability of the social security system, without taking into account the gender impact they produce.

Policies concerning surviving spouses

In line with the contributory systems of other developed countries, widows’ pensions were introduced in Spain in the mid-20th century to provide coverage to women in need as a result of the death of their husband – this presupposed a family model with defined gender roles. Although initially perceived as a form of social assistance (only for widows aged 65 or older who could not work), it has come to be viewed as a replacement income for the deceased husband’s wage (or pension), irrespective of the survivor’s age (since 1972), and compatible with other income.

In 1983 this right was extended to widowers, in accordance with the constitutional requirement (since 1978) for equal treatment. Since then the right has been adapted and adjusted, not without difficulties and contradictions, to take account of major social and political changes, such as the increasing number of women entering the labour market, the increase in number of cohabiting couples, the Divorce Law (1981), and recognition of same-sex marriages (Law 13/2005). As a result, the meaning and role of survivors’ pensions has since been called into question. Objections are raised to a benefit founded on a traditional family model, and its compatibility with other income is cause for doubt (CECS, 2010). Yet it is acknowledged that existing survivor pensions must continue to be paid, given that most are drawn by older women who have never been in paid employment and for whom it is their only source of income.

In Spain, as in other European Union (EU) countries,5 measures have been adopted to toughen the conditions for entitlement, in terms of granting a pension

5. According to CECS (2010), in Denmark couples married after 1992 are only entitled to a single payment survivors’ benefit; in the United Kingdom, survivors’ pensions have been halved; in Germany, for couples married after 2001, the percentage applied has been cut from 60 per cent to 55 per cent for persons who are at least age 47 when their spouse dies, and for others the benefit is limited to 25 per
in the absence of marriage only in situations of financial dependence. At the same time, social assistance measures have been introduced that strengthen the principle of solidarity for widowed persons with low incomes (Table 2.).

### Table 2. Survivors’ pensions: Conditions and changes in legislation since 1994

<table>
<thead>
<tr>
<th>1. Beneficiary: The deceased’s spouse</th>
</tr>
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<tbody>
<tr>
<td>a. If death is due to a common illness, there must be either 1–2 years of marriage or children (2005-2007).</td>
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<tr>
<td>b. In cases of separation/divorce, entitlement depends on the length of the marriage. Divorced men and women only have entitlement if they are entitled to maintenance payments (2007). The surviving spouse or co-habitee is guaranteed between 40 and 50 per cent of the pension (2005-2007).</td>
</tr>
<tr>
<td>c. Extension to co-habiting partners with certified co-habitation of at least 5 years or children together and financial dependence (2005).</td>
</tr>
<tr>
<td>e. Calls for a new approach to the survivor’s pension for people born after 1 January 1967 (2007).</td>
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<tr>
<th>2. Compatibilities</th>
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<tbody>
<tr>
<td>a. Compatible with other income and other pensions (also with SOVI since 2005).</td>
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<th>3. Life pension</th>
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<td>a. The percentage of pension paid has increased gradually from 45 per cent to 52 per cent (2004) and is 70 per cent if there are dependants and insufficient income (2001). It will be 60 per cent (from 1 January 2020) for those older than age 65 whose income does not exceed the minimum pension threshold.</td>
</tr>
<tr>
<td>b. Entitlement to a minimum pension in the absence of sufficient income.</td>
</tr>
<tr>
<td>c. In cases of recent marriage, a temporary pension is granted depending on the length of the marriage (2005).</td>
</tr>
</tbody>
</table>

Proposals for adapting the pension system

The support of international organizations for equal rights in contributory pension systems focused initially on the objective of abolishing the differences between the entitlements to benefits of men and women. It did not take long to realize, however, that the main problem of contributory systems does not lie in the conditions of entitlement but in the inequality of the starting point: women access the system at a disadvantage because they have either stayed at home or have not developed as full careers as men.

Since 1970, international organizations have adopted new ideas about equal treatment: equality can only apply to workers with the same occupational
arrangements; as soon as situations are different, it is necessary to adopt measures that are responsive to the specific needs of the persons concerned. Based on this approach, there is a requirement to review the contributory logic of personal entitlements from the viewpoint of positive discrimination.

The following reflections put the emphasis on a policy of fairness and equity in which what prevails is elderly people’s lifelong right to financial security, irrespective of differences in life expectancy; a policy that takes into account other non-monetary contributions in assessing contributory effort, and the right to have a guarantee of a dignified life. Although there are authors who consider that a contribution rate close to actuarial equivalence is the only objective option possible, this is but an ideological stance in relation to the criterion of equity that the public system must adopt. The choice of such a criterion is a social contract issue, in which citizens decide, in accordance with moral principles, the objectives they consider just. In Spain the majority of public opinion, as conveyed in different pension agreements, considers that actuarial equivalence is not the criterion to use or that it should at least not be the main one.

Moreover, derived entitlements are questioned because of their contribution to perpetuating relations of dependence for women, since the old-age pension belongs exclusively to the husband, and marriage is required for the survivor’s pension. Entitlement to share in these benefits requires relations to be maintained with the spouse who is the right-holder.

In modern society, the family should cease to be the reference institution for the organization of social protection. This is what Sweden, for example, has achieved, because its policy is neutral – state intervention is oriented towards each individual regardless of whether or not they are living in a family. A system of protection must be designed that guarantees freedom of choice, with measures that lead essentially to a progressive transformation of “derived entitlements” into “personal entitlements”.

Based on these arguments, different proposals are now presented to promote sex equality based on direct action on pension legislation.

6. Most Latin American countries that have introduced defined contribution pension schemes estimate benefits using different survival tables for each sex (James, Cox Edwards and Wong, 2008), whereas in the EU, the European Court of Justice has banned insurers (since December 2012) from using the criterion of sex in premium price calculations because it is counter to Council Directive 2004/113/EC implementing the principle of equal treatment. In contrast to the opinion that women should receive lower average pensions than men to compensate for their longer life expectancy (Jiménez Martin, Nicodemo and Raya, 2010), it is understood, as indicated by Dion (2008), that state systems should serve the purpose of providing overall coverage of risks, including those related to gender. Using characteristics of a group that cannot be changed by behaviour (gender life expectancy) is the same as discriminating by race or social class (income, occupation, education, etc.). This also discriminates against certain individuals in a group on the basis of the group characteristic (Judgement of the United States Supreme Court).
**Voluntary contributions**

Some countries (France, Germany, Israel, Japan and Luxembourg) include in their contributory systems the possibility of paying contributions for housewives and mothers who have never worked or who have taken a career break, so that they can meet the minimum level of contribution or any level they wish. This measure could be implemented in the Spanish system by allowing housewives to pay social security contributions under a special arrangement, similar to that covering non-professional carers of dependent relatives (Royal Decree 615/2007).

This proposal seeks to promote the extension of personal entitlements, although it is an option that is only available to relatively well-off families. It is not within the reach of all citizens and, if the system is generous, the greater return will go to those who have chosen to pay the highest contributions. Nor is it a measure that finds favour with either trade unions or feminists, on the grounds that it acts as a deterrent to women joining the labour market. Its implementation would have to be subject to restrictions.

As a subsidiary measure to the foregoing, the Report on the assessment and reform of the Toledo Pact (2011) recommends, as part of a supplementary pension system, a more balanced distribution of tax incentives in terms of sex equality, with greater scope for women without their own income to benefit from the contributions made by their husbands or partners. This right for housewives is currently already recognized in personal income tax regulations. This extends the tax incentive for old-age pension plan contributions to the contributions made in favour of a spouse, although the results that it can give rise to mean it cannot be considered as equivalent to a pension for housewives, in the sense of achieving effective equal opportunities and treatment.

*The retirement pension as an asset of both spouses (joint property)*

Some countries (Germany and Canada) and the State of California consider old-age pensions as an asset acquired during the years of marriage that must be allocated individually and divided in the event of separation or divorce; and if both spouses draw a pension, half of the difference of the higher pension must be transferred to the other spouse. In a system in which the wage is a family wage, contributions are considered contributions of both spouses to fund a family pension.

This is an interesting proposal which the Spanish system should incorporate, since it does not increase spending on contributory pensions and legally regulates a behaviour that although traditional in many Spanish households can be particularly important in the event of separation or divorce. It signifies legal recognition of the right to share the pension and broadens the field of individual rights through shared ownership by both spouses.

More advantageous conditions

More advantageous conditions in the granting of contributory pensions to compensate for a shorter working life would allow for domestic activity (mainly time spent caring for dependants) as part of schemes to get women into work and to promote the sharing of domestic chores and family responsibilities.

Taking into account the positive external effects of motherhood, a challenge is posed by effective contributions (or their equivalent during periods of sick leave, unemployment, etc.) being used as the sole measure of the useful effort made. A contributory system should value also the contribution by women that is not made on an exchange basis. Here, it is a question of opting in favour of a measure that compensates for the lower rates of occupation and employment activity of mothers, the greater temporariness of their contracts, and their greater use of part-time employment.

For example, the contribution period could be further extended to include the time spent caring for young children or elderly dependants, in the same way as periods of paid unemployment or sick leave are included. In addition, there could also be recognition of a number of years of contribution for each child. This option has been officially established in Germany and France, which grant entitlement to 3 and 2 years of contributions, respectively. Another proposal outstanding is to improve the contributory weight of part-time work by raising the value of the periods in which contributions have been paid. It is also important to support a more generous minimum pension policy in order to compensate for the dramatic impact that the reduction in pension rights resulting from the latest reforms may have.

Overall these improvements are a step forward in the recognition of rights in countries in which the presence of women in the labour market is a fact. These positive discrimination measures make it easier for women to establish an

8. According to Esteve Mora (2009), from the standpoint of fair distribution, entitlement should be measured not by monetary contribution, but by the potential contribution in terms of the financial value of their domestic activity. The author proposes that the measurement should be made based on the cost of the resources that society would have had to devote to kindergartens, homes, and hospitals to address these circumstances. See also Meil Landwerlin et al. (2008).
independent employment career and reduce the inequality associated with their working lives.

Granting benefits

Granting benefits to housewives in the form of a domestic wage lacks support. A domestic wage designed so that women stay at home – paid in recognition of the socially-useful function they fulfil, by giving society the children it needs or by looking after the elderly at a reduced cost – supports the division of work and the financial dependence of women. A different matter, however, is the support for temporary assistance that is offered to fathers and mothers for the care of their children within the framework of family policies that are conducive to a work-life balance.

Defending old-age pensions for housewives, which are considered as deferred wages, responds to the same approach sought by a housewife’s wage. Nevertheless, supporting pensions in general for women and only for women has a discriminatory impact, in so far as not all housewives have worked at home or have not done so in the same way and with the same intensity; men who bring up and care for their children should also have the same right.

Widespread support for old-age benefits for women may make sense, but not because of women’s domestic function, but as a citizen’s right within the framework of a universal benefits scheme. The advantages in accepting this approach are numerous: a minimum guaranteed income for elderly men and women would make it possible to take into account all those excluded from the contributory system and provide a solution to any situation of need resulting from the system’s lack of adequacy. In this regard, the Spanish system should make substantial changes to non-contributory pensions, reducing their social assistance aspects (amount and restrictions).

Survivors’ pensions

There is a high level of consensus regarding the important social roles played by earlier generations of women, particularly for undertaking tasks in situations of need. In spite of this, a number of authors consider that a survivor’s pension is an obsolete concept and propose its gradual abolishment (without introducing a replacement) so that this benefit eventually disappears. Simultaneously, improvements should be made to personal entitlements to contributory and non-contributory pensions designed to protect people without means.

9. According to Gorz (1995), this approach prioritizes the social usefulness of mothers (treating them as surrogates) rather than seeking to promote their fuller development as individuals.
What is in doubt is the role, efficiency and equity of survivors’ pensions and, therefore, the advisability of maintaining this benefit (CECS, 2010; Vara Miranda, 2011), on the grounds that:

- It is not justified in actuarial terms: married people do not pay higher contributions than single people, and the pension of married retired people is not calculated taking into account the right to a second pension, that of the surviving spouse.
- It does not cover all situations of need. It equates to a small cash amount that is insufficient for many very elderly women without other income. In addition, it covers only the contingency of the death of a spouse, leaving other similar situations uncovered.
- It does not cover only situations of need. Survivors’ pensions are compatible with other types of income (paid employment, other pensions) and may give rise to situations of over-provision, which are increasing as the presence of women in the job market becomes more firmly established.

Thus, there are a number of issues worthy of attention as regards survivors’ pensions: they are neither a form of social assistance nor a contributory benefit; they are paid for life or may be paid as a temporary benefit arrangement (transition role); their receipt may be compatible with other employment earnings and benefits; the amount paid may be (in)adequate; the flexible nature of the concept of family (Kahale Carrillo, 2011); etc.

Taking into account different recommendations made by researchers and analysts, the following discusses integrating survivors’ pensions with other risks covered by the social security system. We start by clarifying the purpose of survivors’ pensions, while keeping as an aim the equitable coverage of women’s financial security. A series of actions would be as follows:

**The removal of the link between surviving spouses’ and surviving children’s benefits, enabling improvements on current benefit provisions for children.** This would make it possible to design a set of benefits to cover the loss of a spouse that are better aligned with this objective, irrespective of the situation of dependence of any surviving children. The delinking of the benefit for surviving children, however, brings into question the need for extended contributory benefits and opens a debate on the need for a specific non-contributory benefit to cover situations for which there is currently no provision.

In the same vein, recognition of family realities will require acceptance also of provisions for the children of single-parent families of any kind, regardless of the loss of a spouse or partner (Bravo Fernández, 2010). For this purpose, as recommended by Pumar Beltrán et al. (2009), Spain should adopt the kind of reforms implemented elsewhere, transforming survivors’ benefits into a benefit for
situations of need experienced by single-parent families, and for comprehensive provision to be made for children in the absence of one of the parents.

Survivors’ pensions integrated with other risks covered by the system. This should be done so that the death of a spouse gives rise, for the surviving spouse or dependent, to benefits for disability, old age, or unemployment or to parallel means-tested allowances (Ojeda Avilés, 2008).

This way it is possible to take different approaches to situations of financial dependence and to those in which the surviving spouse is financially self-supporting. Together, these benefits can provide coverage both for traditional need-based requirements (offering protection to women belonging to a generation who devoted themselves mainly to the care of their family) and fulfil an income replacement function. Although formally this would involve abolishing the survivors’ pension, in practice the idea is for it to be absorbed by the system’s other benefits, which are redesigned so as to achieve adequate coverage. Thus, for example, consideration could be given to an old-age pension for the present beneficiaries of survivors’ pensions and for those who, at the time of spouse’s death, meet the new system’s age and other eligibility requirements as these relate to the deceased and beneficiary.

This pension could be calculated using a percentage of the regulatory base derived from the deceased’s employment history or based on the deceased’s pension, with an evaluation determining which part of the deceased’s accrued entitlements should be used for calculating the pension to be paid to the surviving spouse. The latter could even be considered a shared pension that is financed by an actuarial reduction made, as appropriate, in the individual pension, in the manner of the reforms in Chile, Argentina and Mexico (James, Cox Edwards and Wong, 2008).

It would also make it feasible to consider increasing the minimum benefits and to consider proposals for reviewing their compatibility with other income and pensions, by either making it fully incompatible, fully compatible (like the systems in Latin America), or establishing some intermediate solution (means test). It even permits the option of considering the survivors’ pension as a non-contributory pension (Vara Miranda, 2011), with no link to contributions made during the working life.

This would make it possible to address particular cases: that of older women who have never been engaged in paid work and whose needs must be met for an extended period (López López, 2007). Such immediate, complete transformation of the pension system is clearly not possible, however (Bravo Fernández, 2010). In the meantime, survivors’ pensions continue to have an income-compensation function, achieving a degree of equality between the sexes not realized in working careers (Ahn and Felgueroso, 2007).
Regardless, this proposal improves on approaches that recommend abolishing survivors’ pensions for younger adults, in that it resolves possible discrimination on the basis of age involved in restricting the benefit, for example, to those born before 1 January 1967. Although this arrangement may rest on the objective fact that most women born on or after 1 January 1967 have now joined the labour market, their independence from their husbands is merely an assumption; we can find sufficient cases where that is not so, and equally so for women born before and after this date.

Consideration could be given also to a temporary transition benefit as part of the present system of unemployment provision. This could be awarded in all cases where there is no pension entitlement, accompanied, as necessary, by job-search support that considers appropriate options for employment.

This temporary benefit to support transition must be intended, above all, to enable the surviving spouse to adapt to an active working life by providing income security from the time of the loss of their spouse and which supports their psychological and social rehabilitation. In addition to providing a temporary transition benefit that ensures that needs are covered, it is very important to focus on the return-to-work objective, including meaningful policy commitments for training and reinsertion (López López, 2007).

The period during which such a temporary benefit is received could also be taken into account as accruable contributions in the surviving spouse’s working career and as a means to stimulate job-seeking behaviour (López Zafra et al., 2009).

**Conclusions**

Pensions always arouse the interest of researchers. They are also a constant focus of attention for politicians and trade unions and one of the issues of most concern for citizens – the impacts of the crisis and current reforms have acted only to heighten this concern.

Most of the reforms that have been introduced have financial sustainability as their focal point and impact on expenditure only – they are increasing the requirements for the accrual of entitlements. This is going to make it difficult to address the problems of inequality and lack of provision with any guarantee of solution.

There is a long way to go in adapting the benefits system to the social and economic system. The social security system must be modernized in response to a more flexible labour market, with reforms that recognize the more important role played by women, albeit that they continue to be a group at greater risk of social exclusion.
This article has analysed the relative standing of women in the old-age pension system and set out different proposals for making changes to the system, with the aim of improving provision for women and reducing sex inequality.

The principal findings and conclusions are as follows:

• Emphasis should be given to extending the provisions of the contributory system by introducing measures of positive discrimination for women to compensate for the disadvantages they face in employment and which will reduce gender disparities in the accrual of entitlements and the distribution of old-age pensions. Social security statistics for 2010 show that women receive only 36 per cent of old-age pensions and that their average pension is less than 60 per cent of that of men. In this respect, measures are proposed for extending personal entitlements by establishing a limited system of voluntary contributions, considering the old-age pension to be an asset of both spouses, improving the treatment of part-time contracts in the calculation of insurance periods, and recognizing additional years of contribution for each child.

• Confirmation of the importance for women of minimum pensions: these account for 45 per cent of their pension income (in 2010), albeit the amount is inadequate, bordering on the threshold of relative poverty (contributory pensions) or below it (SOVI and NCP). The positive impact on sex equality of the policy (2004–2010) of raising minimum pensions above the rate of inflation is acknowledged, although the new regulations (from 2013) specify that the minimum pension, which 62 per cent of women receive, cannot exceed the amount of the non-contributory pension.

This measure and other parametric reforms to reinforce the contribution rate (from 2013) point to the likelihood of a greater negative impact on women in so far as they have shorter working careers, and due to the increased probability of contribution gaps and thus a reduction in the percentage of the maximum pension payable. A higher number of women may be excluded from the system or obtain lower pensions, thereby raising the risk of poverty.

It is therefore necessary to strengthen the non-contributory element so that old-age pensions address basic needs. Contributory minimum pensions should be raised too.

• Changes have been made to survivors’ pensions, on the one hand, making the conditions for entitlement tougher for co-habiting couples and for separated or divorced couples and, on the other hand, increasing the amount paid for minimum pensions and in cases where there are dependants. Measures aimed at improving provision in situations of need – albeit from a distorted approach that favours families instead of individuals –, but which do not recognize the limited capacity of contributory programmes to meet fully such need, would do well to consider the potential of a universal system.
The public survivors’ pension is responsive to a family model that does not represent social reality. Nor is it an earned income, since married people pay the same contributions as single people; it is merely a pension with entitlement based on marital status and as such is indefensible. The survivor pension should be continued in order to cover situations of dependence, but modernized in terms of considering individuals in situations of need, regardless of their family situation.

From this perspective, what is being advocated is the review of the surviving children’s benefit (orphan’s pension), delinking it from the surviving spouse’s benefit. The aim is to extend coverage to realize comprehensive provision for children in other situations of need, by extending current contributory benefits and establishing a specific non-contributory pension.

It is also proposed that survivors’ pensions be integrated with the other risks covered by the system, so that the insured’s death (as well as instances of separation or divorce) enables access to old-age, disability or unemployment benefits, based on the entitlements accrued by the deceased (the insured) and the personal circumstances of the beneficiary. This makes it possible to combine life pensions with temporary benefit arrangements (both contributory and non-contributory) and to address the issue of compatibility with other income, applying the same criteria as for other state pensions.

The Spanish system has expanded provisions to support the most vulnerable groups, but it is still over-diversified, has coverage gaps and limited adequacy. Adapting it to social and economic changes, with the goal of protecting the financial security of the population, requires the gradual transformation of derived entitlements into personal entitlements. This should involve implementing measures of positive discrimination in the contributory system and reforming the inadequate non-contributory system to provide a universal benefit.

If the only goal of the reform is to increase the contribution rate to achieve financial sustainability under the supposed objectivity of actuarial equity, leaving the social assistance tier to solve problems, then sex inequality and coverage gaps will remain unresolved.

Bibliography


Old-age protection for women in the Spanish pension system


Old-age protection for women in the Spanish pension system


Appendix

Since 1985, Spain has operated a three-tier pension system:

- **Tier 1.** Non-contributory system, providing old-age (aged 65 or older) or disability benefits for people without means (their own or support from their family), which is funded out of the general State budget. The amount of these benefits is around 54 per cent of the official minimum wage.

- **Tier 2.** Defined-benefit contributory system for old-age, disability or death (of a spouse or parent), funded by contributions made by employers and the insured, based on contribution rates and contribution calculation bases (estimated from wages). This is the predominant tier.

The system was highly fragmented into different schemes, but substantial efforts have been made to unify provision under the General Scheme, covering employed persons, and the Self-Employed Scheme.

Old-age pensions are drawn by women and men who have a minimum of 15 years’ contributions when they reach age 65. The amount of the pension is estimated in proportion to the number of years for which contributions have been paid and the amount of the contribution bases for the last years (now 15 years, rising from 2013 to 25 years in 2022).

Survivors’ pensions are for life, they make no distinction between sexes, are compatible with other income and, in general, amount to 52 per cent of the contribution base or pension of the deceased.

When pensions from this tier are below the amount of the minimum pension (approximately 94 per cent of the official minimum wage), and a person has no other income or it is very low, they are entitled to a supplementary allowance. These allowances are partly financed by State funding of Spain’s autonomous regions.

- **Tier 3.** A supplementary system that is private and voluntary; it is government-regulated and offers attractive tax incentives.
Alternative care options and policy choices to support orphans: The case of Mozambique in the context of the SADC

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Abstract  Contextualizing the situation of orphans within the Southern African region and drawing on quantitative and qualitative field research, this article analyses care options and social protection policy for orphans in Mozambique, with its focus placed on children in orphan support centres. Seeking to offer new insights and greater understanding of the experiences of children in care and of the social protection available to them, the research highlights that orphaned children living in informal foster care arrangements are more likely to experience abuse, neglect and maltreatment than those living in non-governmental care organizations. The research emphasizes the need for a more careful selection of foster families in which children are placed. Recommendations include the need to focus on capacity building and institutional reforms that provide social protection policies for orphaned children as part of an overall social protection floor. The monitoring and evaluation of organizations providing care to orphaned children is deemed a priority.

Keywords  children, child care, risk of survivors, social protection, social policy, Mozambique, Southern Africa
Southern Africa is experiencing a number of social crises. These crises manifest themselves in high levels of poverty, unemployment, food insecurity, displacement, unacceptably high mortality rates, low levels of life expectancy, and social dislocation. Mozambique, with more than three decades of political independence and a long complex social and economic transition from its colonial past, provides a particular context within which to address such social policy challenges. These challenges are compounded by the effects of relatively new risks and vulnerabilities, such as those related to HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome). In this article, the social policy/social protection challenges confronting Mozambique are viewed through the lens of orphaned children.

Mozambique provides an instructive case study of a country attempting to address the structural conditions that shape the education and health, future employability and life chances of children, while simultaneously responding to the devastating consequences of HIV/AIDS (UNICEF, UNAIDS and PEPFAR, 2006; UNICEF, 2009b). Though the consequences of HIV/AIDS raise many challenges globally, the social challenges confronting countries going through multiple transitions (economic, political and social) as a result of democratization and post-war social reconstruction are particularly acute. Structural changes underway to address economic, social and infrastructural reform also need to take account of the plight of the increasing numbers of orphans and how their marginalization from, or neglect by, social policy interventions can influence development objectives.

Mozambique is grappling with how to bring the social concerns of orphans onto the policy agenda. Initial efforts to prioritize the care and protection of orphaned children are unlikely to shift policy unless these are informed by rigorous evidence-based research. More empirical research is required to better understand the situation of orphans and whether the existing social policy responses adequately address the problems that confront these children. By contextualizing the situation of orphans within the Southern African region, the precise aim of this article is to explore an incipient area of social policy that is not yet prominent on the Mozambique government agenda, despite a growing need for it: policy and programmes that provide alternative care options for orphans.

The remainder of the article is structured as follows. Drawing on recent empirical research undertaken in Mozambique, we first outline the vulnerability of orphans and highlight issues confronting service providers as they attempt to respond to orphans’ needs. We then describe the situation of orphans in Mozambique and – through a survey of selected numbers of orphans and care centres –
identify some of the qualitative shifts that occur in centres where interventions are introduced to address difficulties experienced by children. By offering a comparative analysis of care options in the country against regional trends, the article argues that given widespread chronic poverty, unemployment and new vulnerabilities arising from HIV/AIDS, countries such as Mozambique require a social protection floor to provide basic social protection to address chronic poverty, new risks and vulnerabilities.

**Poverty, risk, and vulnerability: Orphans**

While contemporary research and discourse on social policy and social protection reflect a multidimensional approach to poverty, surprisingly little attention is given to the need for a more nuanced understanding of issues of risk, vulnerability and vulnerable groups (Hoogeveen et al., 2005). Understanding the links among poverty, risk and vulnerability as these relate to those who are likely to be vulnerable is critical for the effective and efficient targeting of social policies. Analysis of the role of risk in poverty dynamics and strategies deployed to respond to risk usually emerge in the context of social protection policies. At another level of analysis, it is often accepted that certain categories of people within the life cycle are more likely to be vulnerable to shocks and risks than others and, as a result, require specific social policy responses. Children, adults who are considered elderly and people living in chronic states of poverty are often characterized as vulnerable and at risk. This characterization relates to many factors that include age, geographical location (rural, urban), levels of income and asset poverty and deprivations in health and education.

Two key features consistently emerge in studies on risk, vulnerability and vulnerable groups. One has to do with the relationship between risk and poverty, and the other relates to those individuals identified as being a member of a vulnerable group and the causal factors that contribute to risk and vulnerability for these groups. Using a life-cycle analysis and overlaying this with an analysis of social and economic trends in the Southern Africa Development Community (SADC)\(^1\) exposes disturbing levels of vulnerability of a certain category of the population. Designated as orphans and vulnerable children, this category of the population experiences multiple levels of vulnerability, risk and hardship.

The increasing numbers of orphans in Mozambique represent a social policy concern that requires comprehensive social protection responses. Orphans are a social policy concern because, without specific government and broader social interventions, they become part of a vulnerable population demographic who are

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\(^1\) As of August 2011, the SADC consists of Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Seychelles, South Africa, Swaziland, United Republic of Tanzania, Zambia and Zimbabwe.
in high risk categories because of extreme poverty and life-cycle events. From this perspective, social protection among other social policy measures has been considered the best way to prevent and protect this vulnerable group of children (JLICA, 2009).

In recognizing that vulnerability is not the same as poverty (Chambers, 2006), orphans nevertheless experience both poverty and vulnerability as they lack parental support, are defenceless, experience various forms of insecurity and are exposed to risks and shocks without adequate support systems. Orphaned children constitute a particularly vulnerable part of any population, because without systematic social policy interventions they could experience multiple deprivations (lack of education, health care and homelessness). They also experience social isolation and are at risk of having their basic human rights violated. Typically, these children lack the physical and emotional maturity and resilience to cope with and overcome the stresses of orphanhood, especially in a context of extreme structurally-based poverty.

The situation of orphans in SADC with a particular focus on Mozambique

Worldwide, the number of orphans has been increasing at a disturbing rate. In 2000, estimates suggested that 35 million children had lost one or both parents due to different causes (Hunter and Williamson, 2000). By 2007, this number had more than quadrupled to 163 million (UNICEF, 2007). Sub-Saharan Africa is the region most affected by the HIV/AIDS pandemic with the adult HIV-prevalence rate six times higher than the global average. In 1990, alarming trends in the region already revealed that approximately 28.4 million children younger than age 18 had lost one or both parents. This trend was projected to increase to about 55.3 million orphaned children by 2007, constituting about 80 per cent of the world total (Hunter and Williamson, 2000). SADC member countries account for almost a third of the total, with 17 million children in the region considered to be orphans (Mkhulisi, 2011).

Out of the total number, the proportion of orphans in each of the region’s countries has not changed much between 2000 and 2007, except for a slight decrease in Madagascar, Mozambique and Zambia, as shown in Figure 1. In contrast, there has been an increase in South Africa, Swaziland and Zimbabwe.

With a total population of 20.5 million, Mozambique ranks among the world’s poorest countries, as evidenced by its ranking at 184 out of 187 countries on the 2011 Human Development Index. While the country’s under-five mortality rate has declined from 201 deaths per 1,000 live births in 1990 to 138 per 1,000 live births in 2008, the 2009 sentinel surveillance showed a national HIV prevalence of 15 per cent – or 16 per cent for pregnant women, with life expectancy of 50.2 years
Approximately 12 per cent of children between ages 0 and 17 – equating to 1.4 million children – were categorized as orphans in Mozambique in 2008, with slightly higher percentages in urban than rural areas (INE, 2009). Given the level of HIV prevalence and infection rates, it is estimated that 670,000 children have been orphaned because of AIDS (USAID Mozambique, 2012). Not surprisingly, there is a strong correlation between the percentage of orphans and vulnerable children and the HIV/AIDS infection rate per province (INE, 2009). Yet, recent evidence shows that the number of orphans due to AIDS has decreased in Mozambique at a higher rate than the average rate of SADC countries, as indicated in Figure 2. The extent to which this decrease may be related to specific social policy interventions remains to be discerned. Engaging with this question first requires an understanding of the conceptual approach within which countries in the region locate their policy responses.

**Conceptual approach to orphans**

Increasing concerns about the situation of orphans in the region has resulted in attempts to set policy, regulations and standards to support orphans at the global
and regional levels. The 26th United Nations (UN) General Assembly Special Session held in 2001 unanimously adopted and signed a Declaration of Commitment by the 189 member states to substantially increase both resources and attention to fight the HIV/AIDS epidemic. This commitment states that by 2005, policies and strategies were to be implemented to strengthen capacities to provide a supportive environment for orphans and children affected by AIDS and to ensure that they have access to education and health services on an equal basis with other children.

At a regional level, in 2004 the African-European Consultation on Children Orphaned and Made Vulnerable by HIV/AIDS in Africa took the debate further. Parliamentarians of participating countries agreed in the Cape Town Declaration on an Enhanced Parliamentarian Response to the Crisis of Orphans and other Children made Vulnerable by HIV/AIDS in Africa. This declaration includes the commitment to develop National Plans of Action for Orphaned and Vulnerable Children.

Furthermore, under the auspices of the African Union in 2006, 13 countries of Eastern and Southern Africa pledged in the Livingstone Accord to develop national social protection strategies (UNICEF, 2008a and 2008b). While the UN drafted the

**Figure 2. Number of orphans in Mozambique and average of SADC, 2003/2007**

Sources: The 2003 data is from UNICEF, UNAIDS and USAID (2004), while the 2007 data is from UNICEF et al. (2009).
guidelines for the Appropriate Use and Conditions of Alternative Care for Children in 2007, the SADC agreed on the Framework and Programme of Action for Orphans, Vulnerable Children and Youth in 2008, to articulate a regional response to meet the needs of orphans, with emphasis on holistic and integrated approaches to orphan issues (FAO, 2009).

At the global level, the International Labour Conference in 2012 agreed in adopting Recommendation No. 202 (2012), concerning national floors of social protection, that these should include basic income security for children, as well as free prenatal and postnatal medical care for the most vulnerable (ILO, 2012).

As such, social protection has increasingly been recognized as the best preventive and transformative measure to protect children as a vulnerable group (JLICA, 2009). To be distinguished from child protection, which is “the set of laws, policies, regulations and services needed across all social sectors – especially social welfare, education, health, security and justice – to support prevention and responses to protection-related risks” for children, social protection is defined as a “set of transfers and services that help individuals and households confront risk and adversity (including emergencies), and ensures a minimum standard of dignity and well-being throughout the lifecycle” (UNICEF, 2008a and 2008b). Social protection is thus a broader framework into which child protection should be integrated.

Social protection is an important part of the policy agenda in many African countries, owing to increasing concerns over food insecurity and vulnerability, the limited impact of “developmental” interventions in poverty reduction, and recurrent humanitarian crises followed by appeals for aid (Devereux and Cipryk, 2009). As such, the need for social protection is significantly greater in sub-Saharan Africa than in any other region of the world, especially in terms of the high levels of poverty and the wide range of factors that make people vulnerable. While structurally-based chronic poverty affects the majority of people, when it comes to the situation of children, women and elderly people, the risks and vulnerabilities that they experience differ and pose additional harm. In countries where wide-scale poverty, risk and vulnerability are endemic and resources are limited it is extremely difficult to make policy choices that prioritize among these. Indicators and measures that distinguish poverty from vulnerability and risk (Chambers, 2006) allow for targeted social protection measures that do not lead to false trade-offs between the need for a social protection floor and specific policies dealing with risk and vulnerability.

Typically, social protection in the majority of sub-Saharan African countries takes the form of humanitarian relief and food-based “safety nets”. In 2008, a com-

prehensive study of 53 African countries showed that existing social security measures in the majority of African countries remain limited to contributory programmes that mainly benefit salaried workers who constitute a relatively small proportion of the total population in many of these countries (Taylor, 2008). Extreme poverty, worsening unemployment and food insecurity create a new urgency among policy-makers in Africa to rethink the importance of social protection as a way of addressing the poverty, risk and vulnerability caused by HIV/AIDS. As already mentioned, existing approaches have little “developmental” impact in poverty reduction, and do little to prevent humanitarian crises followed by appeals for aid (Devereux and Cipryk, 2009).

As a result, the recent trend in Southern Africa is to focus on a basket of social protection measures – including the need for unconditional cash transfers for children (Taylor, 2008; Devereux and Cipryk, 2009). In recent years, social transfers in the form of primary health care, basic education, essential social services and cash transfers have been recognized as essential policy instruments for poverty reduction and the promotion of household well-being and as a platform for the achievement of critical economic objectives (Taylor, 2008).

Children affected by HIV/AIDS require a comprehensive social protection framework that goes beyond cash transfers to encompass essential social service provision (health, education, water and sanitation) as well as other child- and family-oriented support and protection services and policies (Greenblott, 2008; Taylor, 2011). Such social policies and service provision should include early childhood development (ECD), legal protections and empowerment, psychosocial support, bereavement counselling and community-based child protection committees. In addition, referral mechanisms, sustainable options for alternative care, family re-integration, legislation and regulations to ensure equity and quality of social services, and programmes to promote and support livelihoods and employment of vulnerable youth are necessary (Greenblott, 2008). Social protection measures designed to achieve social justice and address risks and vulnerabilities of children should be underpinned by human rights values and a human security approach (United Nations, 1989).

There is consensus that in cases where children are in need of alternative care options such as kinship support, then foster care or formal adoption are appropriate and preferable to temporary residential care. This is especially so as regards the benefits children experience in terms of the permanency and consistency of care and support, and there are cost benefits too (Better Care Network, 2009a and 2009b; UNICEF, 2008a and 2008b; Dunn, Jareg and Webb, 2004; Browne, 2009). Additional support measures that contribute to the well-being of orphaned

3. For example, South Africa has implemented cash transfers in the form of a Child Support Grant that assists in the care of vulnerable children and has a relatively high takeup rate (Samson, van Niekerk, and Mac Quene, 2006).
children include effective selection and gatekeeping of care arrangements, the development of grassroots-level capacity to ensure that safety nets reach those who need them, and community- or school-based counselling services. Financial support measures provided to caregivers and effective monitoring and support for foster children are also essential elements of social protection for orphaned children (Gudbrandsson, 2004; Hutchinson and Thurman, 2009; Smart, 2003; Radeny and Bunkers, 2009; Tolfree, 2003; Badcock-Walters et al., 2005; Yablonski and Woldehanna, 2008; Zaveri, 2008). Beyond such social protection measures, little research and knowledge is available about livelihood support programmes that could be of benefit to orphans as they enter early adulthood. Insights from research undertaken by the UN and Partners’ Alliance for Livelihood placed the focus of social protection for orphans and vulnerable children mainly on agriculture and the limited scope for livelihood support available through this sector (UN and Partners’ Alliance, 2007).

Given that around 12 per cent of children in Mozambique are orphans, government allocations made through the national budget for social protection services and instruments are inadequate. In view of the scale of the problems arising from chronic poverty, vulnerabilities and risk, it is important for the country to have a comprehensive and harmonized approach to social protection and measures that enable the efficient and equitable use of limited resources.

**Policy responses to orphans in Mozambique and possible policy impacts**

Recent studies indicate that significant advances are being made in the development of policies and legal frameworks to support and care for orphans and vulnerable children in some SADC countries (UNICEF, 2007). For example, in Swaziland 41 per cent of households with orphans and vulnerable children were receiving some kind of external support (UNICEF, 2012). In South Africa, care and support to vulnerable children through social assistance measures are likewise providing a lifeline (Samson, van Niekerk and Mac Quene, 2006). The government of Mozambique is also making steady progress by building an enabling policy environment to support and provide for orphans. For instance, the percentage of orphans whose households receive support quadrupled from 5.5 per cent in 2004 to 22.0 per cent in 2008. This indicates that the government of Mozambique recognizes it has an obligation to respond to the rights of orphans and vulnerable children (OVC) as part of its approach to social protection. The commitments and obligations are evident in the government’s ratification of the United Nations’ Convention on the Rights of the Child (1989) in 1994, in the national Constitution that emphasizes child rights, and the passing of a Family Law in 2004. In addition to the Social Protection Act of 2007, the Children’s Act of 2008 and the Juvenile Justice Act of 2008,
the Basic Social Security Regulation approved in 2009 defines four different areas of interventions, including direct social action for households with orphans and vulnerable children (Mausse and Cunha, 2011). These policy and legal changes have resulted in significant progress in policy and planning efforts compared to other countries between 2004 and 2007, as can be seen in Table 1.

Mozambique’s progress in orphan care and support is also evident from indicators such as the school attendance rate among orphaned children aged 10 to 14, revealing an increase from 32 per cent in 2004 to 77 per cent in 2008 (INE, 2009). Taking this significant increase together with other indicators leads to the conclusion that such improvements are the result of policy and legal changes made in certain key social sectors, such as education and social protection. As Figure 3 shows, Mozambique scores slightly below the SADC average in a policy-level evaluation of 12 out of 15 SADC countries in terms of the education sector’s response to HIV/AIDS (Badcock-Walters and Heard, 2010). These results were derived from a desk review of policies, strategies and planning documents on HIV/AIDS in the SADC countries, in terms of their existence, relevance, level of update and achievement. The analysis indicates a trend away from policy and towards strategy, and a need for greater synergy among all the relevant sectors (Badcock-Walters and Heard, 2010). Despite advances on the policy and planning front, Mozambique’s estimated antiretroviral coverage among children (14 per cent) lags behind levels in Zambia (36 per cent), South Africa (54 per cent) and Botswana (90 per cent) (WHO, UNICEF and UNAIDS, 2010).

### Table 1. The OVC Policy and Planning Effort Index (OPPEI) in SADC and Mozambique, 2004/2007

<table>
<thead>
<tr>
<th></th>
<th>Mozambique</th>
<th>SADC Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 National situation analysis</td>
<td>53</td>
<td>86</td>
</tr>
<tr>
<td>2 Consultative process</td>
<td>49</td>
<td>60</td>
</tr>
<tr>
<td>3 Coordination mechanism</td>
<td>64</td>
<td>75</td>
</tr>
<tr>
<td>4 National action plans</td>
<td>59</td>
<td>77</td>
</tr>
<tr>
<td>5 Policy</td>
<td>4</td>
<td>55</td>
</tr>
<tr>
<td>6 Legislative review</td>
<td>10</td>
<td>72</td>
</tr>
<tr>
<td>7 Monitoring and evaluation</td>
<td>43</td>
<td>40</td>
</tr>
<tr>
<td>8 Resource mobilization</td>
<td>48</td>
<td>60</td>
</tr>
<tr>
<td><strong>9 OPPEI Total score</strong></td>
<td><strong>41</strong></td>
<td><strong>66</strong></td>
</tr>
</tbody>
</table>

Impacts of institutional care on the lives of orphans: Research findings from selected orphan care centres

A 2006 study by the Ministry of Women and Social Action in Mozambique reveals that 96.4 per cent of orphans live with biological relatives, which is in keeping with traditional cultural norms wherein family continuity is highly valued (MMAS, 2006). Yet there are orphans, including those who have lost one or both parents (i.e. double orphans), who are not in the care of biological family members and who live in over 140 residential institutions providing care for orphans and vulnerable children in Mozambique (UNICEF Mozambique, 2010).

As part of this study, field research was conducted between November 2010 and January 2011 in seven centres in seven different Mozambique provinces (Figure 4) that provide support to orphans and vulnerable children.

A sample of 75 children between ages 11 and 16 were interviewed. A minimum of 10 children were selected from each centre using a simple stratified random selection process. The sample population constituted 45 per cent girls and 55 per cent boys. In addition to open-ended questions, the research was supported by observation visits to the seven centres to determine the physical environment...
Figure 4. Map of the seven selected centres
in which the orphans live. Three caregivers in each of the seven centres were interviewed as key informants to explore what types of management and forms of support are provided to orphaned children. The findings from key informants are summarized in Table 2.

The next sections provide a profile of the children, their family background and their psycho-physical, socio-developmental, and psycho-social situation. Against the needs and situation of the children, a preliminary analysis is made of the support and resources the seven centres are able to access to provide care for the children.

Table 2. Profile of the seven selected centres

<table>
<thead>
<tr>
<th>Sites</th>
<th>Types of care</th>
<th>Management</th>
<th>Total number of children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catembe</td>
<td>Residential, family-type</td>
<td>NGO</td>
<td>47 (24 boys, 23 girls)</td>
</tr>
<tr>
<td>Beira</td>
<td>Residential</td>
<td>Religious group</td>
<td>50 (38 boys, 12 girls)</td>
</tr>
<tr>
<td>Chimoio</td>
<td>Day-care, skills training</td>
<td>NGO</td>
<td>50 (All girls)</td>
</tr>
<tr>
<td>Chinde</td>
<td>Residential</td>
<td>Community</td>
<td>50 (26 boys, 24 girls)</td>
</tr>
<tr>
<td>Chokwe</td>
<td>Day-care, skills training</td>
<td>NGO</td>
<td>40 (20 boys, 20 girls)</td>
</tr>
<tr>
<td>Boane</td>
<td>Residential, skills training</td>
<td>Religious group</td>
<td>152 (All boys)</td>
</tr>
<tr>
<td>Nampula</td>
<td>Residential</td>
<td>Government</td>
<td>35 (27 boys, 8 girls)</td>
</tr>
</tbody>
</table>

Out of the sample of 75 children in the seven centres, half had one or both parents who were alive, and the other half were double orphans, having lost both parents. As can be seen in Figure 5, the majority of those with one living parent had a mother. Among double orphans, a quarter of them had no other living family member, while two-thirds still had at least a grandparent, aunt or uncle, and one-sixth had siblings living with them in the same centre or cared for in another centre. Interestingly, children in the centre in Nampula were slightly younger than those in other centres. The reasons for the lower age were not verified although it is possible that this centre simply provides care for younger children.

The family backgrounds of the children varied considerably among the seven centres. For instance, the mothers or even both parents of most children in Chokwe were alive, whereas almost 90 per cent of the children in Beira were double orphans. The majority of children in Nampula, Chokwe, Chimoio and Catembe had one living parent and, on average, more children had lost both

4. Some centres were visited during the weekend or school break and some children could have been visiting family or community members outside of the centres.
parents in Boane, Chinde and Beira. The social effects of being displaced because one’s parents are no longer able to provide care owing to ill health or because of other factors are many.

**Differences among children’s physical well-being**

It is possible to assess the physical well-being of children using certain standard health measures such as height for weight and body mass index (BMI). Deprivations in basic essentials such as food and access to health care are made evident through these measures. There is an observable degree of variation among children’s physical status in the seven centres. The BMI and the body fat level, measured by a Bioelectrical Impedance method (adjusted by sex and age), indicate that children in Chimoio and Chokwe are thinner on average than children in other centres (Figure 6). One reason that explains this variation is that the centres in Chimoio and Chokwe are day-care centres and meals are not given to the children, whereas the other centres are residential and offer meals.

For the centres that provide meals, there are differences in the quality, quantity and frequency of these. Yet the evidence points to the positive difference in physical well-being that children experience by having such access, even if meals are infrequent and insufficient. According to a Catembe district officer of the Provincial Department of Women and Social Action, the state has not been able to

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**Figure 5. Family situation of the interviewed children**

![Family situation of the interviewed children](image-url)
provide much food support especially for family-based care. Clearly, for children to achieve their physical and mental milestones, access to nutritious and regular meals are important. Introducing measures that ensure food security for children in these centres highlights that access to food should be part of a social protection floor or basket of measures available to all children.

On the basis of BMI measures or normative measures, the study shows that children in residential centres are generally better off than those in day-care centres. However, when comparing these normative indicators with the experiences of well-being reported by the children themselves there are significant differences. Food availability and the quality of food is reflected in children’s eating patterns and has a proportional impact on their health status, as Figure 7 (Panels A and B) shows, especially in relation to children in Chimoio and Chinde. Further research is required to explain the differences in Chokwe.

Food deprivation impacts on the physical and emotional well-being of children. As a 14-year-old girl in Chimoio states: “I feel bad when I have to go to school without eating, and going to bed with an empty stomach”. This young girl lives with her grandfather who cannot obtain work. The linkages among waged work, households’ abilities to provide food and the health status of children are clear. Also clear are the emotional and psychological impacts on children and their inability to concentrate when they go to school hungry. Normative indicators are helpful in setting a standard measure against which to benchmark children’s physical well-being, but these do not tell the full story of children’s experiences of hunger and how they view their situation.
**Orphan care and impacts on schooling**

The perceptions of children about their learning conditions show, for the centres in Beira, Catembe, Nampula and Boane, that learning materials...
and study conditions at school were adequate for their needs and no obvious experiences of discrimination emerge in their narratives. Some children in Chimoio, Chinde, and – to a lesser extent – Chokwe reflect feelings of poor treatment at school (Figure 8). Nevertheless, the children’s perceptions are not necessarily reflected in how they progress from one grade to another. For example, children in Chinde and Chokwe have already attained 7th Grade on average, as opposed to 5th Grade in Catembe and Nampula. Grade progression in school could also reflect the quality of teaching and other factors outside of the orphans’ care environment. Interestingly, there are indeed some marked differences in educational achievements among orphans. Take for instance the cases of two boys in the same centre in Nampula: one boy in 4th Grade could read, write and calculate, while the other in 5th Grade could not read, write nor calculate satisfactorily. These variations in educational outcomes point to the differentiated impacts of orphanhood on children when combined with environmental and emotional conditions.

Children living in orphan care centres tend to attend school regularly while those who live with family members are more likely to stay away from school or not attend. A double-orphaned sister and brother in Chinde, who live in the care of a pastor in the same community, had dropped out of school. The girl indicated that she had to care for her younger brother. Similarly, three school-age boys in Chokwe who were living with their mother, but whose father had died, were not attending school because of eye infections. They were unable to access information about the support or services they could receive because they were not attending any orphan support centre.
Orphans are more likely to be vulnerable to mistreatment and abuse

There is less variation in the living environments among the centres, except for Chimoio, as indicated in Figure 9. Children participating in the day-care centre in Chimoio tend to feel less safe in their own neighbourhood and at home, with some children reporting mistreatment by foster families or step parents. As an 11-year-old girl in Chimoio stated “I am afraid of my step father who comes home drunk and yells at me, as he does not want me in the house”. Abuse and mistreatment could be minimized with the better preparation of foster families and also through the more effective monitoring and supervision of homes in which orphans are placed.

The experiences of children reflect deprivations in basic essentials such as water, sanitation, and adequate shelter, and feelings of insecurity and lack of safety. Such experiences and perceptions expressed by the children are consistent with indicators of poverty in each district, with rural Chinde, Chokwe and Chimoio having higher incidences of poverty than that of Beira, Nampula or Catembe (Figure 10).5

For example in the centre in Chinde, 12 boys sleep in crowded conditions on the

5. Some children, especially double orphans, did not have any point of reference other than the centres they were living in. Their experiences do not necessarily reflect comparable situations.
floor in one room, and there are times when there is not enough space for them all. A widow with four children in Chokwe lives in a mud-brick house that consists of only one room and conditions are neither safe nor suitable. Once again the links between poverty, deprivations in essential services, health care, living environments and increased vulnerabilities as a result of HIV/AIDS are reinforced by children’s experiences. Illustrative of these, children in Chimoio said they do not always have enough water to drink or to bathe, as their families do not have enough money to pay for water.

**Forms of social support**

Children’s experiences show that processes that help to build social networks and promote social integration are more likely in Catembe, Beira and Nampula than in Chimoio and Chinde. Nevertheless, better social support and integration does not always translate directly into improvements in the psychological well-being of children.

Children in Chimoio and Chinde experience psychological distress and negative emotions, as do children in Catembe who receive more social support. Feelings of social dislocation, isolation and psychological distress as a result of the loss of one or both parents are likely to affect children over a long period despite the existence of social support systems within communities. The existence of support systems and networks in themselves do not mitigate the psychological and emotional harm that children experience as a result of orphanhood. The resilience of children to
overcome emotional and physical harm under conditions of chronic poverty alongside new vulnerabilities as a result of HIV/AIDS requires much more than the existence of informal support systems. This is an area that requires more research to determine the level of emotional and psychological support that could be provided through orphan care centres and through schools.

Government interaction and level of support for centres

Almost all of the orphan care centres indicate active engagement and interaction with government agencies. Many centres receive referrals for the placement of children from district authorities or public hospitals. With the exception of one centre, all were visited at some stage by government officials. Such visits serve the purpose of monitoring centres’ activities, but reports indicate that the visits are irregular. Two centres reported that they received capacity development training, while only three indicated that they received medical or material supplies. Five out of seven centres tested the children for HIV and ensured that children who need antiretroviral (ARV) treatments receive them. Children reported receiving textbooks at school and stated that additional learning support and materials are sometimes available through some centres and schools.

In Nampula, a government-financed centre, services are more consistently provided and the operational costs cover basic facilities and care available to the children. However, financial and professional services are not available to other centres. These ones struggle to obtain funding and support to maintain their centres and their services. As one centre’s manager reports: “The government has become more demanding to put structure in place, without providing any needed support”. At the same time, many of the district authorities of the Department of Women and Social Action explain that they do not have transport to conduct monitoring visits to the centres. They also indicate similar difficulties in visiting foster families. Government officials indicate that government does not have enough funding to provide adequate support to orphan care centres. Among the seven centres, the day-care centre in Chimoio and the community-run residential care centre in Chinde receive the least support. These two centres are situated in rural areas and do not have access to the support networks available to centres closer to urban areas. Especially in remote rural areas such as Chinde, government support and financing is essential. Rural and urban disparities in government provision make the responses for orphan care more precarious and lead to discriminatory outcomes for some children. Given the conditions of wide-scale poverty and the vulnerabilities of children as a result of HIV/AIDS, government support in the form of a social protection floor that includes comprehensive measures to address the physical, social, psychological and environmental well-being of children is urgent.
Conclusions and recommendations

Orphans and vulnerable children experience multiple deprivations, vulnerabilities, risks and hardship. They lack parental support and tend to be socially isolated. Without specific social interventions, they remain vulnerable and at high risk because their resilience to cope is weak. Their developmental outcomes are affected by extreme poverty and life-cycle changes. Social protection measures are essential ways through which their needs can be addressed.

In Mozambique, the foundational efforts to put the necessary legal framework in place have been undertaken. Nevertheless the literature review and field research indicate that few centres or households caring for orphans are reached by government support, while many care institutions remain insufficiently monitored (MMAS, 2006). The next challenge facing Mozambique is one of the legal framework’s effective implementation. Contextual factors that are critical for sustainable implementation and support for scaling-up have to include an enabling policy environment, strong government commitment and well-trained and motivated staff (Kadiyala, 2004). In turn, to ensure regular monitoring and to conduct evaluation visits to families and institutions, there is an important need to develop the capacities of local administrations responsible for social protection (UNICEF, 2009a). Support to rural areas is a priority and special attention must be given to guarantee that available support reaches those most in need.

As for foster families, the findings indicate that if families are not well prepared to receive orphans then children may experience harm, possibly more so than can be the case when in residential care. Urgent government action and measures to carefully select and prepare foster families who are to receive orphaned children into their care are necessary. These may include effective selection and gatekeeping mechanisms for care arrangements, capacity development at the grassroots level so that social protection measures reach all those who need them, and community- or school-based counselling services. Without such measures children are open to abuse or mistreatment in foster families.

At the same time, children’s future livelihoods are a growing concern, particularly in Southern African countries where HIV/AIDS has tremendous detrimental impacts on human capital development (Greenblott, 2008). Under such circumstances, greater emphasis should be given to the importance of programmes that equip children and youth with skills and knowledge to engage in economic activities through vocational and skills training centres. The benefits of such programmes are evident where children have access to them, for example in Catembe, Chimoio and Beira.

Overall the findings highlight that children who have access to care centres are relatively better off than orphans who do not participate in any of these
programmes, who reside with family members and who receive no information or support. Children with access to meals were in better health, underlining that the future expansion of feeding programmes is necessary.

The adoption by the International Labour Conference of Recommendation No. 202 (2012), concerning national floors of social protection, seeks to support the realization of “nationally defined sets of basic social security guarantees which secure protection aimed at preventing or alleviating poverty, vulnerability and social exclusion” (ILO, 2012). The Recommendation includes support for children, calling for basic income security to provide “access to nutrition, education, care and any other necessary good and services” (ILO, 2012).

Mozambique is already on the right path in terms of policy and planning to support orphans, as can be seen in the approval of the Regulation for Basic Social Security in 2009 and, subsequently, the National Strategy for Basic Social Security for 2010–2014 (Mausse and Cunha, 2011). However, the socio-economic context in Mozambique calls for a more systematic and comprehensive social policy response that efficiently addresses both chronic poverty and vulnerability as a result of the impacts of HIV/AIDS, particularly for orphans. The further development of the existing support centres and programmes, accompanied by the realization of comprehensive social protection measures to improve the living standards of communities, including foster families, would be the way forward to better support orphaned children. Such comprehensive social protection measures also require resources to ensure implementation, thus an appropriate government commitment to allocate sufficient finance from the state budget is crucial.

Without the implementation of such comprehensive social protection measures, these vulnerable children will continue to be at risk of being cared for by either foster families who do not have the necessary financial or social capacity to look after them appropriately or by alternative care centres that do so within the capacity of their own funding and quality control mechanisms, but which may not be sustainable in the long run.

Bibliography


Alternative care options and policy choices to support orphans

November-3 December). New York, NY, Better Care Network, Save the Children, UNICEF.


WORLDVIEW

The health care system of the People’s Republic of China: Between privatization and public health care

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Abstract      Chinese health care policy has undergone numerous reforms in recent years that have often led to new challenges, inciting the need for further reform. The most recent reforms attempt to find a middle path between public health care provision and commercial private insurance. In this way, China is following in the footsteps of countries that initially increased the role of privatization in the 1990s and at the beginning of the 21st century, but are now gearing towards public health care. However, this process of constant reform has led to a lack of transparency in the functioning of the health care system, provoking a loss in public trust. There remains an important degree of uncertainty about the future direction of developments in China. Nonetheless, a dual financing approach to health care using tax finance and social insurance might yet crystallize, offering a potential model to inform developments in other countries.

Keywords  health insurance, access to care, quality of care, consumption of health care, China

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Introduction

Before the process of economic reform that started in 1978, every citizen in the People’s Republic of China was guaranteed rudimentary health care. With the subsequent reforms of the health care system, particularly those of the last ten years, there has been a fall in the quality of Chinese health care. Specifically, with the budgets of local governments subjected to cuts, the latter responded by privatizing public services, including health care. This has led to intense debates in Chinese society given that medical care has become unaffordable for many citizens.

Central government recognized this problem and initiated health care reforms. The question, however, is in which direction the reforms should go? Is public health care practicable? Or should preference be given to the privatization of health care services? Finding a consensus among the proponents of these two camps has proven difficult and the issue remains controversial (Liu, 2011).

With the objective of providing an overview and evaluation of the Chinese system of health insurance, the remainder of this article is structured as follows: the next section outlines the concept of health insurance and explains the recent reforms and the discussions that have accompanied these. We then discuss the trend reversal away from the privatization of health insurance towards an increased emphasis on state responsibility and public health care. The article concludes by considering whether these developments are a singularly Chinese phenomenon or whether they reflect broader international trends.

The concept of health care

With the foundation in 1949 of the People’s Republic of China (hereafter, China), an important aspect of the country’s planned economy was that responsibility for health care provision was borne primarily by the State and by state-owned enterprises. With the shift towards the introduction of the market economy in the early 1980s, state-owned enterprises could no longer meet the financial cost of social security and health care alone, not least because of competitive pressures. Reform was sorely required, given that with the gradual breakdown of the health care system a majority of rural residents and unemployed urban residents no longer received medical care from the State and had to finance their own medical care costs. A basic health insurance was established in 1998, but with coverage extended initially only to urban employees. To illustrate the coverage gap in the Chinese system in the late 1990s, approximately 50 per cent of the urban population and 80 per cent of the rural population were not covered by health insurance or had no access to health care (Ministry of Health –
Center for Statistics Information, 2005). Closing this gap is one of the current objectives of Chinese health care policy.

As for many other policy areas in the country, Chinese health care is separated into two parallel systems; specifically, one providing for care in urban and the other in rural areas (Table 1.). The decision about which of these two systems a citizen belongs to depends on the system of household registration (hukou). Once registered as a rural resident, for example, it is difficult for members of such a household to transfer to an urban registration and may only be possible at high financial cost. For this reason, many so-called migrant workers live in urban areas unofficially without any entitlement to receive social benefits, since such entitlements are tied to the original place of residence. In 2009, conditions altered for urban residents, making it no longer possible for these households to transfer their residency registration to a rural area. These bureaucratic hurdles act to impede the mobility of employees and citizens considerably.

An additional important question concerns the attribution of responsibility for health policy in China, since several Ministries are in conflict in this regard. For instance, the Ministry for Health is responsible for health policy and for the New Rural Cooperative Medical Scheme (NCMS). However, responsibility for social insurance policy, and therefore health insurance, lies with the Ministry for Human Resources and Social Security (MOHRSS). Furthermore, separate departments for the respective policy domains exist at the level of the State Council, the country’s chief administrative authority. This constellation of actors leads to difficulties in decision-making processes, since each Ministry has its own objectives and agenda. The Chinese administration is separated into a total of five levels of administration: national; provincial, which also includes the autonomous regions; county; district; and municipal. Different formal interests with influence over health policy exist at the national and provincial administrative levels in particular, a reality that conflicts with centralized governance structures and which leads to problems in

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<th>Table 1. Health care by population group and coverage</th>
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<tr>
<td>Population</td>
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<td>Employed city resident</td>
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<td>City residents without an employment contract</td>
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<td>Rural residents</td>
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decision-making as well as in the implementation of policy and law (Bloom, 2004).

**Urban Employee Basic Medical Insurance (UEBMI)**

As early as 1988, pilot projects were conducted with respect to the UEBMI. The experiences gained from these were included in the “Decision of the State Council regarding the creation of a basic medical insurance system for employees in cities and municipalities” of 14 December 1998, which specifies a nationally-standardized framework for statutory basic medical insurance. All employers registered in cities and municipalities must participate in the UEBMI and insure their employees. Provincial governments have the authority to decide whether companies in rural districts, as well as independent farmers, should insure their employees in the programme. The UEBMI currently covers only about 20 per cent of the population of 1.3 billion people, which equates to more than 237 million people (MOHRSS, 2011). Regardless, taking into account and comparing all branches of social insurance operating in the country, the level of coverage extension attained by the UEBMI is the highest.

Employers and employees jointly pay the total contribution (6 per cent of the monthly payroll is paid by employers and 2 per cent of the monthly wage by employees). The UEBMI was designed based on World Bank advice, i.e. in addition to a solidarity fund, each insured person saves a percentage of his or her salary in an individual medical savings account that is maintained by their respective Office for Human Resources and Social Security. The contributions paid by employers finance the solidarity fund and also their employees’ personal medical savings accounts. The contributions paid by each employee finance only his or her individual medical savings account. The solidarity fund is primarily intended for the payment of the costs of inpatient treatment as well as outpatient treatment for specified severe chronic illnesses. In general, the insured pays for outpatient treatment from his or her individual medical savings account, according to defined minimum and maximum amounts. These specific amounts, as well the value of individual co-payments, are determined by local government. Over time, the system of medical insurance for employees has become less generous as a consequence of reforms. For instance, whereas the former system was, for the most part, free of charge, insured employees must now pay contributions and the level of reimbursement provided for health care costs borne has been reduced (Zhang, 2005).

In addition to the UEBMI, a complementary company health insurance for employees is being promoted. To complete the picture for employees, civil servants and public-sector employees receive additional benefits and a medical financial assistance programme (MFA) exists for vulnerable people in need.
Urban Resident Basic Medical Insurance (URBMI)

When the UEBMI system was introduced, it became apparent that those who were not employed – such as students and people with disabilities – would remain uninsured or excluded from social insurance protection. It was not until 2007 that pilot projects offering basic medical insurance for urban residents who were not employed were introduced in various cities and municipalities. On 1 July 2007, the “Guidelines of the State Council regarding the expansion of the pilot project of the Urban Resident Basic Medical Insurance” were published. Since 2009, the URBMI has been introduced nationally, albeit that participation is currently voluntary.

The URBMI is funded through contributions paid by the insured and government subsidies. In the pilot phase, the amount of the contribution was specified by the respective city government. In accordance with the pilot plan of 2007, the insured person received an annual subsidy of at least CNY 40 from the government,1 of which the central government met CNY 20 for people living in Central and Western China. In 2008, the subsidy was doubled. Since 2012, the subsidies from central and local government budgets amount to CNY 240 per capita (Office of the State Council, 2012). Children and students with severe disabilities, poor elderly people older than age 60, and residents living in deprived areas receive additional subsidies from the local and central governments. The insurance is organized on a pay-as-you-go basis, meaning that the contributions paid by the insured plus the state subsidies are used to finance medical services and no substantial financial reserves are built up. There are no plans to introduce URBMI individual medical savings accounts.

The URBMI is primarily used for the costs of inpatient treatment as well as outpatient treatment for specified chronic illnesses, according to defined annual minimum and maximum limits as determined by the city government. The insurance works to the principle that “receipts determine expenditures”; receipts for medical treatment must be provided within the time requested, otherwise the insurance will not reimburse costs. Since 2010, the reimbursement ceiling is equal to six times the average annual disposable income of local adult citizens; from 2012 onward, it should be no lower than CNY 60,000.

New Rural Cooperative Medical Scheme (NCMS)

During the period of the planned economy, a rural cooperative medical scheme had existed that was based on the principle of mutual help with state support. As a consequence of the introduction of market-oriented reforms, the people’s communes (remin gongshe), which were responsible for many aspects of local

1. In October 2012, CNY 100.00 was equivalent to EUR 12.24 or USD 15.98, approximately.
decision-making in rural areas, were dissolved, farming was de-collectivized and a system of budget responsibility introduced. As a corollary of these developments, the cooperative medical system broke down (Duckett, 2011). In 1986, approximately only 5 per cent of the rural population had access to [public] health care (Hua, 2007). The rural population was left to bear the costs of medication and treatment, costs which were rising steadily owing to inflation and because of the market orientation of the reformed health care system. As a result, there had been a tendency for the rural population to avoid medical treatment, causing illnesses to be more protracted and heightening the risk of the spread of diseases and epidemics. An increased risk of poverty had also occurred in instances where household income has been required, for example, to pay for the treatment of a single family member with a catastrophic illness, such as cancer. Since the 1990s, the Chinese government has undertaken to rebuild the cooperative medical system, albeit in a modified form. In 2003, New Rural Cooperative Medical Scheme (NCMS) was introduced. According to official statistics, by the end of 2009, 0.83 billion people were insured, representing 94 per cent of the rural population (Ministry of Health – Center for Statistics Information, 2009). This result has been achieved despite participation being “voluntary”. In reality, however, the high level of participation can be explained by generous state subsidies to the system and to the pressure to join the NCMS that has been exerted by local governments on the rural population in order to fulfil plan targets. In practice, the NCMS operates more like a mandatory system.

The old cooperative medical system had been financed primarily through the rural collective economy and administered at the level of the village municipality. By contrast, the NCMS – even though it continues to be referred to as a “cooperative system” and is administrated by the Ministry of Health – is essentially financed by farmers’ contributions and subsidies from different levels of government. Only limited support comes from the collective economy. The system’s funds are established and administrated at district level. In principle, the extent of the provision of health care services is delimited by the value of those funds received alone – unless the State provides additional subsidies. The insured farmer initially paid a minimum of CNY 20 per year in contributions and central and local government budgets provided subsidies (Office of the State Council, 2012). Moreover, municipalities and villages should also support the NCMS if they operate collective enterprises. In this regard, district governments are responsible for setting the guidelines for such support. The funds of NCMS – like those of the URBMI – are primarily

2. In addition, since 2002, experiments to develop social insurance to mitigate the financial risk associated with the treatment of severe diseases had been continuing and was introduced nationwide in 2008 (Central Committee of the Communist Party of China, 2002; Ministry of Health and Ministry of Finance, 2008).
used to meet the costs of inpatient treatment and outpatient treatment for specified chronic illnesses. The scope and level of the services are set by the district government.

Over time, the subsidies accorded to the NCMS from central and local finance budgets have increased from CNY 20 per capita in 2006 to CNY 40 per capita in 2008, and currently sit at CNY 240 (as they do for the URBMI). In 2012, the annual contribution to be paid by farmers was set at CNY 60. The annual reimbursement ceiling is equal to eight times the average national annual income (Office of the State Council, 2012).

**Medical Financial Assistance (MFA)**

The MFA programme was deemed necessary because the UEBMI does not extend coverage to all groups of people and because the URBMI is voluntary. Furthermore, the adequacy of coverage is very low, requiring that considerable co-payments are made to finance treatment. These different coverage gaps are expected to be met by MFA. Since 2003, MFA systems have been established in rural and urban areas. In accordance with the “Decision of the Central Committee of the Communist Party of China and the State Council regarding the further strengthening of rural medical care”, various Ministries in 2003 published the “Views regarding the implementation of rural medical assistance”.

By the end of 2005, a nationwide system of rural medical assistance had been set up. Those in need who receive assistance are the families of poor farmers and “Five Guarantees” households. In those areas covered by the NCMS, those in need can receive financial assistance to subsidize their participation in the cooperative medical system. In cases of severe illnesses, families are granted the necessary medical financial assistance. For families in need who do not participate in the NCMS, direct medical financial assistance is limited to hospital care.

In urban areas, those in need are defined as residents who receive assistance for the existential minimum, those who do not participate in the UEBMI, those who do participate in the UEBMI but cannot meet medical costs, and others in difficult circumstances. In all cases, MFA is paid to support the costs of hospital care.

The regulations for the disbursement of MFA in rural and urban areas are set by local governments, who establish and maintain funds. In the poorer central and western areas of China, local governments receive central government support

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3. The “Five Guarantees” households refer to families in rural areas that receive specific assistance. This assistance guarantees those in need with food, clothing, housing, medical care as well as funeral services (Liu, 2011).

4. The existential minimum is the level of income required as a social necessity. It is generally much lower than that required to sustain a nationally-determined minimum standard of living.
The MFA system is still in its early days and although its role is increasingly understood, its broader implementation is taking place only gradually.

**Analysing the reforms**

With the reforms, the quality of care offered by the Chinese health care system has deteriorated. The new health care system covers practically only the risk of severe illnesses completely. This means that basic health care and outpatient treatment have to be self-financed by the insured (Ge and Gong, 2007). In addition, the regulations regarding the minimum and maximum limits for reimbursement are so strict that in the case of UEBMI, on average, approximately 40 per cent of the costs have to be borne by the insured (Gao, 2006); in the case of the NCMS it is more than 70 per cent (Assessment Group, 2006). This represents a distinct drop in the level of coverage in comparison to the care provided at the time of the planned economy.

The UEBMI includes a system of individual medical savings accounts used for the costs of outpatient treatment. This model, copied from statutory old-age pension insurance, has been criticized by observers (Gao, 2006; Rösner, 2004) because the solidarity role of social insurance is given only limited consideration – only 4.2 per cent of total insured wages are paid into the health insurance solidarity fund – with the insured having to predominantly finance basic health insurance (Lin, 2002; Ge and Gong, 2007). Furthermore, the administration costs for the individual medical savings accounts in relation to the low level of contributions that are paid into them are relatively high, while the interest rate paid on individual savings is low. In turn, the individual balances can be used by the insured for purposes other than meeting medical costs, e.g. with the approval of the responsible agencies, they can be used to purchase goods at certain department stores (Ministry for Labour and Social Security, 2007a). This is one reason why it has been repeatedly suggested to do away with individual medical savings accounts – a suggestion that, to date, the Chinese government has chosen not to follow.

With respect to the objectives of the health reforms, the State has so far only achieved one objective, which is the reduction of its own financial burden. The total sum of health care expenses grew from 3.17 per cent of GDP in 1980 to 5.62 per cent of GDP in 2003. However, only 17 per cent of the costs in 2003 were financed from the government budget (Chen and Wang, 2007); the rise in health care expenses was borne by citizens. Health care costs have now become the third most important family expenditure item, after food and education (Ministry of Health – Center for Statistics Information, 2005). Owing to the inadequate provision of social security protection, citizens are forced to save more to finance old age and ill-health. This acts to thwart the development of domestic demand, which...
for the Chinese government is an important objective for sustainable economic growth. Citizens, experts and official research institutes alike have all criticized the health system reform, considering it as having failed (Wang, 2003; Ge and Gong, 2007).

Privatization of public hospitals

The provision of public health services is linked tightly to the design of the social insurance system and its benefits and services. The majority of doctors in China work in hospitals and hospitals play a central role in health care. For this reason, an analysis of Chinese health care must take into account the role of public hospitals as important service providers.

Under the planned economy, public health care was an integral part of social welfare and subsidized by the State. The State controlled the price of medical services and medication to ensure that health care services were affordable to all citizens. Prior to 1978, hospitals received more than 50 per cent of their income from the government budget (Wang, 2005). From 1985 onward, to reduce the burden on the State budget, the government introduced health care reforms and granted more autonomy to hospitals, which led to a substantial degree of privatization. Since 1985, a larger share of the cost of health care has been placed on hospitals and also on citizens (Liu, 2011). By the end of the 1990s, government subsidies amounted to a mere 6 per cent of hospital income (Wang, 2005). To help cover their expenditure needs, public hospitals were authorized by the government to specify the prices of medical services and drugs. Consequently, the income derived from services and drugs has since become public hospitals’ main source of income.

The increased autonomy of hospitals and, in particular, the power to specify prices left the system open to abuse (Meng et al., 2004), with hospital doctors prescribing services and medication not suitable to patients’ needs and issuing inflated invoices. Treatment costs increased drastically in the 1990s, with the result that many patients were unable to meet costs. Commonly, patients either sought to avoid treatment or were impoverished by the high financial burden that treatment implied (Liu, 2011; Darimont, 2009; Duckett, 2010).

An outcome of public health service reform was that the large city hospitals expanded, while health centres for primary and preventive health care in rural areas were closed owing to a lack of state financial support. With reduced access to such care, infectious diseases and epidemics have occurred increasingly in recent years (Wang, 2003). After the SARS (Severe Acute Respiratory Syndrome) crisis in 2003, the health care reform came increasingly into question and the government was urged to take responsibility for the financing and maintenance of the health care system (Ministry for Labour and Social Security, 2007b). As a result, new reform projects were created.
Reform projects in the provinces

Although the self-financing of the public hospitals applied nationally, in 2001 the administrative district of Suqian in the province of Jiangsu introduced a radical reform of its public health care facilities. Suqian had encountered financial difficulties following the financial reform of 1994, wherein the city government having been made responsible for public services, such as education and health care, could not finance them. In consequence, the local government decided not simply to cease subsidies to public hospitals but rather to sell them. By 2006, 134 of the 135 hospitals had been sold by the government. The income was used to finance public health centres and basic health insurance (Research group of the University of Beijing, 2006).

The Suqian reform triggered a fierce debate amongst experts. Renowned economist Li Ling and her research group published a report in the wake of a review of the Suqian reform in which the commercialization and privatization of health care was criticized on the grounds that no cost reduction in health care could be found and public health care had not improved. The complete absence of a price control mechanism for hospitals was remarked upon, which enabled unrestrained price increases. Li Ling argued that local governments’ financial difficulties should be addressed through redistribution between the central and local administration levels; for this, the State would have to take over more responsibility for health care (Research group of the University of Beijing, 2006).

In contrast, a liberal economist, Zhou Qiren, assessed the Suqian reform positively. It was argued that even though citizens continued to be burdened by treatment costs, the State and, in particular, the governments were no longer so. In his opinion, the State should not intervene, but allow for free competition amongst the hospitals (Zhou, 2007).

The debate about the Suqian reform quietened down following the publication of the “Notifications of the Central Committee of the Communist Party of China and the State Council regarding the deepening of the health care reform” in 2009. In this notification, the responsibility of the government for health care and its character as a common public good were emphasized and the complete privatization and commercialization of public hospitals excluded.

In 2009, as a counter model to the Suqian reform, the so-called Shenmu model, was discussed – a model which looks to address issues related to citizens’ dissatisfaction with the health care system and those of high treatment costs and low service levels in particular. Shenmu, a district in the province of Shanxi, has significantly increased health care service levels since 2009, to the extent that a sort of state-financed, free-of-charge health care system now exists for Shenmu citizens. In
contrast to Suqian county, Shenmu is a rich district and the local government can afford to take on the costs for health care and make public health a priority.

The 2009 “Implementation measures of the district of Shenmu for free-of-charge health care” state that all citizens with a Shenmu residence registration can access health care, free of charge, if they participate in health insurance and pay contributions. For outpatient treatment costs, a resident of the district may receive subsidies amounting to CNY 100 per year. For inpatient treatment, the ceiling for reimbursement was increased to CNY 300,000 per year. The minimum reimbursement for inpatient treatment at municipal hospitals is CNY 200 and CNY 400 at district hospitals.

The Ministry of Health and the Ministry for Civil Affairs assessed the first 12 months of the Shenmu experience as very positive. The Minister of Health, Chen Zhu, stated that around 20 per cent of all districts in China could bear the costs of a similar reform. Other experts consider this model to be utopian, however, since it is unclear how poorer regions should finance the free-of-charge health care if this policy were to be expanded nationally (Gu, 2008). Overall, the Shenmu model could not gain traction.

In 2009, a health care reform was set in motion in the province of Anhui wherein health centres – primary health care facilities – were to be financed by the State and the market for pharmaceuticals strictly controlled by the government. Reform in Anhui province, which is one of the poorer provinces located in central China, was overdue, with the weaknesses of earlier reforms having become strikingly apparent. The health care reform can be traced to 23 November 2009, when the provincial government passed the “Preliminary views regarding the comprehensive reform project of the basic health care and medication system”. The system of social insurance is accompanied by state-mandated prices for pharmaceuticals that apply to all of Anhui province. The prices of pharmaceuticals are 52.8 per cent of that paid nationally. While this policy has been attacked by the pharmaceutical industry and slated as a return to the planned economy, pharmaceutical products have become affordable for citizens and co-payments as part of the social insurance system have stayed within limits. Furthermore, medical facilities – such as health care centres in rural or urban areas and public hospitals – are publicly-financed, and are not required to depend on the income from the sale of pharmaceuticals. In principle, treatment for mild ailments should be sought at health centres, with hospitals treating only more severe cases, and rehabilitation should be undertaken at home. Overall, the costs for treatment and hospital stays for the insured population were lowered to 11.47 per cent of the total costs (Zhu, Gu and Chu, 2011). The Anhui reform model is considered exemplary, and is to be implemented nationally.

These experiences, to date, suggest that only a comprehensive reform involving the market for pharmaceuticals, social insurance regulations and public health care...
is capable of addressing the weaknesses apparent in current Chinese health care provision.

**Tendencies in Chinese health policy**

Increasing levels of dissatisfaction among the population with the inadequate provision of health care led the government to make improvements in social policy outcomes one of the most important political objectives outlined in the 6th Plenum of the 16th Central Committee of the Communist Party of China in 2006 (Duckett, 2010). With the goal of building a “harmonious socialist society”, a comprehensive, universal social security system is to be established by 2020. This task was formulated in the “Decision of the Central Committee of the Communist Party of China regarding some important questions regarding the structuring of a harmonious socialist society”: “Everybody enjoys a basic livelihood, everybody enjoys basic medical care” (Hu, 2007). To this end, since 2006 increasing state financial support has been directed towards public services. Furthermore, at the 5th Plenum of the 16th Central Committee of the Communist Party of China, a decision was taken to support efforts to increase domestic demand. In this regard, an expanded social security system is viewed as one way to enable citizens to spend more on consumer goods (World Bank, 2006).

Increasing criticism of the health care system compelled the government to initiate new reforms. In 2006, a health care reform coordination group was established in which 16 Ministries and Commissions of the State Council were involved. The State Commission for Development and Reform and the Ministry of Health prepared the reform plan. At the end of 2007, the State Council published the new health care reform guidelines in a report to the Permanent Committee of the National People’s Congress (NPC). However, owing to a number of disputes, the reform plan was not passed by the Central Committee of the Communist Party and the State Council until 17 March 2009 (Central Committee of the Communist Party of China, 2009). The guidelines provide local governments with considerable leeway and many provinces have initiated their own health care projects. However, with different reform concepts being pursued in different provinces and even cities, an outcome has been a weakening of clarity and transparency.

**Consensus regarding increased government responsibility**

Chinese social scientists agree that the government has the capacity to take on more financial responsibility for national health care (Wang, 2005). The guiding principles of the renewed health care reform, laid down by the Communist Party of China in the decision regarding the design of a socialist harmonious society in 2006 (Central Committee of the Communist Party of China, 2006), state:
“The character of the public health system as a public good has to be maintained, the responsibility of government has to be increased.”

The objectives of health care reform are to establish a basic medical system and to assure effective and affordable health care services for citizens (Central Committee of the Communist Party of China, 2006). In accordance with the 2006 decision, the health care system should include basic health insurance for urban employees (UEBMI), the new rural cooperative medical scheme (NCMS), basic health insurance for urban residents (URBMI), and medical financial assistance (MFA). Furthermore, it should include public health care interventions, which encompass disease prevention, treatment of infectious diseases and epidemics, maintenance of hygiene, as well as health care services for mothers and children. A network of public medical facilities is being created by the government; all medical facilities will be coordinated and administrated by local health authorities. Also, the supply of pharmaceuticals was to be assured, with the government to set the prices for essential drugs. In future, public health facilities were no longer to be permitted to generate profits from the sale of pharmaceuticals (Central Committee of the Communist Party of China, 2006). In accordance with the Statements of the Communist Party of China and the national government from 2009, governments at all levels are responsible for financing public health care and medical facilities as well as for subsidizing public hospitals and health care. In the 2009 Notifications, the health care system was for the first time called a “Public good for all citizens” (Central Committee of the Communist Party of China, 2009). This is, to date, considered the most significant step of the health care reform, since previously the focus had been placed primarily on reducing health care costs (Wang, 2009).

Disagreement with respect to the health care financing model

The debate in China has since moved on to consider more precisely how the costs of health care are to be distributed. A decisive issue is how costs are to be distributed across government, society and citizens. Another concern is which health care financing model is to be used: is it to be mainly financed through tax funds or via contributory social insurance? So far, the Chinese government has not made a clear decision in favour of one or other approach and, indeed, is searching for common ground. This approach, however, is creating uncertainty about health care policy.

In the opinion of Ge Yanfeng and his group from the Research Centre of the State Council for Development, a basic health care system should be introduced into the existing health care system which comprises health insurance as well as medical assistance. This system could be financed by the State through tax funds.
Common illnesses could be treated at public health facilities free of charge. Social health insurance would intervene for the treatment of severe or cost-intensive illnesses not covered by the basic care system, and the two systems would be complementary (Ge and Gong, 2007).

The creation of tax-funded basic medical care is deemed advantageous by the State Council’s Research Group, owing to the current high levels of income disparity and high levels of poverty, especially among the rural population and in less-developed regions. Those with low incomes do not have the financial means to participate in health insurance. The government could solve this problem through state subsidies and medical assistance. The administration costs, however, would be very high in isolated rural areas. Furthermore, given the current organizational structure and administration of the health insurance system, the system would have great difficulty operating effectively (Ge and Gong, 2007).

The introduction of such a tax-funded health care system has been critically presented as a “Return to the Chinese tradition of state responsibility” (Wang, 2005), since under the planned economy, the State was responsible for the social security of its employees. Overall, it bears similarity to the British National Health System and combines the socialist tradition with European experiences and liberal influences so that this model might be capable of forming a basis for consensus (Wang and Ding, 2006).

A draft prepared by the Ministry of Health offers a vision of a three-tiered health care system that largely mirrors the concept presented by the research group led by Ge Yanfeng (Wang and Ding, 2006). As the first tier, all citizens are guaranteed basic medical services through standardized tax-funded health care. The second tier offers mandatory health insurance for severe illnesses. Designed for employees, this tier is jointly financed by employees and employers and provides coverage also for insured employees’ family members. Finally, the third tier comprises commercial complementary health insurance.

The tax-funded basic medical care model is preferred by many experts (Liu, 2005; Li, 2006). In contrast, Gu Xin proposes a social health insurance system, which in China is referred to as the “German model”, in order to achieve the objective of comprehensive medical care. In contrast to the costs of the creation of a new social security system, the transition costs of the health care reform could be drastically reduced through the improvement of the existing health insurance systems (Gu, 2008). In accordance with Gu’s reform plan, the following measures should be implemented: the levels of coverage under the different health insurance schemes could be extended through higher state subsidies and the conversion of voluntary systems into mandatory systems; health insurance benefits should not only cover the treatment of severe illnesses but frequently occurring illnesses; and medical expenses should be reimbursed by social insurance up to 70–80 per cent of the costs incurred (Gu, 2008).
The Ministry for Human Resources and Social Security is leaning towards implementing a social insurance model that – to the extent possible – covers all citizens (Wang and Ding, 2006). A Research Institute for Social Security report argues that the government could not finance a tax-funded basic health care system. With such a system, the high financial burden to the government and risk of citizens’ dissatisfaction with the quality of health services could lead to direct confrontation between the government and citizens. This could be avoided through the introduction of a third party system – a social insurance carrier (Ministry for Labour and Social Security, 2007c).

For the Communist Party of China and the government, stability in society takes highest priority. The setup of the URBMI and the NCMS were intensified in 2008 and financially accelerated by the State. Political efforts are aimed at extending coverage for basic medical care to 90 per cent of the total population (Central Committee of the Communist Party of China, 2009).

**Final considerations**

Current Chinese central government policy emphasizes the value of solidarity and recognizes health care as a necessary public good to ensure well-being. Henceforth, public hospitals will no longer be permitted to generate profits through the sale of pharmaceuticals and shortfalls in hospital finance will be met through government subsidies. These new measures show that after three decades of the commercialization and privatization of health care, a paradigm shift is taking place in health policy.

State subsidies for public hospitals and health insurance benefits levels have been significantly increased to reduce individual costs for accessing health care (Central Committee of the Communist Party of China, 2009). From 2009 to 2011, a total of CNY 850 billion was spent by governments on the health care system (including CNY 332 billion by the central government), of which two-thirds were directed towards people in need. In 2012, the subsidies for the NCMS and the URBMI were increased to CNY 240 per capita. Clearly, the State has taken on more responsibility and is facing up to its obligations.

At the same time, however, the market economy is developing and free competition is being pushed to the fore in the setup of the pharmaceutical system (Central Committee of the Communist Party of China, 2009). To have a stronger influence on controlling prices, pharmaceuticals were to be procured centrally. In spite of this, pharmaceutical manufacturers have come out as the reform “winners” and the policy for the central procurement of pharmaceuticals, having encountered stiff resistance, was dropped (Yang, 2009; Duckett, 2010). Instead, price competition is being permitted for essential drugs, with the State’s role limited to one of providing price recommendations. Essentially, the reform of the
pharmaceuticals market has been stopped, a result traceable to the influence of interest groups on the political decision-making process, including the lobbying activity of the pharmaceutical industry in Chinese politics. This has happened in the face of growing anger among citizens caused by ever more costly medicines, an anger that has sometimes been vented against doctors and hospital personnel (Bloom, 2004; Döring, 2008). In the end, a compromise will have to be found.

Overall, the current reform is a short-term improvement plan, but not a complete reformulation of the health care system. A consensus regarding the financing model does at present not exist, despite different suggestions and models, as the examples of Shennu, Suqian and Anhui illustrate. In the reform plan, the cancellation of the UEBMI individual medical saving accounts (Gao, 2006; Ge and Gong, 2007), as suggested by numerous observers, was not incorporated. However, cost reimbursement was regulated in the Social Insurance Act which came into force on 1 July 2011. On the positive evidence of several pilot projects in different provinces, a direct billing process is now anchored in the Social Insurance Act. The health care costs to be borne by the basic medical insurance funds are directly billed between the social insurance body and the respective medical facility or pharmacy. This direct billing process should furthermore also be possible between provinces.

Due to the great financial muscle provided by central government, it can be anticipated that the objective of improving the health care system will be achieved in the foreseeable future. However, the sustainable development of the health care system cannot be guaranteed by financial support alone and a theoretical foundation and comprehensive reform plan are equally needed. At present, the central government is substantiating the reform plan. Needing greater clarity is the financial distribution between central and local governments. Furthermore, a basic model of health insurance is required that conforms to the broader Chinese reality and which meets the expectations of the public – at present too many experiments and special models exist. The current situation leads to a lack of clarity for citizens, which does not build trust. Finally, regulations have to be created regarding the control of medical services and drug supply. These elements do not just affect the health care reform, but also impact the further reform of the finance system and the development of the “socialist market economy”. If no changes are introduced in these areas, health care reforms will be destined to fail. Economic reforms are feeding growing inequalities, which are increased further through the privatization of health care. Counteracting this situation will remain a challenge for the government for some years to come.

Typically, the high degree of decentralization of the Chinese health care system has increased discrepancies between rural and urban health care. Furthermore, with many pilot projects having been initiated somewhat arbitrarily, a fundamental concept of health care provision is lacking. This situation has generated social
injustices, given that some citizens receive free health care while others have to meet the costs in full. This runs counter to the vision of health care as a public good accessible by everyone. Removing the differentiation between the urban and rural population could be a decisive step. Furthermore, stronger national legislation in the area of health care is desirable to minimize discrepancies, create transparency, and thereby achieve trust in the system among the population.

The current debate regarding health reforms in developing countries focuses on access to health care at affordable prices and on reducing the burden on the state budget. In the 1990s, many countries sought to privatize health care. In recent years, however, these reforms have proven impracticable – sections of the population have been left excluded from social protection against the risk of illness. In the search for the best solution, different options exists as regards social insurance, tax-funded preventive health care and private health care. For some, tax-funded models are preferable (Baeza and Packard, 2007). This model, however, can only be applied in countries of the global South to a limited extent, since the national tax system may be underdeveloped and the total tax take too low. Therefore, pluralistic approaches would appear more promising. In some countries, social security cash benefits systems were established that combined tax-funding and social insurance (van Ginneken, 2007). Historically, to insure against the risk of illness, countries have tended to use either a social insurance or a tax-funded model of health care protection. A blend between Bismarck and Beveridge was not envisaged. If China is viewed in this light, the health care system being developed could prove trend-setting for other countries of the global South, given that a synthesis of both models may compensate for their respective disadvantages.

Bibliography


The health care system of the People’s Republic of China: Between privatization and public health care


European unemployment protection systems – like the rest of the welfare state established after the Second World War (notably pensions) – were based on the premise of stable employment and the “male breadwinner” model. But by the mid-1960s, this model was trending towards steady decline in Europe. Determinant factors in this movement were rapid technological change and globalization (which changed the international division of labour and was accompanied by mass dismissals). And while the potential for job growth may have shifted to the service economy, this was characterized by more diversified and less stable employment relationships. The existing unemployment protection systems, modelled on lifelong, full-time and stable employment with only temporary stints of unemployment, were thus ill-equipped to offer effective coverage in labour markets dominated by “atypical” and “flexible” employment.

Over the past two decades (1990–2010) – a period whose beginning and end were marked by a major recession and high unemployment – few comparative and comprehensive studies have been devoted to the question of how to manage the risk of unemployment in the context of labour market change and transition to the service economy. This volume thus fills a gap in helping to explain some major policy shortcomings.

The book consists of two parts and an introductory chapter. Part I contains 12 national case studies that highlight the history, objectives, focus and institutional as well as political context of unemployment protection and how it has adapted to changing economic and societal contexts during the past two decades. Part II contains a cross-European comparative analysis in four chapters, comparing the changing nature of the transition between non-employment and employment, the changing composition of working-age benefit receipt, adjustments in active labour market policy (ALMP) in a changing economic context, and the transformation of unemployment protection.

The purpose of traditional contributory unemployment insurance that emerged across Europe in the first half of the twentieth century was to provide income replacement during cyclical or frictional unemployment. While in most countries this insurance has been – and still is – compulsory, in others it was voluntary, run by trade unions and subsidized by the state (known as the Ghent system). Most countries also have social assistance – a secondary system of unemployment assistance that is usually means-tested and paid at a lower benefit level than employment insurance – for people who do not qualify for the social insurance benefits (e.g. because of an inadequate period of contribution or for those who have exhausted the period of entitlement to insurance benefits). While unemployment insurance existed alongside, and sometimes was coordinated with, labour exchanges or other employment services, it generally did not include ALMPs. An exception to this was Sweden, where public works programmes have existed since the
pre-war period, and which were further developed in the 1950s for retraining redundant workers from non-performing firms. Beyond Sweden, the authors argue, the income replacement function of unemployment benefits helped improve the skills and job-matching of the industrial workforce, providing a “breathing space” or opportunity for skills upgrading. Therefore, income replacement schemes should not be qualified as merely “passive”, as opposed to the so-called “activation” approach that has become prominent over the past two decades. Moreover, unemployment benefits also provide a shock absorber by sustaining demand in times of economic downturns.

While acknowledging cross-country institutional differences in unemployment protection, the authors argue that they present less diversity than in other areas of social protection (e.g. pensions and health care). This may be indicative of the centrality of unemployment insurance to the functioning of industrial labour markets in all countries, which share similar institutional characteristics and an economic logic. This logic has changed with the transition to service-based “atypical” employment with a rise in low-skilled and low-paid work, wherein the risk of unemployment is no longer merely cyclical or frictional but increasingly structural.

Between the late 1970s and early 1990s, the reaction of welfare states to this changed risk profile and to growing pressures on public budgets differed, albeit while retaining some common features. Countries rooted in a Keynesian approach still tended to consider unemployment as a transitory crisis and thus spared the core workforce (the “insiders”) from cuts in benefits. In countries where Keynesianism was weakly institutionalized and a monetarist approach had developed, these resorted more to means-testing and cuts in the level and duration of benefits for workers in atypical jobs. During this period, as the duration of unemployment increased and its incidence rose, the design of the social protection system tended to encourage the unemployed and other excluded categories to quit the labour market via different exit routes (e.g. early retirement, disability, extended parental or other leave, or “inactivity”). This enabled governments to limit open unemployment, while claiming advances in social rights. Masking unemployment was also accompanied by a massive expansion of ALMPs that focused mainly on providing public or para-public temporary employment, especially for unemployed youth, weakening the original role of public employment services. Moreover, other benefit schemes, originally designed for people not expected to be active in the labour market (single mothers, people with mental health problems and with an assessed incapacity for work, or those excluded due to skill obsolescence) were increasingly used to label people as economically inactive, blurring the division between employment and non-employment benefits, a trend defined a decade later as “welfare dependency”.

This perverse outcome led to a policy reversal by the mid-1990s that closed the multiple labour market exit routes and sought to reorient unemployment protection systems towards enhancing flexible labour relations, thereby contributing to the expansion of the service sector. This, in turn, required a fundamental institutional change of traditional unemployment protection systems towards what the authors argue is a process of “triple integration”.

First, “benefit homogenization” (or standardization) which delinks the social right to benefits from the level and duration of contributions (i.e. by reducing benefits’ generosity, weakening or eliminating their link to earnings or a contribution record, and reducing the differential between insurance- and assistance-based benefits, or offering a universal flat rate).

Second, “risk re-categorization” which blurs the distinction made between the risk of unemployment and other risks facing the working-age population – i.e. a distinction around which
social protection systems have been organized. This process has the potential of allowing the low productivity service-based economy to grow by enhancing its capacity to mobilize as much as possible the potentially active population. Risk re-categorization can be achieved, for example, by harmonizing benefit levels and obligations (particularly job search) among the unemployed and other risk categories, or by creating a single benefit scheme for all working-age people, arguably the most radical measure, where job-search obligations and access to additional support services would be targeted to the needs of individual claimants. Another development to reinforce such risk re-categorization is the recent emergence and rapid increase of in-work poverty in several countries, generating a “new” risk of poverty while being employed, leading to social assistance measures for the working poor. This has blurred the former distinction for entitlement to social assistance vis-à-vis the non-working and the working population – making employment status a less relevant operational category for labour market and social policies.

Third, “benefit activation” has emerged in many welfare states since the early 1990s in response to the rising difficulties of transition from unemployment to work among the low-skilled, and to the existing disincentives for such transition. A growing reliance on activation requires a better articulation, if not integration, of the administrative structures dealing with labour market programmes and job search with those providing benefits for all claimants of working age, including those outside the labour market. This requires a change in the regulations related to the differing specific obligations of activation, as well as common administrative units responsible for “passive” and “active” measures and for benefits and services for the unemployed as well as other benefit claimants (i.e. “single gateways” and “one-stop shops”).

Contributors to this volume have tried to assess the extent to which such institutional transformation has taken place in European unemployment protection systems between 1990 and 2010. The countries chosen for the case studies were selected to reflect the full variation in institutional structures and political and economic context. They include unemployment protection systems embedded in very different welfare systems (referring to Esping-Andersen’s classification), ranging from the “liberal” system (United Kingdom), the “conservative-corporatist” (Belgium, France, Germany and the Netherlands) and the “social democratic” (Denmark and Sweden – which include the voluntary state-subsidized unemployment protection run by the trade unions). It also includes two Southern European countries where unemployment protection was underdeveloped in the late 1970s (Italy and Spain), two Central and Eastern European countries that reformed their welfare systems in the transition process to the market economy in the 1990s (Czech Republic and Hungary) and one non-European Union country that had very low unemployment in the 1980s (Switzerland). In these countries the limits of earlier policies to cope with rising unemployment became evident, as the role of social policy reform to enhance a dynamic and inclusive labour market was increasingly stressed by the European Commission – 1993 White Paper – as an essential component of growth and competitiveness, followed by the launch in 1997 of the European Employment strategy.

The case studies tend to confirm the authors’ assumption that changing labour market risks led to changes in unemployment protection. The ensuing dynamic reform process was facilitated by several years of growth between the mid-1990s and most of the following decade, until the outbreak of the global crisis in 2008. They include some comments on the nature and impact of this crisis.

The comparative chapters of Part II look at how patterns of transition between unemployment, inactivity and work have changed across countries, noting the extent to which reforms rendered
labour markets more inclusive but also more precarious. The cross-country trends show that changes in unemployment protection often involved shifts of working age non-employed people between different benefit support systems, but evaluation of these shifts is difficult due to insufficient comparable cross-country data. As changes in unemployment protection are closely linked to changes in ALMPs, this part also provides a macro-level comparative assessment of policy developments in this area. These developments often led to the triple integration process, though to an extent that differs among countries and across the three dimensions (benefits, risks and activation).

The inter-disciplinary analysis of this volume constitutes a precious tool for policy-makers, social actors and academics about how and why unemployment and labour market policies evolved in different ways in different political contexts, and what were the outcomes and implications for regulatory arrangements, institutional adjustment and social inclusion/exclusion. Also useful are the comments on the changing role of trade unions over time and in different countries – in some cases cooperating in the reform process, while blocking it in others – and the changing focus and rationale for reforms in the different countries and periods.

Particularly pertinent is the focus on the wide-ranging impact for the welfare state of the transition from the industrial era to the service economy, particularly in addressing the risk of unemployment. Given the protracted “hangover” of the global crisis, which threatens the world economy as much as the sustainability of the welfare state and social cohesion, the authors should be encouraged to pursue their analysis of its policy implications in a low-growth or no-growth economy with declining job-creation potential, rapid demographic ageing, global imbalances and low social protection coverage.

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This volume provides a useful comparative overview of the evolution of national unemployment benefit systems in Europe and North America. Initially these sought to provide income security to wage earners, but this primary purpose has been lost with the gradual erosion of the wage-earner’s employment status during the past 30 years. This has come as a result of the paradigm shift from collective towards individual responsibility for unemployment, which has had important ramifications in the wake of the global financial crisis of 2008.

The volume starts with two comparative chapters followed by national case studies. The first chapter offers an overview of unemployment benefit systems and highlights the main reforms undertaken over the past decade (or still in process), reflecting governments’ changing agendas and the debates surrounding them among stakeholders. Attention is drawn to the influence of national, European and global contexts, which together affect the scope of social protection. The chapter starts by comparing expenditures on labour market policies and unemployment, noting that these contrast sharply among European Union (EU) countries, though these differences do not reflect unemployment levels. Arguably, passive and active expenditure are not mutually exclusive. The former (i.e. expenditure on income guarantees and on early retirement) accounts for the bulk of expenditure in most countries, but the level of active expenditure is positively correlated to passive expenditure. Only in Bulgaria and Sweden does active expenditure exceed passive expenditure. Belgium, Denmark, Germany and the Netherlands boast high volumes of both passive and active programmes, while the Mediterranean countries, the United Kingdom and the Eastern European “new” EU member States have low passive expenditure. In the United Kingdom, activation is a key political objective, relying primarily on funding job placement agencies rather than on activation per se.

The book notes with caution that there has been some convergence of benefit spending among the EU-15, for whom expenditure levels kept rising until 1997, declining thereafter (except for a peak in 2000) and reverting in 2005 to 1993 levels. The author investigates whether there is a link between the level of spending on benefits and the unemployment rate and finds a strong negative correlation between unemployment levels and benefit spending in most countries (EU-15 plus Norway between 1990–2005, and EU-25 between 2000–2005). However, over the same period in Denmark there is no correlation between the two, while in the United Kingdom it is positive, reflecting lower benefit spending as the labour market improved. Employment contraction and rising unemployment following the “Great Recession” imposes a major challenge to the social protection system, whose ability to function as an economic and social shock absorber in the recession was impaired as a result of major adjustments made to benefit programmes during the past two decades. In the United States, by contrast, where unemployment insurance is financed by employers’ contributions alone and is devoted mainly to periods of temporary job loss, the...
counter-cyclical logic of the benefit entitlement period has been significantly extended and benefit amounts increased by the government’s successive stimulus measures introduced since the end of 2008. And yet, neither the Federal Government – for which unemployment insurance represents a low expenditure –, nor the trade unions, have attempted to reform the system’s institutional structure that was established in 1935. The author concludes that the general trend of contracting the scope of unemployment insurance in favour of social assistance benefits that are linked to activation, might lead gradually to a shift to a universal social protection system associated with minimum levels of benefits and protection against unemployment and poverty.

The second comparative chapter reflects upon the possible influence of a European approach to the reform of national unemployment benefits, including their method of financing, and to public employment services. The author notes that while national developments frequently precede European discourse, the latter’s influence is not at the level of policies but rather on the level of diagnosis. It offers support for individual responsibility and for solutions based on the early activation of the unemployed and other recipients of welfare benefits. On the one hand, the focus is placed on certain categories of unemployed, notably young people, to the detriment of the long-term unemployed, and on priority actions for specific groups, such as training for migrants, rather than other kinds of active expenditure (i.e. partial subsidies). On the other hand, the recent European debate on “flexicurity”, which favours combining a substantial level of unemployment benefit with a deregulated labour market and compulsory training, has displaced to an extent the earlier influence of the OECD’s focus on “making work pay”. In practice, this links the concepts of “making work pay” and the Nordic-inspired “lifelong learning”. But in the wake of the economic crisis it is not yet possible to identify the direction of the new discourse on unemployment. The author argues that institutional inertia may explain the emphasis of pre-crisis debates on flexicurity, while the lack of consensus on what caused the crisis hampers the formulation of appropriate responses. This, however, has not ruled out some institutional innovations such as subsidized short-time work (part-time benefits) that may have a longer-term impact beyond the crisis, and the rejection of early retirement that has been used extensively in the crises of past decades.

The bulk of the volume consists of 16 national case studies covering Belgium, Bulgaria, Canada, Denmark, France, Germany, Greece, Hungary, Italy, the Netherlands, Poland, Portugal, Spain, Sweden, the United Kingdom and the United States. These address the institutional set-up of unemployment insurance and assistance, the tightening of eligibility criteria, reductions in benefit amounts and in the duration of benefit entitlement, the linkage between entitlement and participation of the unemployed in activation measures and, last but not least, the tightening of the definition of what constitutes “suitable employment” – a definition that the unemployed must accept at the risk of losing part or all of their benefit entitlement. These “conditionalities” characterize developments across Europe and beyond, which were identifiable already in the 1990s – years characterized by massive unemployment which raised concerns among governments and employers about the cost implications for the public purse and for business competitiveness (particularly where unemployment insurance is financed by employer and employee contributions). The resulting erosion of benefit levels and entitlements in the following decade came to be legitimized by the rhetoric of benefit dependency that constitutes a disincentive to work, and the related emphasis on “activation” promoted by the OECD (to “make work pay”), and the European Commission in the European Employment Strategy (EES) and the Lisbon Strategy.
Despite these common trends, the authors point to significant disparities across countries, reflecting national cultural, political and institutional characteristics. For instance, in the level and duration of benefits, the extent of coverage against the risk of unemployment, the institutional set-up and the way it has been repeatedly restructured (though not always producing the expected results, notably with attempts – not always successful – to merge employment placement services and benefit paying agencies towards a “one-stop shop”), and the differing role played over time and among countries by the social partners, government agencies and local authorities.

The national case studies provide a useful toolbox of institutional changes and outcomes in the different countries, which highlight their successes and shortcomings. Taking into account a no-growth or recession context and high and long-term unemployment in an increasingly fragmented labour market, wherein a high proportion of the working-age population are excluded from unemployment coverage and from meaningful training leading to decent jobs, these studies will be most helpful for policy-makers and social stakeholders.

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