

VOLUME 18



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SHARING Innovative Experiences

Successful Social Protection Floor Experiences



Global South-South Development Academy

The series *Sharing Innovative Experiences* is part of the multidimensional strategy of the UNDP Special Unit for South-South Cooperation (SSC) to promote knowledge-sharing in the South. It presents Southern solutions to Southern challenges through the use of Southern expertise.

Each volume of case studies focuses on a specific topic that is identified by the Special Unit on the basis of its corporate priorities and their links to the Millennium Development Goals. The Special Unit works with partners to identify Southern initiatives that represent successful practices. A technical committee recommends initiatives that can be considered successful in their particular context. Following the methodology of the Global South-South Development Academy, representatives of the selected initiatives are invited to document their experiences in individual case studies and to present them at an international workshop for extensive sharing of information with other practitioners. The case studies are subsequently reworked to meet the criteria for publication.

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ISSN: 1728-4171

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One United Nations Plaza
New York, NY 10017 USA

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Design: Alamini Design, 145 West 28th Street, 12th Floor, New York, NY 10001, alaminidesign.com
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SHARING

Innovative Experiences

VOLUME 18

Successful Social Protection
Floor Experiences



Global South-South
Development
Academy





THE UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP) is the UN's global development network, an organization advocating for change and connecting countries to knowledge, experience and resources to help people build a better life. It is on the ground in 166 countries, working with them on their own solutions to global and national development challenges. As they develop local capacity, they draw on the people of UNDP and its wide range of partners.



THE SPECIAL UNIT FOR SOUTH-SOUTH COOPERATION, formerly known as the Special Unit for Technical Cooperation among Developing Countries (TCDC), was established by the United Nations General Assembly within UNDP in 1978. It carries out its United Nations mandate to mobilize international support for sustained South-South cooperation for development. It encourages developing countries to become important providers of multilateral cooperation, fosters broad-based partnerships for supporting South-South initiatives, supports the efforts of the South to pool the vast resources of Southern countries as a way of achieving common development goals, and facilitates South-South policy dialogues.



THE INTERNATIONAL LABOUR ORGANIZATION (ILO) is the international organization responsible for drawing up and overseeing international labour standards. It is the only "tripartite" United Nations agency that brings together representatives of governments, employers and workers to jointly shape policies and programmes promoting Decent Work for all. This unique arrangement gives the ILO an edge in incorporating "real-world" knowledge about employment and work.

The ILO was founded in 1919, in the wake of a destructive war, to pursue a vision based on the premise that universal, lasting peace can be established only if it is based on social justice. The ILO became the first specialized agency of the United Nations in 1946.

Contents

Foreword	5
Preface	7
Acknowledgements	11
Introduction	13
1 Extension of the Universal Family Allowance: The Universal Child Allowance – Argentina	23
2 The Dignity Pension (Renta Dignidad): A Universal Old-age Pension Scheme – Bolivia (Plurinational State of)	43
3 Broadening Social Protection and Integrating Social Policies – Brazil	61
4 The Rural Social Insurance Programme – Brazil	81
5 Building a Social Protection Floor – Burkina Faso	99
6 The National Social Protection Strategy for the Poor and Vulnerable: Process of Development – Cambodia	123
7 The <i>Red Protege</i> , the Social Protection System, 2006-2010 – Chile	157
8 Developing a Basic Rural Medical Security System – China	177
9 The Subsidized Health-care Scheme in the Social Protection System – Colombia	209
10 Towards a Universal Pension Protection Scheme – Ecuador	239
11 Rashtriya Swasthya Bima Yojana – India	257
12 The Mahatma Gandhi National Rural Employment Guarantee Act – India	271
13 A Social Protection Floor – Mexico	291
14 Setting Up a Social Protection Floor – Mozambique	313

15	Social Protection: An Ongoing Process – Rwanda	333
16	Child Support Grants – South Africa	361
17	The Universal Coverage Scheme – Thailand	385
18	The 500 Baht Universal Pension Scheme – Thailand	401

Foreword

We are pleased to welcome the publication *Successful Social Protection Floor Experiences*, the eighteenth volume in the series *Sharing Innovative Experiences*. This book presents 18 case studies on social protection floor policies from 15 countries of the global South. It is the first to bring together examples of good social protection floor practices for South-South learning.

Access to health services, education, food, water, housing, sanitation and information as well as enjoyment of a basic level of income security are human rights enshrined in the Universal Declaration of Human Rights. Social protection is an important factor in enabling people to exercise these rights. The social protection floor approach combines all these social services and income transfer programmes in a coherent and consistent way, preventing people from falling into poverty and empowering those who are poor to escape the poverty trap and find decent jobs. In the absence of social protection, people are subjected to increased risks of sinking below the poverty line or remaining caught in poverty.

The international community has recognized the fundamental contribution of social protection floor policies in accelerating the achievement of the Millennium Development Goals. In particular, recent experiences have demonstrated the impact of the social protection policies on gender empowerment.

Moreover, there is strong evidence that social protection contributes to sustainable and resilient economic growth by raising labour productivity and enhancing social cohesion. During the recent economic crisis, social protection policies in many countries have helped to stabilize the aggregate demand and to boost the economic recovery by generating income and jobs.

We hope that this collection of best practices will be a useful tool for all stakeholders – governments, social partners, social protection institutions, and other national and international stakeholders – involved in decision-making or in the process of building and implementing national social protection floors.

It is also our hope that the experiences presented in this publication will stimulate discussion and action towards strengthening social justice that will ultimately contribute to improving the lives of the people of the South.



Michelle Bachelet
Under-Secretary-General,
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Preface

About 80 per cent of the global population lives in social insecurity, unable to enjoy a set of social guarantees that enable them to deal with life's risks. Approximately 1.4 billion people live on less than \$1.25 a day according to recent World Bank estimations. Most of them are women and children, work in the informal economy, and/or belong to socially unprotected groups such as people living with disabilities or HIV/AIDS or migrant workers. A national social protection floor is a powerful instrument for addressing this permanent human crisis.

The social protection floor (SPF) approach promotes access to essential social transfers and services in the areas of health, water and sanitation, education, food, housing, and life- and asset-saving information. It is an approach that emphasizes the need to implement comprehensive, coherent and coordinated social protection policies to guarantee services and social transfers throughout the life cycle, paying particular attention to vulnerable groups. The challenge is how to cover the entire population effectively, especially those who are at risk or who are already in a situation of deprivation, and in a sustainable manner.

Many developing countries have already successfully taken measures to build their nationally defined social protection floors or to introduce elements thereof. The results of programmes in these countries show us that the impact of the social protection floor on poverty, vulnerability and inequality can be dramatic. The knowledge, expertise and experience that these countries have gained in their own efforts at establishing a social protection floor represent a valuable source for other countries interested in planning, expanding, extending or reorienting their social protection systems. It is well recognized that the knowledge, skills and technical expertise that can be exchanged through South-South cooperation are in many

cases those that are particularly suitable for meeting similar development challenges faced by other countries of the South.

This volume of *Sharing Innovative Experiences* presents 18 case studies from 15 developing countries on their efforts to develop and implement a social protection floor. The case studies result from a joint initiative of the Special Unit for South-South Cooperation of the United Nations Development Programme (UNDP), the International Labour Organization (ILO) and other United Nations agencies of the United Nations Social Protection Floor Initiative, which issued a call for nominations of initiatives with successful social protection floor experiences. The experiences were evaluated according to the criteria established by the Selection Committee, comprised of representatives of the Special Unit, ILO and the United Nations Children's Fund (UNICEF). The criteria included involvement of national institutions, number of elements of the social protection floor that are addressed, and the potential for replicability of the experience. The 18 experiences nominated from among the 36 that had been proposed from 24 different countries were then developed into case studies, which were discussed extensively at an international workshop in Turin, Italy, in July 2010.

The case studies were prepared by national and local governmental agencies, scientific institutions and development practitioners. Each case study describes the process and key factors in the development and implementation of a social protection floor, including obstacles and challenges encountered along the way and how these were overcome.

The case studies also illustrate how innovative the concept of a social protection floor is. It is a new approach that enables better coordination between the different ongoing social protection activities in the country and the actors involved in the design and implementation of social protection policies. Moreover, the concept can be adapted in very different economic and social contexts in order to fulfil the very different needs of societies. As the case studies presented in this volume attest, this approach has, for example, allowed countries to explore innovative ways of funding social protection (as illustrated by the Renta Dignidad case study in Bolivia) and coordinating mechanisms to maximize the impact of the transfers (Bolsa Família in Brazil) and has fostered the development of employment policies (the Mahatma Gandhi National Rural Employment Guarantee Act in India) adapted to the specific needs of low-income countries as well as emerging economies.

The social protection schemes presented are not all at the same level in the implementation process. Some of the case studies are examples of comprehensive national social protection strategies with over a decade of experience; other studies will describe certain elements of the social protection floor that are still in the planning process. The objective of this publication is to share experiences, to demonstrate the technical and

financial feasibility of (elements of) the social protection floor and to document the process of putting these elements in place in countries of the global South with different levels of development and facing different challenges, and to do so within the framework of South-South dialogue that is encouraged through this publication.

To increase the impact of the Turin workshop, each case study has been edited into a non-technical version, making it accessible to a wider audience, and published in this *Sharing Innovative Experiences* volume. As with other books in the series, the present volume will be distributed free of charge throughout the South. By providing such a collection of best practices, it is hoped that developing countries, with their limited human resources, will be able to select the most appropriate measures and adapt them to their own particular development.

As with other books published in this series, the present volume is also being made available online (ssc.undp.org) with the hope that the best practices that it contains will be able to reach an even wider audience.



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Acknowledgements

The present publication is part of a broader knowledge-sharing process promoted and coordinated by the Special Unit for South-South Cooperation of the United Nations Development Programme (UNDP) that issues this series, *Sharing Innovative Experiences*, in support of South-South learning. It results from a joint initiative of the Special Unit and the International Labour Organization (ILO) in collaboration with the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) in the context of the Social Protection Floor Initiative launched by the United Nations Chief Executives Board for Coordination and as a contribution for the work of the Social Protection Floor Advisory Group.

We would like to thank the coordination team – Francisco Simplicio, Christian Jacquier, Christine Bockstal, Veronika Wodsak and Griet Cattaert – for producing the whole volume, including editing and checking all the chapters to ensure coherence and consistency throughout.

The 18 case studies in this volume were prepared by national and local governmental agencies, scientific institutions and national practitioners. Sharing experiences of developments in social protection relies on national experts' willingness to contribute and share. Without their enthusiastic commitment to make their stories known, this kind of global overview would not be possible.

The preparation of these case studies also involved a long list of social protection experts whose names are too numerous to be mentioned individually. They include ILO experts of the Social Security

Department, who supported and encouraged the authors throughout the development of this publication.

Participants were invited to present and discuss their experience at an international workshop in Turin, Italy, in July 2010 that was kindly hosted by the International Training Centre. We would like to thank Ginette Forgues and Irene Nori for efficiently organizing this well-run event and Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) for funding the translation services.

We wish to express our sincere appreciation to Lourdes Herмосura-Chang of the UNDP Special Unit for South-South Cooperation, who provided logistical, administrative and technical support to this publication. We would also like to thank Jonathan Curiel for reviewing the case studies and Deolinda Martins for her suggestions on improving the text. Our gratitude also goes to Barbara Brewka, an independent professional commissioned by the Special Unit to carry out editorial reviews and layout coordination during the publishing phase.

The talent and commitment of each member of this diverse group helped to move the project forward efficiently and effectively. We express our thanks to them all.

Introduction

At present, 80 per cent of the global population does not enjoy a set of social guarantees that enable them to live a life in dignity and deal with life's risks. Ensuring basic social protection for these people, many of whom are struggling just to survive, is a necessity. The United Nations Social Protection Floor Initiative promotes universal access to essential social transfers and services.

Since the onset of the global financial and economic crisis, people around the world have faced lower incomes and fewer employment and livelihood opportunities as well as reduced access to social services, benefits, remittances and credit. While some voices already declare the end of the crisis, experts agree that we are now only starting to feel its social consequences.

The Secretary-General of the United Nations requested that urgent attention be given to the social impacts of the current global financial and economic crisis. On 5 April 2009, the High Level Committee on Programmes of the United Nations Chief Executives Board on Coordination committed to decisive and urgent multilateral action to address the global crisis through the deployment of all United Nations resources and its capacity to respond rapidly and effectively. An inter-agency agreement was reached on nine joint initiatives, among them the Social Protection Floor Initiative. This Initiative considers the provision of essential services and transfers for all individuals in need of protection in an effort to prevent them from falling into abject poverty or to assist them out of poverty.

The agreed objective of the Social Protection Floor Initiative is to support policies and activities that extend countries' social protection systems and basic social services in line with the needs of their population, especially poor and vulnerable groups, through an integrated approach that responds to the current crisis contexts as well as to countries' longer-term development needs

and perspectives. The related working definition of the social protection floor was agreed as guarantees that secure the availability and provision of and effective access to an essential level of quality social protection goods and services to all. On the supply side, this includes availability of quality health services, education services, water, sanitation, housing, food, and life- and asset-saving information. On the demand side, people are empowered to access these services through rights-based entitlements of in-kind or cash transfers. A key aspect of the social protection floor (SPF) concept is the holistic approach of looking simultaneously at supply- and demand-side factors for a range of social protection goods and services across the life cycle and for all population groups. This does not mean that countries should immediately start to establish schemes for all target groups and elements of the floor. Rather, a careful analysis of capacities, needs and existing schemes already in place will enable a rationalization of the policy-making process for a gradual building up of the social protection floor. The holistic approach is intended to facilitate the prioritization and sequencing of the different elements of the floor.

Every country in the world will already have some elements of the social protection floor in place and provide certain levels of benefits for (parts of) the population, sometimes through contributory schemes, sometimes also non-contributory schemes. Additionally, there are traditional and informal social protection elements that need support to be sustained. Also, many countries are currently being supported by different United Nations agencies to improve the delivery of social transfers and services as defined in the social protection floor framework. The Social Protection Floor Initiative builds on and does not crowd out these efforts that countries and United Nations agencies are undertaking, providing a holistic framework for the improved coordination and impact.

The social protection floor is emphasizing the importance for people of standing on a solid floor of living a life with dignity and investing in their skills and development to climb up to higher levels of well-being. The social protection floor is not a ceiling of benefits or an alternative to statutory social security schemes that are based on contributions and provide higher benefit levels. Rather, statutory social security schemes and social protection floor benefits are mutually reinforcing and depend on one another: without a basic level of investment in health, education, nutrition, etc., workers will not reach the skill level required to be employed in the formal economy. If, however, a social protection floor guarantees that everyone in a society will enjoy this basic level of social services and transfers, more people will be able to enter the formal economy and statutory social security schemes, which is important for their sustainability since risks will be pooled over a larger population. On the other hand, budgets for social protection floor benefits are politically easier to defend and financially easier to sustain, the larger the population that moves into formal employment.

The social protection floor is on the global development agenda. For example, Economic and Social Council Resolution 2010/12 adopted by the Commission for Social Development in February 2010 “urges Governments, with the cooperation of relevant entities, to develop systems of social protection and to extend or broaden, as appropriate, their effectiveness and

coverage, including for workers in the informal economy, recognizing the need for social protection systems". The September 2010 MDG Summit outcome document, Keeping the promise, states that "promoting universal access to social services and providing social protection floors can make an important contribution to consolidating and achieving further development gains" (para. 51).¹

Many developing countries have already successfully taken measures to introduce elements of national social protection floors. A key strength of the social protection floor approach is that it does not start from scratch but with a careful analysis and stock-taking of existing structures and strengths and weaknesses of schemes and programmes in place. Building on the national social protection system by improving coordination of different activities, exploring synergies and increasing efficiency will free resources for extending social protection to those currently not covered.

Impact of Social Protection Floor Programmes

A number of programmes have demonstrated that the impact of the social protection floor on poverty can be dramatic. Among the programmes that have been evaluated and analysed in detail are the Universal Child Allowance in Argentina, Renta Dignidad in Bolivia, Bolsa Família and the Rural Social Insurance Programme in Brazil, the General System of Social Security in Health in Colombia, the Mahatma Gandhi National Rural Employment Guarantee Scheme in India, programmes of the Ministry of Social Development (SEDESOL) in Mexico, the Vision 2020 *Umurenge* Programme in Rwanda, the Child Support Grant in South Africa and the Universal Coverage Scheme in Thailand.

Social protection programmes in the global South: Examples of assessed impact.

Country	Programme	Type	Coverage	Impact
Argentina	Asignación Universal por Hijo (AUH)	Universal child allowance	85% of Argentine children	<ul style="list-style-type: none"> 85% of Argentine children Reduced poverty (-22%) and extreme poverty (-42%); Positive impact on household income (for poorest households income almost doubled, for poor households income increased by 30%); Reduction in income distribution gap.
Bolivia (Plurinational State of)	Renta Dignidad	Universal old-age pension (non-contributory)	800,000 beneficiaries (97% of total eligible beneficiaries)	<ul style="list-style-type: none"> 5.8% reduction in extreme poverty between 2007 and 2009 (especially in rural areas).

¹ United Nations General Assembly, Draft resolution referred to the High-Level Plenary Meeting of the General Assembly by the General Assembly at its sixty-fourth session (document A/65/L.1, 17 September 2010).

Social protection programmes in the global South: Examples of assessed impact (cont'd.).

Country	Programme	Type	Coverage	Impact
Brazil	Bolsa Família	Conditional cash transfer	26% of the population	<ul style="list-style-type: none"> Reduced the poverty gap by 12% between 2001 and 2005; Contributed one third to the decline in income inequality over the last decade.
Brazil	Rural Social Insurance Programme	Non-contributory pension and disability programme for the rural poor	80% of agricultural workers - 66% of rural population	<ul style="list-style-type: none"> Reduction of 4 million poor people (53.5% of the rural population was still poor but this figure would have jumped to 68.1%); Reduction of 4.1 million indigent people (26.1% of the rural population was indigent in 2008, but without social transfers it would have been 41.3%).
Colombia	The General System of Social Security in Health	Universal health coverage	90% of the population	<ul style="list-style-type: none"> Facilitated the use of health services, especially among the poorest population and the rural population; Reduced poverty by more than 2% and inequality by more than 3%.
India	Mahatma Gandhi National Rural Employment Guarantee Scheme	Wage employment programme	52.5 million households	<ul style="list-style-type: none"> Increase in minimum wages for agricultural labourers; Decreased out-migration from villages; Women's empowerment; Positive impact on the geographical-ecological environment.
Mexico	Oportunidades (Human Development Programme)	Conditional cash transfer	25% of the population	<p>Positive effects on:</p> <ul style="list-style-type: none"> Education in rural areas: including increase in attainment; Health: including increased preventive medical check-ups, 11% reduction in maternal mortality and 2% reduction in infant mortality; Nutrition: including increase in the absolute height of children and families' increased total consumption.
Rwanda	Vision 2020 <i>Umurenge</i> Programme	Public works, direct support and financial services	9,692 households benefited from direct support transfers – 78,004 benefited from public works	<p>Ongoing evaluations:</p> <ul style="list-style-type: none"> Reduced poverty; Contributed to improvements in human poverty dimensions (such as education, health, food security and nutrition), community asset development, the environment and social participation.
South Africa	Child Support Grant	Means-tested non-contributory cash transfer	10 million children - take-up rate ranges between 78% and 80% of the children who are eligible	<ul style="list-style-type: none"> Reduced the poverty gap by 28.3%; Reduction of income inequality (all three social grants – old-age pension, disability grants, child support grant – lower the Gini coefficient by 3%.)
Thailand	Universal Coverage Scheme	Universal health care	80% of the population	<ul style="list-style-type: none"> 88,000 households in 2008 were prevented from falling below the poverty line; Increased access to care; Increased quality of care.

Social Protection Is a Human Right

Social protection has its roots in international instruments. For instance, Article 25 of the Universal Declaration of Human Rights states that “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”. It is also stipulated in article 22 of the Declaration that everyone has rights to social security and social protection.

Social Protection Is a Social Necessity

A minimum of income security and access to services is the material basis for the functioning of families and households, which in turn provides the basis for social cohesion that is pivotal for the peaceful functioning of societies and States. There is ample evidence from European countries but also from developing countries with elements of the social protection floor in place such as Brazil, Mexico or South Africa that national social protection systems are effectively reducing poverty and inequality. In Mexico, the poverty gap was reduced by 30 per cent and the headcount poverty rate by 17 per cent by the Oportunidades programme between 1997 and 1999. In Brazil, the Bolsa Família programme accounted for 16 per cent of the recent drop in extreme poverty. Evidence from studies on the impact of basic social transfers in 30 developing countries has indicated not only substantial effects on poverty reduction and inequality but also on the improvement of social development indicators such as school enrolment and health and nutritional status. In some countries, cash transfers have also helped to reduce child labour, provide access to labour markets, improve social status and promote gender equality by strengthening the social status of women in households and communities.

Social Protection Is an Economic Investment

Without investment in a basic social protection floor, countries will not be able to develop the full productive potential of their population. People who are vulnerable due to poverty, ill health, lack of education, social exclusion, etc. struggle to make investments in their future or their children’s future and are at a constant risk of being affected by the next shock.

Evidence from developing countries demonstrates that social protection empowers people to invest in productive activities and engage more in the labour market, stimulates local economies (including important counter-cyclical effects such as stabilizing aggregate demand in times of crisis) and has a positive impact on human capital with long-term productivity gains. For example, through social transfers, health insurance and family support policies, social protection has been shown to encourage labour-market participation in low- and middle-income countries by guaranteeing public works

opportunities, covering the costs of job-seeking and supporting family childcare responsibilities – with strong effects for women in particular. Public works programmes can also build relevant public goods and infrastructure in local communities, contributing to growth (see, for example, the Indian case study, “The Mahatma Gandhi National Rural Employment Guarantee Act”). Social insurance can overcome market failures, contributing to efficiency by enabling households to use their resources more effectively, and encouraging the risk-taking and innovation essential for growth.²

Only if people can move out of low-productivity and subsistence-level activities can an economy grow. Higher incomes can also help to generate tax revenues for the financing of a social protection system, permitting the necessary infrastructure and services to be further enhanced – creating a virtuous cycle that can help to achieve higher levels of welfare and growth. A social protection floor is thus a necessary condition for a successful fight against persistent levels of low productivity and informality. Lessons learned from previous crises (such as the Asian crisis of the 1990s) and the current financial and economic crisis have shown that only if systemic, longer-term social protection measures are in place is it possible to effectively cushion the impacts of economic downturns. Social protection is thus a mechanism for making growth pro-poor and inclusive.

Affordability and Sustainability

Social protection programmes, properly designed and delivered, can be affordable in a range of social, demographic, and economic conditions. The case studies that follow present country-level evidence from the developing world that some components of the social protection floor are already being implemented and are proving to be affordable in countries at different levels of income and development. The Bolsa Família programme in Brazil is the biggest social transfer scheme in the world, presently covering 50 million people at a cost of about 0.4 per cent of gross domestic product (GDP). South Africa has also extended the coverage of its child grant system substantially, reaching 10 million poor children in 2010 at a cost of 3.4 per cent of GDP, demonstrating the high political priority and government commitment to social protection. In India, the 100-day National Rural Employment Guarantee Scheme has been rolled out nationwide, and a new act mandates the extension of basic social security coverage to about 52.5 million households not covered previously. Social protection programmes have also been successful in sub-Saharan Africa, whether in middle-income stable countries or in low-income post-conflict fragile countries, such as Rwanda.

Currently countries at the same level of national income per capita spend very different shares of their resources on social protection. The difference in social spend-

²Ravallion, M. (2006), “Transfers and Safety Nets in Poor Countries: Revisiting the Trade-offs and Policy Options”. In *Understanding Poverty*, A. Banerjee, R. Benabou and D. Mookerjee, eds. New York: Oxford University Press.

ing between countries at the same level of economic development amounts to up to 15 per cent of their national incomes. Thus fiscal space can be created for social protection, even at low levels of GDP, assuming that there is the political will to do it. The measures needed to increase fiscal space are different for each country, ranging from increasing the effectiveness of a country's tax and contribution collection mechanism to broadening the tax base or modifying taxation design.

Countries can grow with equity, i.e., providing some form of social protection from the early stages of their economic development. There is evidence that economic growth that does not include a concept for equity and equality is not sustainable in the long term. In countries that have experienced high growth rates over the past several years, for example China, the social protection floor is crucial for securing and distributing the growth benefits and social progress that have been acquired and for preventing any future shock from pushing the economy backwards. Emerging economies such as China are already facing enormous demographic and social challenges that can be addressed only through an extension and a better coordination of social protection policies. For example, massive internal migration accentuates the effects of a rapidly ageing population on the dependency ratios in certain provinces, which raises the issue of coping with old-age dependency in a country that has no universal old-age minimum revenue or pension system. Unless a minimum level of social protection is provided to all, the increasing inequalities that have been associated with high growth rates in emerging economies over the past several decades will threaten economic and social stability. In this light, the Chinese Rural New Cooperative Medical Scheme targeted to rural residents, which is explained in this volume, is a major step towards more balanced and sustainable economic development.

It is vital not to forget that affordability is a function of a society's willingness to finance social transfers through taxes and contributions. Therefore, no analysis can be separated from the adequacy (in terms of impacts) and the viability of the programme. Affordability relates to fiscal space and international aid, but also to political choices. The political commitment and incentives for leaders have been the key to almost all successful social protection schemes.

At the same time, the resources committed need to be used effectively. A generous budget allocation for social protection financing is not going to produce the desired results without putting in place a sound implementation structure at all levels and for all areas: processes for the information and education of rights and obligations under a certain scheme, the membership registration and management, the service delivery, the monitoring and evaluation, the financial management and other matters need to be carefully designed and staff need to be trained to carry out these tasks. The institutional and administrative capacity must thus be adequate. Social protection programmes further

require interministerial and inter-sectoral capacity-building and teamwork since they tend to function better when in synergy with other social and economic policies.

Innovative Experiences in the South

There is no best solution or “one-size-fits-all” formula. Each country has different needs, development objectives and the fiscal capacity to achieve them and will choose a different set of policies. A country will have to establish minimum performance standards of national social protection policies by seeking to ascertain that all people have a right to social transfers that guarantee effective access to a minimum set of goods and services and hence allow a life in dignity for all. By presenting a comprehensive and integrated approach that exploits the complementarities of policies addressing different but related areas, the social protection floor goes beyond a list of development objectives to be achieved. It provides a framework for exploring synergies across sectors and setting priorities, thus avoiding a compartmentalized view of how to achieve progress without taking the holistic picture into account.

Some of the schemes described in the case studies contained in this volume are already being shared. For example the Oportunidades programme in Mexico, Bolsa Família in Brazil and the Mahatma Gandhi National Rural Employment Guarantee Act in India have contributed to exchanges of information with countries in different regions of the world.

Some countries are going through the first stages of developing a social protection floor. Burkina Faso is reforming its social protection mechanisms to implement universal health coverage following in the successful footsteps of Ghana and Rwanda. Other countries have already gone further in developing social protection schemes. For example, Bolivia in 2008 created a universal non-contributory pension for all people 60 years of age and over, financed by a share of the special hydrocarbon tax and dividends from capitalized public enterprises.

Finally, other countries have been able to capitalize on their own experience with social protection in order to improve their social protection systems following the logic of the social protection floor concept. The case of Chile shows how a country constantly adjusts its social protection system in light of different social, economic, political, demographic and intellectual developments. Indeed, the logic of combating widespread poverty through emergency policies targeting the most vulnerable is being progressively replaced in Chile by a logic oriented towards guaranteeing and extending rights to the entire population and institutionalizing essential social protection policies.

Building a social protection floor is an incremental process; access to essential health services is generally a top priority at the starting point. Burkina Faso and Rwanda, for example, have begun to develop a pluralistic approach, based on the synergy between

traditional mechanisms of social security, micro-insurance and social transfers. The mechanisms of social insurance, micro-insurance and free care often already exist in a fragmented and sometimes competing fashion and cannot individually solve the challenge of extending social protection. It is thus indispensable to coordinate these elements to ensure efficient coordination and complementarity – instead of wasteful fragmentation and competition.

The principles of universality, progressiveness and pluralism underpin the overall construction of the social protection floor. They also rely on the two dimensions of the social protection floor: vertically, they generate investment in human capital that will enable people to move out of a vicious poverty cycle and low-productivity activities into formal employment and self-financing, contributory, higher-level social security benefits, and horizontally, they promote the right of everyone to a minimum level of social protection.

Innovative financing mechanisms could also play an important role in the future. Some countries do not have the resources necessary to build a social protection floor in the short term. These countries will need to call for external solidarity in order to take the first steps towards this goal.

The concept of the social protection floor is rights-based but it leaves a maximum of flexibility for national adaptation with respect to how and through which entitlements transfers in cash and in kind are organized. What is important is that everyone who is in need of protection can access essential goods and social services and essential social transfers. The concept thus sets minimum standards with respect to the access, scope and level of social protection provided by national social protection systems rather than prescribing their specific architecture.



Argentina

Area	3,761,274 km ²
Population ⁱ	40,518,951
Age structure	
• 0-14 years (%)	25.4
• 15-64 years (%)	64.1
• 65 years and over (%)	10.5
Infant mortality rate (per 1,000 live births) both sexes ⁱⁱ	13
Life expectancy at birth (years) female	79.2
Life expectancy at birth (years) male	71.7
Maternal mortality ratio (per 100,000 live births) ⁱⁱⁱ	77
GDP per capita	
• Current US\$ ^{iv}	8,236
• PPP (current international \$) ^v	14,313
• Constant local currency	9,614
Consolidated social public expenditure (% of GDP) ^{vi}	24.2
Pension coverage (% of population) ^{vii}	92.8
Unemployment rate (%) ^{viii}	7
Human development index (HDI) rank ^{ix}	49
HDI poverty indicators: Human poverty index rank	13
HDI health indicators: Life expectancy at birth rank	50
HDI education indicators: Literacy rate (97.6%) and rank	31
HDI education indicators: Enrolment rate (88.6%) and rank	36

Extension of the Universal Family Allowance: The Universal Child Allowance

1

Emilia E. Roca

Argentina

Summary

- Promotes economic security of children and adolescents;
- Launched in November 2009;
- Transfer is equivalent to the benefit that children of formal workers and of beneficiaries of unemployment insurance receive;
- Coverage of 0 to 18-year-olds who are children of unemployed and informal workers as well as of beneficiaries of other programmes who were transferred to AUH;
- 3.5 million new beneficiaries (85 per cent of Argentine children are covered);
- Closely linked to essential services, particularly education and health care.

Target Group	Programme	Benefit
Childhood and adolescence	Universal Child Allowance (Asignación Universal por Hijo, AUH)	Arg\$180 (US\$46.20) per month per child provided that those of school age attend school and in all cases register for health-care services.
	Family Allowances (Asignaciones Familiares)	Arg\$180 (US\$46.20) on average per month per child (provided that those of school age attend school) of formal salaried workers and social security old-age, invalidity or survival beneficiaries. Additional transfers for childbirth and adoption.

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INTRODUCTION

The discussion taking place in academia, international agencies, other organizations and in Argentina about the establishment of a social protection floor starts from different conceptions of the economy and social policies, which lead to conceptually diverse proposals. Discussions on linking social protection and employment in particular are perhaps the most intense since they involve political and social actors with very different positions.

In the case of Argentina, the drive to establish a universal child allowance was a longstanding demand, based on proposals from various sectors, social actors, unions and politicians. The main objective was to develop and implement a massive public policy campaign in order to reduce poverty, especially extreme poverty, and benefit the lower-income sectors. In this sense, the configuration of a more precarious and fragile labour market, which had previously excluded a large segment of workers from social security benefits and thus from this policy instrument, could repair the effects of this failing. However, the proposal does not mean abandoning the goal of achieving a labour market and an employment sector that guarantee social security coverage and adequate incomes.

From an alternative theoretical perspective, there is an advancing school of thought that locates the source of the problem not in the lack of jobs but in the

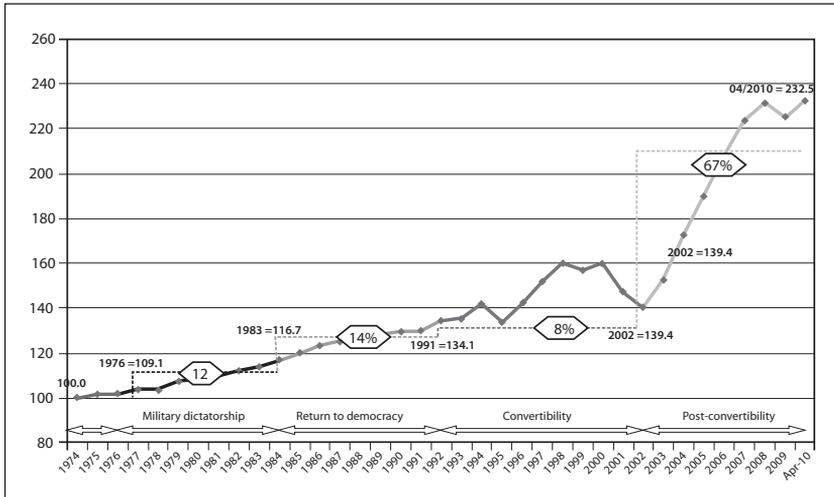
“lack of social integration because of the type of employment offered by the economic system” (Lo Vuolo, 2001). This type of thinking emphasizes the need to separate income security from job security and proposes a more comprehensive notion of labour.

Thus, taking as a reference the analytical framework used by Groot and van der Veen (2002), international experience shows that systems of income transfers are slipping from traditional so-called “conditional welfare” schemes to other variants. These variants include workfare schemes as well as proposals regarding the concepts of “basic income” and “participation income”.

Despite the substantive changes in the labour market mentioned earlier, since 2003 Argentina has seen a very significant increase in registered jobs. This showed that the creation of employment, protected employment and better working conditions are obtained from the reformulation of an economic policy that had and still has as its cornerstone job creation and job quality (graph 1). The momentum towards the generation of formal jobs exposed the fallacy of the “end-of-work” theory that arose from orthodox economic models and that appeared to be an irreversible characteristic. This empirical evidence was able to promote and support alternative Keynesian economic policies of underpinning demand by generating more and better jobs and by having an active State presence in the distribution of income.

Despite these substantial changes in the labour market, however, there still remained a very significant proportion of workers and families with no social security coverage. It should be noted that Argentina had a rich and historical institutional experience in social security, including the subsystem of Family Allowances (Asignaciones Familiares)

covering the children of registered workers. Therefore, the implementation of the Universal Child Allowance (Asignación Universal por Hijo, AUH) Decree was analysed and approved within the legal framework of this social security system, which granted full rights to all children whose parents had been excluded from the formal labour market.



Graph 1 | Index of contributors to the pension system, 1974-2009 (base 1974 = 100).*

Source: DGRP and SGI (from 1974 to 1993) and SIGyP and SIPA (from 1994 to 2009).

*This graph was created based on data originating from the affidavits of the employers (firms) in the Argentine Integrated Retirement System (Sistema Integrado Previsional Argentino, SIPA), which contain the number of workers and the amount of real wages from which are established the inputs and contributions of workers and employers, respectively. The number of self-employed workers with contributions to the system is established in a similar manner.

BACKGROUND

Dr. Néstor Kirchner assumed power in May 2003 after the deep crisis of 2001 and 2002 marked by the collapse of convertibility (1 peso = \$1, lasting from 1991 to 2001), which meant the declaration of default of the external and domestic debt, hyperinflation, rising unemployment and poverty levels never seen before in the country. Since his assumption of power, the Government of Argentina has made a

strong and growing commitment to labour and social issues. In accordance with these premises, the policies implemented have led to a new role for the State, which involves not competing with the private sector but governing the relations between market and society through the recovery of labour institutions and the social security system, and, therefore, proposing a readjustment of the system as a principal support of social protection policies.

Indeed, progress is now reaching the population in a significant way, with more than 17 million beneficiaries largely covered through the social protection system. In fact, the inclusion of more than 2.3 million more adults in retirement benefit schemes as well as the extension of coverage of family allowances, following implementation of Decree 1602/2009 (Universal Family Allowance per Child for Social Protection), guarantees that more than 9 million children and adolescents now receive social security benefits. Indeed, Decree 1602 allowed the inclusion of more than 3.7 million children and adolescents under 18 years of age in the social security system, further adding to the 6.5 million covered by contributory systems.

These policies were also accompanied by a strong inclusion of citizens from highly vulnerable sectors through a significant expansion of coverage of non-contributory pensions (NCPs), with more than 700,000 people receiving some of the benefits of the NCPs. Especially significant was the growth of benefits for mothers of more than seven children and for old-age and invalidity pensions, which quintupled. These extensions of social security coverage were complemented with actions designed to strengthen the employability of the unemployed and active workers through employment, training and education programmes. These programmes have enabled Argentina to significantly increase the population covered by different interventions of the national government, again giving the State a central

role in improving the living conditions of the population, especially the most vulnerable.

It is significant to note that the Government has allocated resources equivalent to more than 40 per cent of the national budget for the provision of benefits of the various subsystems and policies previously mentioned (contributory and non-contributory retirement and pensions, family allowances, unemployment insurance, employment and training policies, etc.).

The Ministry of Labour, Employment and Social Security, in conjunction with other State agencies including the Ministries of Social Development, of Education and of Health, is charged with implementing these social policies. These policies cut across various aspects and multidimensional axes that require a very strong linkage and coordination in order to achieve the proposed objectives.

The Ministry of Social Security, as the government agency responsible for the design, monitoring and implementation of policies regarding systems under its control (such as the retirement and pension system and the subsystem of Family Allowances and of unemployment insurance), and the Employment Ministry (responsible for employment and training policies and training) constitute the central agencies of the Ministry of Labour in the implementation of social protection policies.

It is important to mention the crucial role played by the National Social

Security Administration (Administración Nacional de la Seguridad Social, ANSES), a dependent organ of the Ministry of Labour (through the Social Security Secretariat) that, by its great capacity for territorial management and deployment, enables the Government to reach the country's most remote places and most vulnerable populations. In this context, the Social Security Secretariat should not only address the search for appropriate mechanisms for resolving the most pressing social problems but it must also prepare for those issues that arise from improvements in the conditions of employment, the links to labour and social rights, and better working conditions, all of which require a sustained effort in terms of management and financing resources in order to function effectively and efficiently. In fact, all these policies strongly impact both the budgetary requirements and the management and administration requirements of the various subsystems, thereby allowing the adaptation of institutions that are the foundation of the Argentine social security system to new realities and the needs of the target population.

The priority is also to assess the impact of these policies: to be able to measure the policies applied and effective improvement in the living conditions of the target population. In terms of dealing with the new challenges to social security, the sanction of Decree 1602/2009 by President Cristina Fernandez de Kirchner is particularly relevant. The implementation of the Universal Child Allowance (AUH) has meant a substantive and

arguably structural change and certainly one that will indisputably be remembered as one of the most important milestones marking the rich history of labour legislation and social protection in Argentina.

BRIEF REVIEW OF THE SUBSYSTEM OF FAMILY ALLOWANCES

Argentina had a rich historical and institutional experience in social security. Such institutions include the subsystem of Family Allowances that covers children of formal-sector workers under Law No. 24714.

The first rules and laws and even some collective agreements include clauses referring to the family wage that forced employers to pay a salary plus cover their workers' minor children. Also noteworthy is the scale for bank employees (Law 12637/1940), which in 1943 was extended to employees of insurance and reinsurance companies. Similarly introduced was the family wage for railway employees and the creation of a common fund to support workers with family responsibilities (by Decree 3771/43). In this way, coverage was extended to workers in other fields (Marasco, 2010).

In Argentina, the rights of workers and their families have Constitutional status. Indeed, rights referring to social security were incorporated into the 1949 Constitution and, after its repeal, were subsequently incorporated into the 1957

Constitution, which required the law to provide effective and comprehensive family protection as well as family allowances – a requirement established in Article 14 bis of the Constitution. In 1956, the Collective Agreement of Commercial Employees (No. 108) established a family compensation fund for employees of the sector, giving an allowance per child (Marasco, 2010). Later this was extended to other groups of workers not covered by the previous rule (Decree 7913/57 and 7914/57). Finally, it was Decree No. 18017 of 1968 that allowed the “universalization” of family allowances of a contributory nature for all dependent workers in both the private sector and the National Public Administration.

Therefore, the existence of a subsystem of family allowances in the regulatory framework of the Argentine social security system has allowed the establishment of an institutionalized system that provides benefits for children and young people and places the country at an advanced level of social protection, especially in Latin America.

Later, after the economic ups and downs suffered by the Argentine economy during the 1980s – a period called the “lost decade of Latin America” by the Economic Commission for Latin America and the Caribbean (ECLAC) and others (gross domestic product (GDP) per capita had fallen to about 20 per cent, accompanied by uncontrollable price increases, hyperinflation, rising unemployment and poverty) – the process culminated with

the implementation of a neoliberal economic model in the 1990s, a hyperinflation process also called a market “coup”. This meant the elimination of the instruments, laws and regulations governing the markets for goods and services and especially rules governing the labour market. According to most neoliberals, the relaxing or elimination of these rules relieved the market of the “ties” that constrained it. It also affected the flow of resources from corporate contributions to the social security system since the percentage of employer contributions that funded the social security system was lowered. This was used, as was convertibility, as a means for reducing labour costs in a context of strong foreign-exchange restrictions, a means that clearly affected employer contributions for family allowances. Thus, in order to reduce the financial impact that these resource-reduction measures had on the system, usual benefits were cut (spouse, large families, etc.). At the same time, salary caps were fixed for the recovery of allocations and differential amounts of benefits according to a salary scale in order to promote the lower wages.

The Family Allowances scheme is currently governed by Law 24714/96, which is divided into two subsystems: a contributory system and a non-contributory one. The first group includes all formal-sector dependent workers/employees registered in the social security system. The non-contributory group comprises the retirees and pensioners of the Argentine Integrated Retirement

System (SIPA) and beneficiaries of non-contributory pensions. In the case of family benefits to retirees, benefits are financed from the resources of SIPA, and, in the case of the non-contributory pensions, from the national budget. National public-sector workers are also beneficiaries of the system. Indeed, while for public employees of the provincial jurisdictions benefits are set according to provincial laws, in both cases (national and provincial), given the federal character of the national organization, the scheme is contributory and financed from general resources of those jurisdictions.

The benefits provided under Law 24714 relate to child and disabled-child benefits, prenatal and maternity benefits and those of an extraordinary nature such as birth, adoption and educational assistance. The amounts vary by wage level and geographical area. Workers with a salary over a certain limit (currently Arg\$4,800 = US\$1,215) are excluded from the system and the amounts of benefits vary according to the beneficiaries' area of residence. The Family Allowances scheme also excludes domestic workers and self-employed or independent¹ workers even if they are registered and provide contributions.² The National Social Security Administration pays family allowances directly to workers in all fields, be it in urban (industry, commerce,

services) or rural activities. The population of children and young people covered would reach approximately 4.5 million, to which must be added about 2 million children covered by the system of public employees, both national and provincial.

UNIVERSAL ALLOWANCE PER CHILD FOR SOCIAL PROTECTION (AUH) DECREE 1602

As already noted, Argentina had a rich and historical institutional experience in social security, in particular with the subsystem of Family Allowances covering the children of registered workers. Given this background, the implementation of the Universal Allowance per Child for Social Protection (AUH) Decree was analysed and approved within the legal framework of the social security system, recognizing this allowance as a full right for all the children whose parents had been excluded from the formal labour market.

The preamble of the AUH Decree clearly sets out the doctrinal and conceptual foundations that characterize the governments that have led the country since 2003. Public policies of the most

¹This situation has an explanation: in a contributory system, independent workers' contributions do not include contributions to the subsystem of Family Allowances whereas employer contributions for employees do include them.

²The above-mentioned contribution is made with respect to employer contributions for the retirement and pension system, Family Allowances and the National Employment Fund (versus 25 per cent of total contributions, percentages that do not reflect the rebates granted during the 1990s and later corrections). Since the company pays the allowances, all documentation stays in its possession and the State does not regularly check it. In this sense, it is very difficult to estimate the number of benefits paid since in the Affidavits from Employers (Declaraciones Juradas, DDJJ), only the amounts are declared, not the cases (children for whom it is recovered).

diverse political parties have incorporated societal demands to improve the situation of households and of vulnerable children and adolescents. This assistance is implemented from a basic social security institution, which is the Family Allowances subsystem governed by Law 24714. First, when referring to Family Allowances as a substantive subsystem of social security, the proposal does not refer to a “novel” model of public intervention but rather recovers and extends the scope of this system to children not covered because of circumstances imposed on the labour market that left workers without access to social security and to the protection of labour standards. These situations resulted from the implementation of economic policies based on the deregulation of markets, mainly the labour market, and on residual and targeted social policies that catered only to the situations of greatest exclusion, and not always successfully.

These neoliberal policies, which do not include equity as a condition, had a devastating effect on low-income households, with children and adolescents the main victims since they constitute the most vulnerable population. This was the situation that public policy was required to correct through a system that starts from a concept of rights and allows households (a) to maintain regularity in minimum incomes and (b) to lessen the possible consequences of loss of a home or the household head’s job as well as drops in the informal sector due to recurring crises or economic changes.

In terms of Decree 1602, one is dealing with the need to correct the consequences of neoliberal policies, which have meant an incessant decline in the number of formal-sector jobs and thus a loss of rights to social security benefits such as family allowances – a loss that has left a very significant proportion of workers and their children without access to such coverage. On the contrary, economic, social and labour policies implemented since 2003 made it evident that the growth model based on the domestic market and the re-industrialization of the country as a base of support – rooted in employment and the improvement of the incomes of workers and retirees – enabled the economy to significantly generate jobs between 2003 and 2008. Indeed, over 4.5 million jobs were created, of which over 2.6 million were in the formal sector. This allowed the unemployment rate to drop from 22 per cent in 2002 to 8.8 per cent in 2009. This behaviour of the labour market is the context in which the decision was taken to expand coverage of Family Allowances through the Universal Child Allowance (AUH). This decision does not deny that sectors remain that have not benefited from these developments and that there is a need to deal with cases that are the most affected by exclusion and the lack of social security coverage.

With consistent and adequate economic policies, it is possible to change trends that seemed to be directed more by supernatural forces than governed by economically and socially inefficient

policies. It is precisely the exposing of the fallacy of the “end-of-work” theory of the 1990s, which urged proposals for the universalizing and uncoupling of social protection in employment, that enabled the State to address the challenge of social inclusion sustained in social security and regulations. Thanks to the enshrinement of the subsystem of Family Allowances as a right, workers no longer have to rely on patronage or arbitrary policies.

The commitment to registered job growth remains the “social added value” of inclusion in the Social Security system, which means that these “new” workers are being covered by the scheme, in particular for family allowances. The number of children covered by the subsystem of Family Allowances since the creation of more than 2 million formal jobs has increased to about 1.5 million children and adolescents, showing the importance of formal employment, which, of course, is not at issue. To the extent that the jobs created by consistent and appropriate economic and labour policies tend to be formal, the number of children covered by Social Security will increase. Then both the contributory and non-contributory systems set out in Decree 1602 will be working in harmony, like communicating vessels. Thus unemployed workers and their families will be protected even in circumstances such as the present, where the cycle of economic growth loses momentum and falls in recessions or crises.

CONTEXT

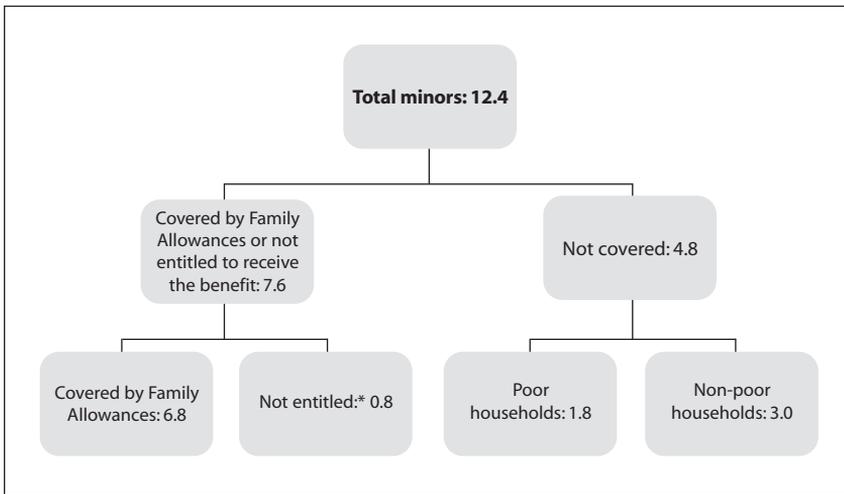
The demographic estimates for Argentina (National Institute of Statistics and Censuses (INDEC)-Latin American and Caribbean Demography Centre (Centro Latinoamericano y Caribeño de Demografía, CELADE) establish that, by 2009, there were approximately 12.4 million children under 18 years of age living in both rural and urban areas – mostly in the latter. Argentina, unlike other Latin American countries, has a high percentage of urban population, with nearly 90 per cent of the people living in cities and mainly in big cities (although only about 40 per cent live in the Greater Buenos Aires region, which includes the city of Buenos Aires and its suburbs). It is important to take this demographic situation into account when making comparisons between policies and programmes of different countries on the South American continent.

At the same time, as noted earlier, the existence of the subsystem of Family Allowances for workers in the formal sectors or those registered in the Social Security system enabled approximately 6.5 million children and adolescents to benefit from the child-allowance tax system. On the other hand, there remained a relatively smaller proportion, about 800,000, who did not have that advantage because their parents had wages above the ceiling imposed by the law

and/or deducted from the family income-tax charges for children under 18 years of age, which ultimately was a form of subsidy per child. Therefore, the group of children excluded from the benefits of a family allowance amounted to a figure closer to 5 million (see figure). On the other hand, based on indicators arising

from the Permanent Household Survey (Encuesta Permanente de Hogares, EPH),³ it was determined that about 40 per cent of these children belong to poor households (poverty defined by income method) while the other 60 per cent belong to non-poor households.

Minors covered and not covered by the subsystem of Family Allowances, 2009 (in millions).



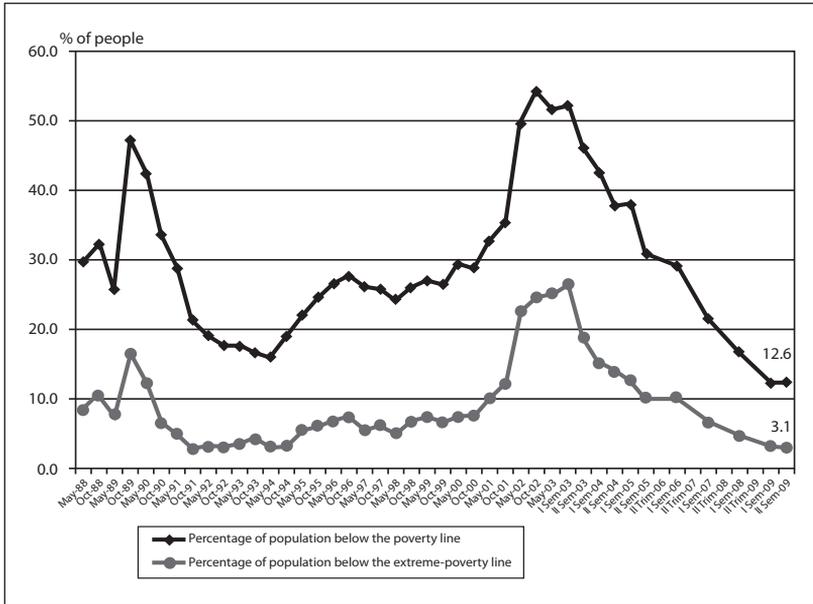
Note: *Children of households whose parents are paid a salary higher than Arg\$4,800 (US\$1,263) or are employers or qualified independent professionals.

Source: Prepared by the Secretariat for Social Security Policy of the Ministry of Labour, Employment and Social Security (Ministerio de Trabajo, Empleo y Seguridad Social, MTESS) based on data from the Permanent Household Survey (EPH) and the 2001 Census (National Institute of Statistics and Censuses (Instituto Nacional de Estadística y Censos, INDEC)).

This situation is very significant since, right in the middle of the 2001/2002 crisis, the distribution of children was reversed between the poor and non-poor categories. Indeed, in 2002, 6 of every 10 children under 18 years of age belonged to households that were

below the poverty line (UNICEF, 2004). This means that, beyond the implementation of the AUH Decree (graph 2), Argentina has very significantly improved the levels of the population affected by poverty.

³The Permanent Household Survey (EPH), undertaken monthly by the National Institute of Statistics and Censuses (INDEC), is a continuous survey that takes place in 31 urban areas of Argentina. The Survey produces quarterly data for agglomerates of the population and is the basic source for these kinds of studies and statistical simulations. INDEC publishes the data quarterly.



Graph 2 | Evolution of the percentage of people living below the poverty and extreme-poverty lines, Greater Buenos Aires, 1988 to May 2009.

Source: Prepared by the Secretariat for Social Security Policy, Ministry of Labour, Employment and Social Security (MTESS), based on data from the Permanent Household Survey (EPH) (National Institute of Statistics and Censuses, INDEC).

SIMULATION EXERCISE ON THE IMPACT OF THE UNIVERSAL CHILD ALLOWANCE

To assess the impact that the implementation of the AUH Decree will have on the poverty and extreme poverty of households in Argentina, a simulation exercise was conducted based on micro data from the Permanent Household Survey of the total covered population. The Survey makes it possible to work with raw household data in terms of demographics and socio-economic and occupational characteristics of household members. The data indicated, first, the

strong impact of the Universal Child Allowance (AUH) on extremely poor households (i.e., those whose income is below the extreme-poverty⁴ line). Indeed, the proportion of extremely poor households is reduced by about 50 per cent. It is also significant to assess the impact of the AUH on poor households (i.e., households whose income is below the value of the basic total basket); taking this into consideration reduces their numbers by about 22 per cent. In absolute terms, some 1.3 million people, of whom some 800,000 are under 18 years of age, would be taken out of poverty. On the other hand, the population of extremely poor households that exceed this situation

⁴“Extreme poverty” refers to the inability of households to cover a basic food basket (la canasta básica, CBA), defined as meeting the caloric requirements and energy necessary for an adult (30 to 59 years of age). Moreover, the poverty line is defined from the CBA and includes other expenses necessary for life such as housing, clothing, utilities (gas, electricity, transport, etc.). In the work of ECLAC on Latin America, it is typical to use this methodology for calculating poverty.

would amount to approximately 70,000, and of these more than 50 per cent, or about 450,000 children, would climb out of extreme poverty (table 1).

The other exercise that took place related to requirements, including those concerning whether the household or its members were informal workers, received an income below the minimum wage, and

were not self-employed workers registered in Social Security, as established by the AUH Decree. In this way, the values of the population still to be covered were adjusted, thereby enabling the estimate of the financial resources required to meet the proposed objectives. It was determined that between 3.8 million and 4 million children would be able to collect the Universal Child Allowance (AUH).

Table 1 | Estimated impact of the AUH on poverty and extreme poverty by region, fourth quarter 2009 (as a percentage).

Region	Poverty			Extreme Poverty		
	Initial Situation	With AUH	Variation	Initial Situation	With AUH	Variation
Greater Buenos Aires	8.2	6.4	-21.4	2.2	1.3	-42.4
Northwest	12.4	9.6	-22.9	2.8	1.7	-37.9
Northeast	17.2	13.4	-21.8	5.1	2.7	-48.4
Cuyo	10.5	8.0	-23.5	2.8	1.4	-49.9
Pampeana	7.1	5.5	-22.4	2.4	1.5	-40.8
Patag�nia	4.3	3.7	-14.6	1.8	1.4	-26.6
Entire country	8.7	6.8	-21.9	2.5	1.4	-42.3

Source: Prepared by the Secretariat for Social Security Policy, Ministry of Labour, Employment and Social Security (MTESS), based on data from the Permanent Household Survey (EPH) (National Institute of Statistics and Censuses, INDEC).

It is very important to note that the action taken in terms of expanding the Family Allowances subsystem has a greater impact in the poorest regions of the country, especially the Northwest and Northeast regions (table 1). This situation is explained primarily by the relative level of income, which is lower than the national average, but also in terms of the demographic composition of households living

in these regions, especially the number of children and/or dependents. Other reasons include a lower participation in the labour market for women and older adults. The most noticeable impact can be seen in the Northeast region, whose poverty rate has been reduced by almost 50 per cent (similar to what occurs in the Northwest), whereas in the Greater Buenos Aires region, which has the largest concentra-

tion of people in the country, the reduction can reach as high as 42 per cent. In terms of poverty, the impact according to geographic area or zone ranges from 24 per cent in the western Andean region of Cuyo to 15 per cent in Patagonia, Argentina's most depopulated zone.

Another aspect of this strategy to

reduce poverty and extreme poverty is the aforementioned impact of the AUH on household income. For the poorest households (i.e., the indigents), income after receiving the AUH almost doubled, while for poor households, the impact is less since the income grows on average 30 per cent (table 2).

Table 2 | Impact of the AUH on the income of poor and extremely poor households, fourth quarter, 2009.

Level of Household Income	Initial Situation	With AUH	Variation
Extremely poor households	Arg\$295.02	Arg\$538.51	82.5%
	US\$77.63	US\$141.71	
Poor households	Arg\$801.41	Arg\$1,035.02	29.1%
	US\$210.89	US\$272.37	

Source: Prepared by the Under-Secretariat for Social Security Policy, Ministry of Labour, Employment and Social Security (MTESS), based on data from the Permanent Household Survey (EPH) (National Institute of Statistics and Censuses, INDEC).

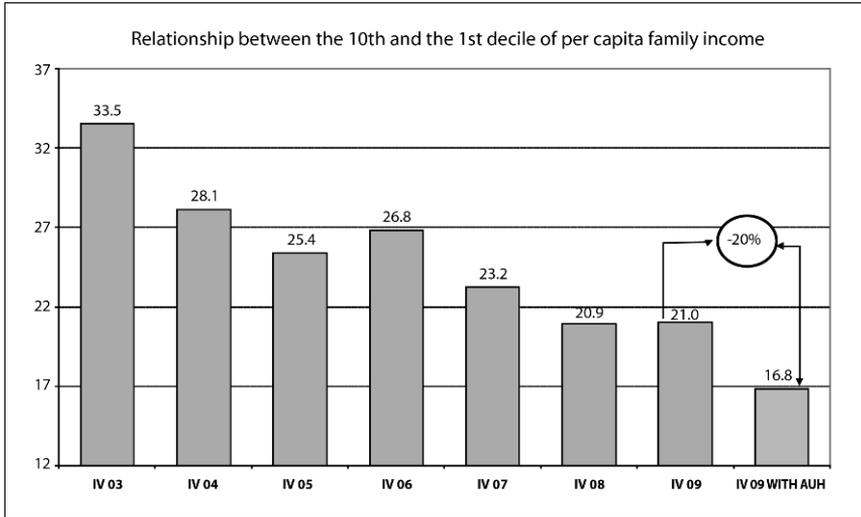
Income distribution is another very important indicator when assessing the impact of an income transfer policy such as the one put in place after the enactment of Decree 1602 (which created the Universal Child Allowance, AUH). Income distribution is measured either by the gap between the average income of the richest decile and the income of the poorest decile (median income decile 10/median income decile 1, sorted by per capita family income), or by the Gini coefficient. In the first case, the income gap is reduced by almost 20 per cent. After the enactment of the AUH Decree,

the highest-income decile dropped from being 22 times larger than the lowest-income decile to being 18 times larger. To get an idea of the 2001/2002 post-crisis situation, it is worth mentioning that the highest-income decile was 34 times larger than the lowest-income decile. In other words, the average income of the top decile exceeded in proportion the median income of the lowest decile. The reduction of the gap from 2003 until the present (graph 3) is the result of public policies tending to improve income distribution by increasing the minimum pension, extending coverage for the elderly, and

periodically adjusting the minimum wage and pensions – policies that, in conjunc-

tion with the AUH, allowed further improvement of income distribution.

Graph 3 | Evolution of income distribution and its impact on the AUH, fourth quarter 2003-fourth quarter 2009.*



* The income of the total population is divided into deciles. The number of each column is the result of the division between the highest income and the lowest income.

Source: Ministry of Labour, Employment and Social Security (MTESS) (Under-Secretary for Social Security Policy) – National Institute of Statistics and Censuses (INDEC) (Permanent Household Survey).

Other indicators of inequality, such as the Gini coefficient, also showed very significant signs of improvement even before the launch of this measure. Indeed, a glance back at 2003 shows that the policies pursued by governments after 2003 (by Nestor Kirchner and by Cristina Fernandez) had and still have the objective of a continuous improvement in income distribution since they improved the purchasing power of low-income sectors and further enabled a model based on the domestic market as an indispensable engine of economic growth. Thus, between 2002 and 2009, the extension of the social

protection system (increase of pensions, contributory family allowances and the AUH) reduced the Gini coefficient by 15 per cent, from 0.54 in 2002 to 0.46 in 2009 (Ministry of Labour, Employment and Social Security, 2010).

The annualized estimated cost is more than 10,000 million pesos (US\$2,632 million) for all potential beneficiaries and nearly 8,000 million pesos (US\$2,105 million) for the 3.7 million children already covered (this represents between 0.6 per cent and 1 per cent of the Argentine GDP).

Table 3 | Evolution of the implementation of the AUH, November 2009-May 2010.

	Nov. 2009	Dec. 2009	Jan. 2009	Feb. 2010	Mar. 2010	Apr. 2010	May 2010
Number of children	3,439,314	3,550,138	3,356,121	3,518,692	3,518,245	3,677,409	3,684,441
Number of beneficiaries	1,795,620	1,766,380	1,642,568	1,734,329	1,812,273	1,920,072	1,927,310
Average number of children per beneficiary	1.9	2.0	2.0	2.0	1.9	1.9	1.9
Amounts transferred (in thousands of Arg\$)*	583,711	599,000	566,928	595,443	613,521	641,257	642,956

*These amounts, annualized, amount to US\$2,000 million, or 0.7 per cent of the GDP, the average benefit per family being US\$90.

INSTITUTIONAL FRAMEWORK FOR THE IMPLEMENTATION OF THE UNIVERSAL CHILD ALLOWANCE

As mentioned earlier, the Universal Child Allowance (AUH) was created in 2009 by Decree No. 1602 of the Executive Branch. Subsequently, its implementation has been regulated by Resolution No. 393/2009 of the National Social Security Administration, the agency responsible for paying the benefits. This regulation establishes: (a) who may be beneficiaries of the allowance; (b) the requirements to be met to access the allowance; (c) the data sources to be used to determine the beneficiaries; and (d) the means and dates of payment to beneficiaries. To facilitate

operational management, the Resolution established an Advisory Committee comprising representatives of the Ministries of Social Development; Labour, Employment and Social Security; Health; Education; and the Interior. In addition, in compliance with the provisions of Decree 1602, Resolution No. 132/2010 was established, insuring delivery, by the National Social Security Administration to each responsible adult holder of the AUH, the National Book of Social Security, Health and Education for each child under 18 years of age in the adult's charge.

Prior to its launch and from the announcement of its creation by the authorities of the National Executive (comprising the President and the Cabinet of Ministers), a plan was imple-

mented for mass distribution in all media, which was supported by audiovisual material, presentations on the issue in several areas, delivery of brochures to the community, and an active presence of advising officers in places with massive turnouts.

FURTHER CONSIDERATIONS REGARDING THE UNIVERSAL CHILD ALLOWANCE (AUH)

With respect to the implementation of the AUH Decree, one item to highlight is the obligation on the part of mothers/fathers or benefit holders to comply with certain requirements established by the policy. These relate to compliance with health check-ups and vaccination of boys and girls as well as with the schooling cycle for those of school age.

To verify and monitor compliance with these requirements, the National Book of Social Security, Health and Education, comprising the holder's details, an affidavit about the person's employment status and the income earned, was created and delivered for each child (more than 3.5 million books). The book is a legal instrument that should demonstrate that the child meets the requirements, as certified by those responsible, be it the physician in the cases of vaccination and sanitary control or the school headmaster to certify the fulfilment of the schooling requirement. The existence of the book is crucial since it will enable individual monitoring of children who are beneficiaries of the

Universal Child Allowance (AUH). Moreover, it constitutes a prerequisite for the recovery of the 20 per cent that was withdrawn from the original amount (Arg\$180) deposited in a savings account in the name of the holder. This book is also an important instrument for effectively monitoring the history of each child and adolescent in relation to the control of his or her health and education. The implementation of the above requirements and their enforcement constitute what is undoubtedly the greatest challenge presented by the AUH.

CONCLUSIONS

Highlights of the discussion on the Universal Child Allowance (AUH) programme include the following:

- Allowances are reaching more than 1.9 million homes.
- The average amount per household is Arg\$342 = US\$90.
- 32 per cent of allowances were granted in the Province of Buenos Aires, 8.5 per cent in Cordoba and the same percentage in Santa Fe. These three provinces, along with Salta, Tucumán, Mendoza and Chaco (just under approximately 5 per cent each), account for almost 60 per cent of the total allowances granted.
- In May 2010, almost 3.7 million AUH benefits were authorized in addition to the 6.8 million contributory Family Allowances of the national Social Security system

and of national and provincial government workers. This means that 85 per cent of Argentine children are already covered by the subsystem of Family Allowances.

- 51 per cent of children covered by the AUH have not received any social assistance in the form of money transfers, according to data from the National Social Security Administration registers.
- The incidence of poverty falls by 21.9 per cent. This means that more than 700,000 children under 18 years of age climb out of poverty.
- The percentage of extremely poor households is reduced by 42.3 per cent, meaning that more than 400,000 children are no longer extremely poor.
- Inequality is reduced by 20 per cent (measured as the ratio of the income of the first decile to that of the tenth decile).

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^{iv}World Bank, *World Development Indicators 2008* and *Global Development Finance 2008*.

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^{vi}Economic Policies Department, Ministry of Economy and Production, 2008.

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^{ix}UNDP, *Human Development Report* 2009.



Bolivia (Plurinational State of)

Area	1,098,581 km ²
Population ⁱ	10,426,154
Age structure	
• 0-14 years (%)	35.8
• 15-64 years (%)	59.6
• 65 years and over (%)	4.6
Infant mortality rate (per 1,000 live births) both sexes ⁱⁱ	41.7
Life expectancy at birth (years) female	68.5
Life expectancy at birth (years) male	64.2
Maternal mortality ratio (per 100,000 live births) ⁱⁱⁱ	222
GDP per capita	
• Current USD ^{iv}	1,683
• PPP (current international \$)	IMF: ^v 4,451 World Bank: ^{vi} 4,426
• Constant local currency ^{vii}	3,060
Unemployment rate (%) ^{viii}	6.8
Human development index (HDI) rank ^{ix}	113
HDI poverty indicators – Human poverty index rank	52

The Dignity Pension (Renta Dignidad): A Universal Old-age Pension Scheme

2

Marcelo Ticona Gonzales

Bolivia
(Plurinational State of)

Summary

- Launched in 2008 as a universal benefit for all people 60 years of age and older;
- Universal non-contributory pension;
- Identification documents are needed to register for the scheme; biometric registry is being developed;
- Benefit can be paid monthly or accumulated over up to 12 months. Amount equivalent to about \$340 per year; 75 per cent of this annual benefit amount for those already receiving a pension from the Social Security System;
- 800,000 beneficiaries (2010);
- \$500 million paid;
- Financed by a fixed share of the special direct tax on hydrocarbons (impuesto directo a los hidrocarburos (IDH) – oil and gas revenue), with contributions from all levels of government, and dividends from capitalized public enterprises (association with the multinational enterprises, which are now undergoing nationalization);
- Impact: a 5.8 per cent reduction in extreme poverty between 2007 and 2009 (especially in rural areas).

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INTRODUCTION

In the past two years, the Plurinational State of Bolivia has reduced the indicators of moderate and extreme poverty by 2 and 6 percentage points, respectively. At the beginning of this period, 60 per

cent of Bolivians lived in poverty and 38 per cent were living in extreme poverty. The reality faced by other Latin American countries as well as by Caribbean and African countries is not much different.

Faced with this reality for decades,

various schools of economics and social sciences have discussed and studied the relevance and effectiveness, in terms of economic and social development, of granting subsidies or direct transfers to vulnerable groups. Beyond this discussion, however, the international community must also be made aware of the concrete results from the implementation of social protection measures. These measures, which resulted in the acceleration of poverty reduction, match the policy objectives of the Social Protection Floor Initiative proposed by the United Nations and, ultimately, dignify the elderly in the Plurinational State of Bolivia.

For the Plurinational State of Bolivia, now being able to guarantee a social protection floor for the elderly has been one of the most important and far-reaching social accomplishments in the country's history. Along with other social measures, it has also had a clear impact on poverty reduction and the quality of life of the country's citizens. In this way, the Dignity Pension (Renta Dignidad), a benefit established within the Bolivian non-contributory Social Security Scheme, has improved the beneficiaries' living conditions.

POLICY DESCRIPTION

In order to understand the dimensions of the State's policy of treating the elderly with dignity, it is necessary to refer to the new Political Constitution of the Plurinational State of Bolivia, which was drafted by the Constituent Assembly and

the Legislative Branch and approved by about two thirds of the population in January 2009. The Constitution, which became effective in February 2009, states in Article 67:

"I. In addition to the rights recognized in this Constitution, every person of adult age has the right to a dignified old age that has quality and human warmth.

II. The State shall provide an old age pension within the framework of full social security, in accordance with the law".

The payment of the Renta Dignidad began in 2008 through Law No. 3791 of November of that year. With the approval of the new State Constitution, the benefit became part of the country's Constitutional rights under the following name: Universal Income for the Elderly, or Dignity Pension (Renta Universal de Vejez, Renta Dignidad).

As part of the country's policies of income redistribution and poverty reduction and the efforts to dignify the life of citizens, this benefit guarantees, for the first time in the country's history, a monthly income for life to all Bolivian residents age 60 years and above.

The Renta Dignidad is part of the country's universal or non-contributory Social Security Scheme. The annual benefit amount for those who do not receive a retirement pension from the system is Bs2,400 (US\$340). For those who do receive another pension, the benefit is 75 per cent of this amount, or Bs1,800 (US\$255). The main idea

behind this distinction is to prioritize, through a higher payment, the segment of the population that has no old-age pension whatsoever without neglecting the universal right to one.

In the first half of 2010, of the 800,000 beneficiaries of the Renta Dignidad, 83 per cent were not already receiving any pension from the Social Security Scheme as a result of working in the informal sector and having extended periods of unemployment. Therefore, it can be argued that allotting greater benefits to those who do not receive a retirement pension is consistent with the policy of redistributing income and guaranteeing greater efficiency in the implementation of the policy, given that elderly individuals who do not receive a pension are the ones with the greatest needs.

Following the same design of the Renta Dignidad and using its same source of funding, a Funeral Expenses provision has also been established to give a total of Bs1,800 (US\$254) to those who can prove that they have paid the funeral expenses of a recipient of the Renta Dignidad. The purpose of the provision is to contribute to the needs of the family after the death of a beneficiary. In operational terms, this provision has served to complement the monitoring of beneficiaries' survival. It has also become an incentive for families to report deaths in a timely manner, thereby preventing identity theft.

Under a national policy of income redistribution, the funding of the Renta Dignidad comes from the direct tax on

hydrocarbons (impuesto directo a los hidrocarburos, IDH), which is derived from the exploitation of hydrocarbon resources, a sector that generates surpluses in the national economy. Dividends from public companies active in strategic sectors also finance this non-contributory benefit. The Renta Dignidad has hired an independent entity that manages the resources, enables an online payment system and controls the transactions.

ORIGIN OF THE PROGRAMME

The Renta Dignidad is framed in accordance with the principle of the universality of social security. It is the first of the country's social protection floor policies whose benefits are guaranteed by Constitutional law to all Bolivians 60 years old and older living in the country. However, it is important to mention earlier benefits that had their origin in the pension reform of 1996.

THE PENSION REFORM OF 1996: THE EXPERIENCE OF THE SOLIDARITY BONUS

The Solidarity Bonus (Bono Solidario, Bonosol) was a cash transfer for all Bolivians 65 years of age and older that was established in 1996 as part of the social and economic reforms undertaken between 1993 and 1997. A centrepiece of the administration's economic reforms was the capitalization of major strategic State enterprises (State-owned companies in sectors such as air transport and railways, oil, electricity and telecommu-

nications) whereby, on 31 December 1995, 50 per cent of the shares of each of these companies were transferred to foreign investors through an international tender, and around 48 per cent were transferred to Bolivians 21 years of age or older (who formed the closed group of Bonosol beneficiaries). The remaining shares were transferred to minority shareholders. The 48 per cent stake of the capitalized companies was designated for the Collective Capitalization Fund (CCF), which began with assets totalling more than US\$1,500 million. The administration of the Fund was commissioned through an international bidding process to two pension-fund administrators.¹ These administrators had the role of representing the stock of Collective Capitalization Fund shares in meetings between the capitalized companies' shareholders and the company's boards. The designers of the social benefit considered that the annual dividends generated by the capitalized companies would enter the Collective Capitalization Fund and be used to pay the Bonosol. The amount of the benefit could be modified after financial and economic evaluation.

The funding of the Bonosol was subject to the dividend policies decided at meetings of shareholders from the capitalized companies. These policies oscillated between two extremes: (a) reinvestment of profits from the capitalized companies in strategic sectors, meaning that no dividends were paid and, therefore, that

resources were not made available to finance the Bonosol; or (b) the payment of the Bonosol, which meant that there was a reduced ability to reinvest in or expand these industries. The decisions taken must therefore balance the development of strategic sectors with ensuring benefits for the country's elderly.

The first annual payment of US\$248 was made in 1997 to each of the beneficiaries of the Bonosol who were 65 years of age by December 1995. Logistically, it was the first experience of a mass payment that generated disorder at payment points.

Since the group of beneficiaries enrolled in the capitalization scheme was a closed group of Bolivians over 21 years of age in December 1995, the Bonosol benefit cannot be described as universal because it will cease to exist as soon as the last of these beneficiaries passes away.

During the ten years of existence of the Collective Capitalization Fund, the framework described earlier generated resources that were used to pay the non-contributory benefit. In parallel, the administrators of the pension fund represented the shares owned by Bolivians. During the last years of the existence of the Bonosol, the obligations of the Fund reached US\$100 million annually, a figure that could scarcely be matched by the dividends paid and destined to the Fund. This threatened its sustainability and therefore the continuity of the benefit payment.

¹AFP Futuro de Bolivia and AFP Previsión were subsidiaries of the financial groups Argentaria and Banco Bilbao Vizcaya, respectively. To date, AFP Futuro de Bolivia is a subsidiary of the Swiss group, Zurich Financial Services.

INTERMEDIARY PROFITS

From 1998 to 2007, the Bonosol underwent changes in the design of its financing, payment amounts and beneficiaries. Between 1998 and 2001, it was replaced by another benefit, the so-called "Bolivida", which reduced the group of beneficiaries to Bolivians 50 years of age and older by 1995. It also reduced the amount of the benefit to between US\$56 and US\$60 per year.

In 2002, the payment of non-contributory benefits was suspended and then restored in 2003 under the name "Bonosol", returning also to the characteristics of the initial design: (a) beneficiaries are Bolivians who are 21 years of age and older in December 1995, (b) funding comes from the dividends of the capitalized companies, and (c) the annual payment amount is US\$257, with revision of the amount every five years.

With respect to logistical aspects, the first significant show of progress was the completion of a database of capitalization beneficiaries that was based on the electoral roll. The second was the implementation of online payments through the financial system, accompanied by a reduced number of in-person payment centres.

The regulatory framework of the Bonosol stipulated that, every five years, the amount of the payments, which could vary positively or negatively, had to be re-evaluated depending on the availability of the Collective Capitalization Fund. Prior to the existence of the Renta

Dignidad, the availability of financing for the Bonosol was evaluated and it was concluded that to maintain the benefit, it was necessary to reduce the amount by at least 15 per cent (with this reduction, the benefit would total about US\$190 per year), a situation that would generate immediate rejection and social conflict.

The political context helps to explain the evolution of these non-contributory benefits, given that both the name change and the benefit amount have been the subject of election promises and not of the Government's economic and social policies. However, prior to the Renta Dignidad, no major conceptual change had been carried out regarding the universality of the benefit, extension of funding or mode of payment.

UNIVERSAL OLD-AGE INCOME

The Renta Dignidad emerged from a different background from that of previous non-contributory benefits. Social policies, the universality of social security and poverty reduction are now political priorities, and the implementation of the Renta Dignidad is the realization of this vision of development. Furthermore, unlike the country's previous benefits, this non-contributory benefit was not put forth as a strategy for earning votes.

The economic scenario in the country was also essential for the implementation of the Renta Dignidad. Oil-export earnings have improved since 2006 owing to the international rise of prices and to the recently approved policy

framework for the distribution of oil revenues, which substantially increased tax revenues from this sector and the investment in its productive chain.

What were the factors that gave rise to the *Renta Dignidad* as a universal social protection policy? It could be argued that the origin of this non-contributory benefit derived from a favourable political and economic situation and a timely decision. It is inspired by a vision of poverty reduction based on the social reality of Bolivians.

LEGAL BASIS OF THE RENTA DIGNIDAD PROGRAMME

To ensure the continuity and effectiveness of a social security programme, Bolivian social policies suggest that its legal basis must guarantee two fundamental components: (a) the right of access, and (b) the obligation to address this right. In the case of the *Renta Dignidad* in the Plurinational State of Bolivia, these principles are fulfilled by the fundamental law of the country, the Constitution of the State.

The first section of the *Renta Dignidad* law responds to Article 67 of the Constitution, which establishes the obligation of the Bolivian State to provide old-age annuities under the Social Security System and the right of older adults to a dignified old age. However, prior to the approval of the new Bolivian Constitution, this benefit was created

with a State law in 2007, with payments beginning in 2008.

In this context, the Constitutional framework and a specific law are in force in the country, establishing the Universal Old Age Income (*Renta Dignidad*) as a universal right of all Bolivians and setting the minimum required age for payment at 60 years. Therefore, the guarantee of the continuity of the programme remains established in the highest law of the country.

Regarding the financing of the programme and its legal framework, the Law on the *Renta Dignidad* specifies that funding sources are detached from structural economic policy. Rather, part of the income tax on hydrocarbons allocated to the General Treasury of the Nation and regional budgets² should finance the non-contributory benefits. This means that the funding guarantee and payment continuity of the *Renta Dignidad* are, in addition to being established in the programme's specific law, defined in the hydrocarbon-sector regulations providing for the transfer of surplus resources to social policies.

As for the management of *Renta Dignidad* payments, a series of Supreme Decrees and Administrative Resolutions have been issued by the Executive Branch and the pension regulator, respectively, enabling the operational running of the benefit. In turn, this regulatory legal framework allows the Constitutional right and obligation to operate in a flexible and timely manner.

²Contribution of 30 per cent of resources by the Direct Tax on Hydrocarbons from resources of the prefectures, municipalities, the Indigenous Fund and the General Treasury of the Nation.

FUNDING

In compliance with the principles of solidarity and sustainability of Bolivian Social Security, funding for the Renta Dignidad reflects the economic and social policy of redistributing income from sectors that generate surpluses to highly vulnerable sectors.

There are two funding sources for the Renta Dignidad: a direct tax on hydrocarbons and dividends of capitalized public enterprises.

DIRECT TAX ON HYDROCARBONS (IDH) AND THE RENTA DIGNIDAD

The Plurinational State of Bolivia is a country with large oil reserves. The production and exportation of this natural resource constitute one of the main components of the national gross domestic product (GDP). In 2003, the political management of the sector changed. In that same year, the "October Agenda" was established as a result of social mobilization of civil society organizations, which demanded the recovery-of-oil policy by the State and tangible benefits for the sector.

Three important factors have had and continue to have an impact on the revenues derived from the hydrocarbon sector in the country:

- the modification of the regulative framework for the collection of tax

revenue on hydrocarbons and its regional allocation.³ Until 2005, the Act on the Hydrocarbon Sector established taxes on the production chain that did not bring large revenues to the General Treasury of the State. However, with the amendment of the Act on the Hydrocarbon Sector and of the percentage taxed, tax revenues from the hydrocarbon sector became more relevant as of 2006. They have become one of the main sources of State income both for the current expenditure and for the financing of long-term projects such as productive investments, national social projects and local government projects;

- the evolution of international oil prices, which led to better export prices of Bolivian gas to Argentina and Brazil. It is common knowledge that the international prices of raw materials have a considerable impact on the global economy and have had a historic growth cycle in the past several years. Given that the Plurinational State of Bolivia is a country with a primary export economy, this cycle has significantly favoured revenues from the production and exploitation of hydrocarbons and hence the collection of tax revenues from this sector. However, it is important to note that the fact that this factor is external to the Bolivian

³The amount of the Direct Tax on Hydrocarbons (IDH) collected in 2008 and 2009 was US\$950 million and US\$923 million, respectively, 12 per cent higher than under the previous legislation. The reduction in 2009 is due to the effect of reduced international oil prices.

economy suggests the need to take preventive funding decisions to face shocks that might affect international prices and hydrocarbon incomes; and

- the new economic policy for the hydrocarbon sector, which allowed the return of the hydrocarbon production chain to the Bolivian State through the recovery of the equity stake in strategic enterprises.

Thus, with the purpose of addressing comprehensive policies in this area, the companies of this sector, which had been privatized and capitalized a decade ago, now find themselves under the administration and representation of the Bolivian State.⁴ This enables priorities on productive investments to be articulated in close relationship with the benefits granted and in function of income sources.

Funding for the *Renta Dignidad* from the hydrocarbon sector is 30 per cent of the total revenue from the Direct Tax on Hydrocarbons (IDH), which reached US\$220 million in 2008 and US\$237 million in 2009. The social welfare policy committed the allocation of a proportion of national and regional budgets, obtained through the IDH, without affecting the implementation of investment programmes.

Funding from the hydrocarbon sector made it possible to implement a social and economic policy of income redistrib-

ution through national and regional budgets in a positive economic and political environment. However, as the hydrocarbon price may vary because of externalities, it is important that the strategy of investment in the sector consider that this source of revenue should grow in proportion to the payment obligations through improvements in production capacity and export.

DIVIDENDS FROM CAPITALIZED PUBLIC COMPANIES

The second source of financing of the *Renta Dignidad* comes from the payment of share dividends from the capitalized public companies.

As described in the first stage of the *Bonosol* payment, after the privatization of State enterprises (the sale of Bolivians' shares in strategic public enterprises to multinational corporations), it was decided that the dividends generated by these companies were to be used to finance the non-contributory Social Security Scheme. About 48 per cent of the shares of each of these companies was transferred to the ownership of Bolivians over 21 years of age in December 1995 through a trust administered by managers of private pension funds, the Collective Capitalization Fund.

Currently, the dividends generated by capitalized enterprises are distributed in favour of shareholders, and the resources of the Bolivian people are allocated to the Universal Income Fund for Old Age.

⁴The State corporation, *Yacimientos Petrolíferos Fiscales Bolivianos* (YPFB), owns majority shares in oil companies that were capitalized by foreign capital.

To date, seven of the ten capitalized companies in 1996 have undergone a process of nationalization, transferring the stakes previously owned by Bolivians to the Bolivian State. Given the current State policy, this measure allows decisions to be balanced between reinvestment in strategic sectors and the financing of social assistance programmes such as the Renta Dignidad.

RENDA DIGNIDAD: MANAGEMENT AND IMPACT

PAYMENT MANAGEMENT

Significant logistical and technological advances have been achieved in the management of payments of the Renta Dignidad at the national level. First of all, the Government developed a database of beneficiaries. The database had its origin in the electoral and civil registration system and subsequently relied on other sources of data on the identity of beneficiaries. As a result of documentary and information-technology efforts throughout the whole country, this database is updated daily according to the reporting of deceased beneficiaries, cases of perfect homonyms, the incorporation of new beneficiaries, and modifications of identity, residence, address, etc.

The reception of new procedures and updates of new beneficiaries as well as of the database are the responsibility of the management entity of the Renta Dignidad, which transfers these requests

to the public institution in charge of regulation of the pension system. The Authority for the Monitoring and Control of Pensions (Autoridad de Fiscalización y Control Social de Pensiones) validates this information and makes the appropriate modifications. The Authority, in coordination with a private electronic payment-processing entity, manages the Renta Dignidad payments made in real time on a daily basis, ensuring that the payments are available in over 1,100 payment centres at the national level, including branches of financial institutions and the payment centres of the National Armed Forces.

For its part, the pension payment system has been optimized to include the amount of the Renta Dignidad in the monthly payslips of retirees. This is relevant since there are six entities that manage pension payments: the entity paying pensions from the recent income distribution system; the military social insurance institution; the two pension fund administrators; and the two insurance companies handling old-age benefits in the individual capitalization system.

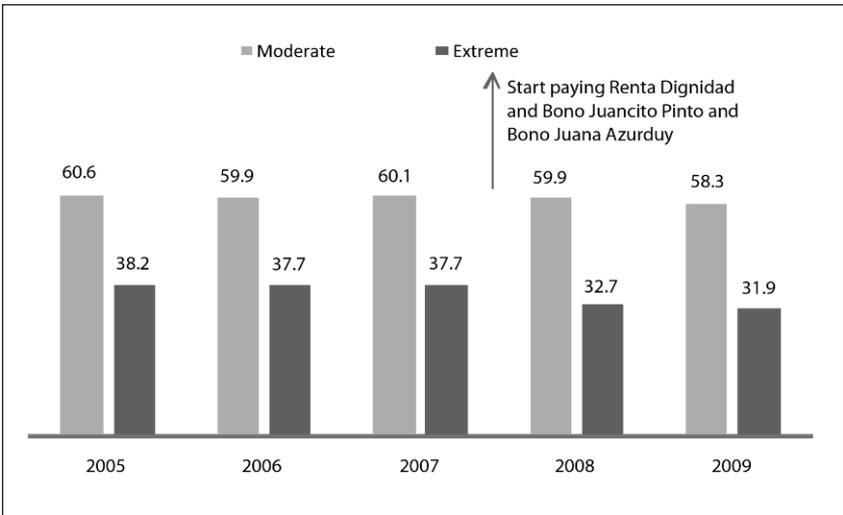
At the national level, the payment centres are available in more than 900 financial-institution platforms, operating online transactions in real time. Regarding the logistics of benefit payments, it is important to emphasize the operational innovation of employing the Armed Forces to pay out the Renta Dignidad. There are more than 200 pay points between the military installations

and the mobile military units. The mobile military units are equipped with mobile satellite equipment interfaced to the main database of beneficiaries, enabling people to collect payments online from any location in the country. The system has also achieved greater geographical coverage in urban areas and, more significantly, in rural areas. For salaried retirees, the benefit is included in their payslips, while for unsalaried retirees, the payment is available in financial-system platforms and mobile military units and is made monthly or cumulatively for a maximum of twelve months. It has been shown that beneficiaries choose to accumulate between three

and four months of benefits and/or ask to receive them in year-end periods.

UNIVERSALITY: THE IMPACT OF THE RENTA DIGNIDAD

The success of the policy of social-security universality can be quantified by the change in poverty indicators and their social impact. As for economic indicators, the Renta Dignidad, along with the implementation of other social policies, has accelerated the reduction of moderate and, especially, extreme poverty. Extreme poverty was reduced from 37.7 per cent in 2006 to 31.9 per cent in 2009 – a rapid downward trend (see graph).



Incidence of moderate and extreme poverty (as a percentage).

Source: 2009 Fiscal Report, Ministry of Economy and Public Finance.

The impact of the Renta Dignidad on the daily lives of beneficiaries is closely related to the context and social role of the elderly in the Plurinational State of Bolivia as well as their spending profile. In terms of consumption, beneficiaries

use their monthly benefit to finance spending in three main areas: food, housing and services. With regard to food expenses, beneficiaries contribute to the family budget for household spending on basic necessities. In relation to expendi-

ture on services, the elderly prioritize the payment of basic services such as water, electricity, gas and public transportation. The monthly amount of the Renta Dignidad is sufficient to cover the average consumption of electricity, water and gas for a family of four. Finally, with respect to housing, the Renta Dignidad benefit helps the elderly to cover rent or mortgage payments for the family group to which they belong. In short, the benefit has served to dignify the participation of the elderly in society, enabling them to contribute to spending on the basic needs of their family groups.

As for the number of beneficiaries of the universal Renta Dignidad programme, in the first half of 2010, there were about 800,000 beneficiaries, 55 per cent of whom were women. Since the establishment of the benefit, more than US\$500 million has been paid out in benefits, which have an annual growth rate of 8 per cent.

The universality of the programme can easily be substantiated by its level of coverage. The number of beneficiaries who successfully received the monthly benefit or the accumulated benefit has reached 97 per cent of the total number of eligible beneficiaries. This means that only 3 per cent of adults 60 years old or older need some type of administrative help (mainly an adjustment of identity information registered), which will activate their payment once the process is complete.

Finally, the outcomes of implement-

ing social measures, including cash transfers to vulnerable sectors, have allowed the Plurinational State of Bolivia to be declared a middle-income country⁵ since per capita income has exceeded US\$1,100. This has opened up the possibility of accessing international cooperation programmes similar to those of the other emerging economies of the region.

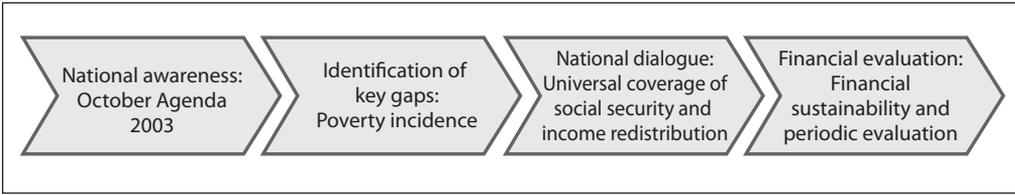
ENGAGEMENT WITH THE SOCIAL PROTECTION FLOOR

The conceptualization of a social protection floor – defined as a strategy to guarantee a minimum level of monthly cash income through a transfer component – helps to explain the scope of the Renta Dignidad in the Plurinational State of Bolivia. In addition, the activities promoting the development of a social protection floor (from the recovery of sovereignty over natural resources resulting from the “October Agenda” in 2003 to granting the benefit after the assessment of financial sustainability) help to explain the evolution and implementation of the benefit in the country (fig. 2).

The Renta Dignidad programme is a significant, historic step towards the strategy of implementing a social protection floor. It is thanks to this programme that a universal social right for the elderly has been established through the Bolivian State Constitution. In operational terms, it has ensured that all Bolivians 60 years of age or older living in

⁵Classified as such by the World Bank in 2010 by examining the level of income per capita of the inhabitants of a country.

Implementation of the Renta Dignidad: Social protection floor process.



Source: Prepared by the author.

the country are now covered through an economic transfer programme that guarantees a minimum income for this vulnerable societal group.

It is important to note that an overall set of social and economic policies to benefit vulnerable groups has been developed. For example, a financial transfer for primary school children, the Bono Juancito Pinto, has been established to promote the continuation of their schooling. There is a State subsidy that pays pregnant women to deliver their babies at public health centres instead of at home. Called the Bono Juana Azurduy

benefit, this programme also grants women a subsidy when they make prenatal visits to a health centre and when they have routine check-ups in the first two years of the child's life. There is also a programme to extend the coverage of free health insurance to all seniors through the Social Security for Seniors programme. These programmes form part of a comprehensive strategy for assistance and social protection of highly vulnerable groups and are funded through public resources. In December 2009, 27.7 per cent of the population benefited from social transfers (box 1).

Box 1. Populations benefiting from conditional cash transfers

The high levels of poverty, inequality and social discrimination reported in the Plurinational State of Bolivia demanded the implementation of a set of social measures aimed at the most disadvantaged segments of the population. Since 2006, conditional cash transfers have constituted a fundamental instrument in the short term, mitigating the recurrent needs of the population through direct cash transfers and making this State benefit conditional on a given behaviour, whether it is attending school, visiting health clinics or frequenting relief centres in old age.

In December 2009, 27.7 per cent of the population, or 2,840,334 people, benefited from cash transfers: 16.9 per cent benefited from the Bono Juancito Pinto, which covers students from the first to the eighth grade of primary education (formal), students receiving alternative youth education and special education students; 7.5 per cent of the population received the Renta Dignidad, aimed at people 60 years old or older; and the remaining 3.3 per cent benefited from the Bono Juana Azurduy, launched in May 2009 and aimed at mothers and children under two years of age.

The Renta Dignidad, a successful programme of universal social protection, is part of a strategic set of programmes that direct resources towards measures that secure and ensure a life of dignity for Bolivians. This comprehensive strategy has close ties with and the same purpose as the Social Protection Floor Initiative since it is aimed at upholding people's basic rights through its services and transfer components.

CONCLUSIONS AND FUTURE CHALLENGES

Within the framework of social consensus and political representation, a decision taken in the context of a limited economy has responded to the challenge of allocating part of the revenue generated by one of the country's main natural resources, and it is beginning to bear fruit. This is evident not only in strict adherence to economic and social indicators but also in terms of socio-cultural impact. It allows every Bolivian to be assured that his/her country will guarantee a monthly, lifetime income throughout his/her old age, which will allow him/her to contribute to supporting the family and to remain an active part of society.

For its part, the fundamental and universal right of access to an old-age pension has been secured, having been established as a right by the Constitution of the State of Bolivia itself, a move that thereby ensured its continuity. The new Political Constitution of the Plurinational State of Bolivia, which was approved by

universal suffrage just a year and a half ago (January 2009), responds to the social demand of the population and converts it into an inalienable right.

The funding sources of the Renta Dignidad, which are derived from the tax on hydrocarbons, are also a sign of political, economic and social consensus. The will of the people, which was to be able to receive a tangible benefit of ownership and sovereignty over their natural resources, has been translated into a policy of income redistribution. A sector such as the surplus-generating hydrocarbon sector directly contributes to the financing of the universal benefit.

Every goal has not yet been reached, however, and the road ahead is still arduous. The following are considered to be some of the challenges faced by the Renta Dignidad:

- The first challenge is to consolidate political consensus among society, regions that finance the Renta Dignidad and the beneficiaries through their social representatives in order to ensure that the right to the benefit is fully entrenched as a fundamental right for all Bolivians and can transcend generations.

It is also essential that the universal welfare policy for the elderly be a part of Bolivian culture through solidarity, which will result in the allocation of State resources from a surplus sector to a vulnerable one. This will also ensure that these measures can be

replicated for other vulnerable groups or groups exposed to poverty.

- Given that the main source of financing comes from oil and gas revenues that depend on external prices, investments in the hydro-carbon sector are necessary to maintain and increase income levels. In addition, the administration of the Renta Dignidad fund must make prudent investments in order to capitalize on the surplus and generate financial support for periods in which incomes do not allow for self-financing.

While financing can be secured, in the medium term the amount of the benefit may reach a monthly Bs679 (US\$97) national minimum wage. Based on the analysis of the impact on resource allocation, the increase of the benefit is predicted to be gradual for groups with a higher incidence of poverty or lower income.

- The Renta Dignidad Act makes provisions for its payment to be available in cash or in kind, which means that a form of transfer can be implemented whereby the benefit is paid in products and basic necessities and that national production can be guided to a market consisting of beneficiaries. This design will depend on the integration and evaluation of policies to encourage production and policies of income redistribution.

Since there has been a significant financial effort by the State in the

payment of the benefit, part of these resources could be used to encourage production – subsequently generating employment and economic development – and to allow the beneficiary to have the final say in the choice between a payment in cash or in kind. Of course, this design will also depend on the consensus of the collectives of beneficiaries.

- Regarding the operative part of the benefit payment, the biometric registration of beneficiaries still remains to be completed. This would eliminate the need to present personal identification documents in order to receive the benefit and, in turn, would minimize the chances of impersonation in the collection of benefits.

Parallel to this challenge, a personal Social Security number will be given to each beneficiary, enabling the identification of beneficiaries to be related to their work history and the benefits that they can access throughout their life.

- Another challenge is that of integrating the Bolivian Social Security System through a pension system that links social and economic policies, including the Renta Dignidad and the Solidarity Retirement Pension (Pensión Solidaria de Jubilación).

Finally, as presented at the beginning of this case study, one of the main conclusions regarding the impact of the Renta Dignidad in the Plurinational State of Bolivia is the acceleration in poverty

reduction. Detailing this successful experience testifies to the real impact of the implementation of income-redistribution

policies and social assistance on vulnerable population groups, such as older adults, who can now have a life of dignity.

Box 2. The Solidarity Retirement Pension: Ensuring dignified retirement for workers.

In order to ensure a decent pension for Bolivian workers and achieve universal coverage of the pension system, the Solidarity Retirement Pension (Pensión Solidaria de Jubilación) has been developed.

The Pensión Solidaria de Jubilación, part of the semi-contributory Social Security Scheme, is aimed at ensuring a minimum amount of retirement income, which increases in proportion to the years contributed, for those dependent and self-employed workers whose pension amounts under the individual capitalization system are considerably lower.

The first group of beneficiaries of this pension comprises retirement-age workers whose pension amounts in the individual capitalization system are low – even below the national minimum wage. This is owing to long periods of unemployment and, during the stages in which workers were active, low income and contribution levels (well below the average wage).

In the medium and long terms, the second group of beneficiaries would comprise self-employed workers, including truckers, farmers, housewives, union leaders, individual consultants, construction workers and workers in other sectors, all of whom now have the incentive to make contributions to a long-term social security scheme since it guarantees payment of a minimum retirement pension independent of the capital accumulated in the workers' individual retirement savings accounts.

The age of access to the Pensión Solidaria de Jubilación is 58, and the amount increases along with the years of contribution. For example, a worker having made contributions for 15 years is guaranteed a pension of 100 per cent of the national minimum wage (US\$97) while a worker with 35 years of contributions will receive a pension between US\$190 and US\$370, with adjustments made annually in order to maintain purchasing power.

Under income-redistribution policies, the funding sources for the benefit are: (a) a mandatory employer contribution of 3 per cent based on the payroll of his/her employees; (b) a labour contribution of 0.5 per cent; (c) solidarity contributions of people with monthly incomes 20 times higher than the national minimum wage (US\$1,900); and (d) 20 per cent of the premiums collected for risk, without affecting pension funding.

Finally, the Pensión Solidaria de Jubilación institutes policies that modify access to this Pension depending on gender, including (a) a reduction of the minimum age required for access for working mothers of one year for each child born (with a maximum of three years), and (b) the implementation of a uniform mortality table for men and women in order to calculate equitable pensions in the individual capitalization system.

ⁱ National Institute of Statistics, 2010.

ⁱⁱ Ibid.

ⁱⁱⁱ Ministry of Health and Sports, 2008.

^{iv} National Institute of Statistics, 2009.

^v International Monetary Fund, World Economic Outlook Database, October 2010, data for 2009.

^{vi} World Bank, World Development Indicators Database, October 2010, data for 2009.

^{vii} National Institute of Statistics, 2009.

^{viii} National Institute of Statistics, Social and Economic Policy Analysis Unit (UDAPE), 2009.

^{ix} UNDP, *Human Development Report 2009*.



Brazil

Area	8,547,403 km ²
Population ⁱ	191,971,506
Age structure	
• 0-14 years (%)	26.4
• 15-64 years (%)	67.1
• 65 years and over (%)	6.6
Infant mortality rate (per 1,000 live births) both sexes ⁱⁱ	18
Life expectancy at birth (years) female	76.2
Life expectancy at birth (years) male	68.8
Maternal mortality ratio (per 100,000 live births) ⁱⁱⁱ	110
GDP per capita	
• Current USD ^{iv}	8,205
• PPP (current international \$) ^v	10,296
• Constant local currency	8,136
Unemployment rate (%)	7.3
Human development index (HDI) rank ^{vi}	75
HDI poverty indicators – Human poverty index rank	43

Broadening Social Protection and Integrating Social Policies

3

Brazil

Rômulo Paes-Sousa

Aline Ribeiro Dantas de Teixeira Soares

Fernando Kleiman

Summary

- Coordinated programmes from 19 ministries as well as partnership with civil society;
- Introduced the food and nutrition-security issue into the public policy agenda (Brazil and abroad);
- Aims at ensuring the production, availability and regular access to adequate food for everyone.

Component

Main Federal Programmes

Access to food

- Conditional cash transfer: Bolsa Família (Family Grant) Programme;
- Food and nutrition programmes: food at school (National School Meals Programme (Programa Nacional de Alimentação Escolar), food for indigenous and specific population groups, rainwater cisterns, community restaurants, food banks, urban community agriculture, food and nutrition monitoring, distribution of vitamin and mineral supplements, nutrition education programmes;
- Tax incentives: Worker Food Programme (Programa de Alimentação, PAT);
- Tax reduction: lower prices for basic foods (basic food basket).

Income-generation

- Social and professional training;
- Solidarity-based economy and productive inclusion;
- Food security and local development consortium (Consórcio de Segurança Alimentar e Desenvolvimento Local, CONSAD);
- Community productive arrangements;
- Development of cooperatives of recyclable material collectors;
- Production-oriented microcredit programmes.

Partnership promotion and civil society mobilization

- Social assistance reference facilities (Centro de referência e assistência social, CRAS);
- Social mobilization and education for citizenship;
- Capacity-building for public and social agents;
- Campaigns and donations;
- Partnership with private sector and NGOs;
- Social Development Councils.

Summary (cont'd.)

Component	Main Federal Programmes
Incentives to small-scale farming	<ul style="list-style-type: none"> • National Programme for Enhancing Small-scale Farming (Programa Nacional de Fortalecimento da Agricultura Familiar, PRONAF); • Harvest insurance; • Small-scale farming insurance; • Small-scale Farm Production Purchasing Programme (Programa de Aquisição de Alimentos, PAA).



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INTRODUCTION

Social protection policies in Brazil should be analysed over a long-term trajectory that explains not only much of the success achieved but also some of the challenges to be faced. This case study aims to describe this trajectory with respect to the consolidation of a social protection system in Brazil, including the achievement of some results as well as challenges to be dealt with in the near future. First there is a short description of the process through which social policies have become effective rights to be provided by the State. Then, in order to understand the dimension and complexity of the Brazilian social protection network, the role, policies and programmes of the Ministry of Social Development and Fight against Hunger (Ministério de Desenvolvimento Social e Combate à Fome, MDS) are discussed, including the efforts to integrate benefits and services, which are provided in a systemic approach. This is followed by an analysis of the most significant recent results and, finally, a discussion of the necessary steps towards the consolidation of these policies as an integrated social protection network.

SOCIAL POLICIES

Brazil, a country with a population of 190 million, occupies more than 50 per cent

of South America. Per capita gross domestic product (GDP) is around US\$10,296 (PPP) (World Bank, 2009), and the country has been experiencing a period of economic stability and growth. Despite recent improvements regarding the reduction of socio-economic inequalities, 30 million people are still poor and 8.9 million are extremely poor,¹ making Brazil one of the most socio-economically unequal countries in the world. Besides historical inequity, Brazil accumulated two decades of comparatively low average growth rates (1990s to the beginning of the 2000s) as compared to the index on population increase.

From a historical perspective, a more structured, articulated framework of social policies, relating overall to the formal labour market, dates back to the 1930s although there were some isolated initiatives on social protection in Brazil earlier than that. In the 1930s, a social dimension of the State emerged as part of a populist policy framework implemented by a dictatorial mandate. At first, such concessions were restricted to certain organized urban workers; however, throughout the decades, there was progressive incorporation of new labour segments.

For more than half a century, most of the advances towards the consolidation of a social protection system were only incremental and restricted to the field of contributive participation in social security.

¹MDG Report, Brazil, 2010; poverty line based on the minimum wage; thus, extreme poverty stands for incomes below one quarter of the monthly minimum wage.

Other social protection initiatives were undertaken by private institutions, with donations to charity and largely known forms of social help. In this sense, there was a weak, fragmentary social protection system in which the Catholic Church influenced groups that prevailed over State action.

It was with the discussion and approval of the Constitution in 1988 that a new landmark point was established as a universalized social security model came to life that was grounded in citizenship rights. After the Brazilian military dictatorship in the 1970s, many different citizen groups and grass-roots movements gained space in the public arena and brought their issues to the country's agenda. Thus, a social security system based on the pillars of social insurance, health and assistance was established in a very propitious environment.

Nevertheless, many of the rights brought up by the Constitutional text were approved with legally conditioned disposals, which still had to undergo regulation in order to become effective. Even with the broadening of fields and groups that were now enabled to access these rights, a large part of the population still remained excluded from social protection policies.

Even so, it is important to state that the Constitution of 1988 launched a new paradigm in the field of social security in Brazil. After its approval, there has been considerable evolution regarding its implementation, especially over the last several years, owing to the political will

of President Lula.

The institutional design foreseen in the Constitution became a reality in the early 1990s and, as a consequence, the implementation of the new Constitutional rules strongly changed the design and operational structures of the social protection scheme in Brazil. With respect to the implementation of health and social assistance policies at the sub-federal level, 27 State governments (including the Federal District) and more than 5,500 municipalities played important roles in the accommodation of new structures to support some public policies that can be seen as the seeds of the current Brazilian social protection system. This is the case even though the same design does not seem to apply to social insurance, which, throughout, has been centralized in design and operation. However, the process of decentralization included a great deal of fragmentation, and, as a consequence, the lack of coordination among different government levels made it virtually impossible to build a holistic, effective social protection system.

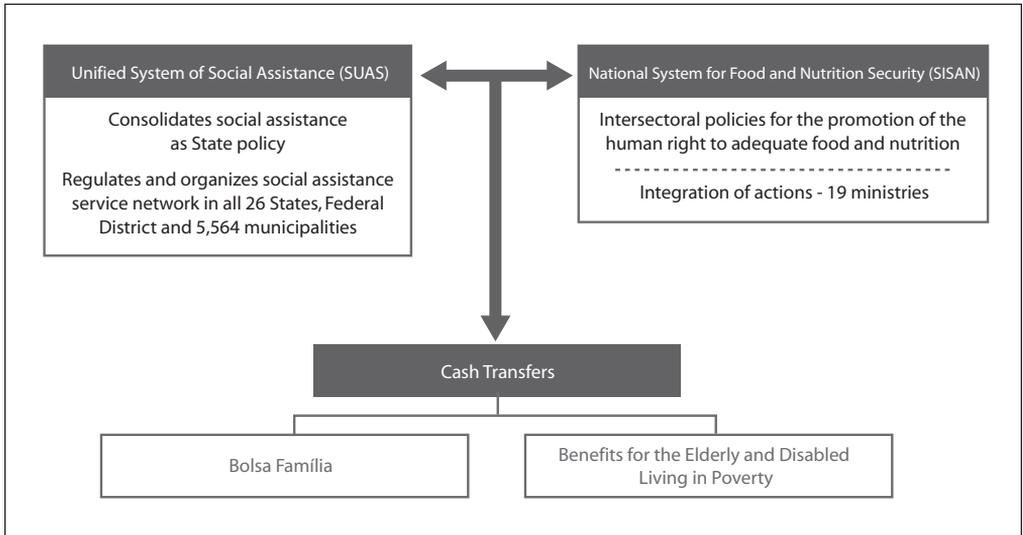
THE MINISTRY OF SOCIAL DEVELOPMENT AND FIGHT AGAINST HUNGER

In January 2004, the government of President Lula decided to promote a new social agenda integrating non-contributive social protection policies for the poor/vulnerable population. It did so in order to enhance the articulation and coordination of actions in three fields:

social assistance, food and nutrition security, and conditional cash transfers. Thus, since its inauguration in 2004, the Ministry of Social Development and Fight against Hunger has played an important role in broadening social pro-

tection and integrating social policies and their contribution to the reduction of poverty and inequality in Brazil (fig. 1). Nowadays, social protection is important not only to guarantee social rights but also to foster economic performance.

Figure 1 | Areas encompassed by the Ministry of Social Development and Fight against Hunger.

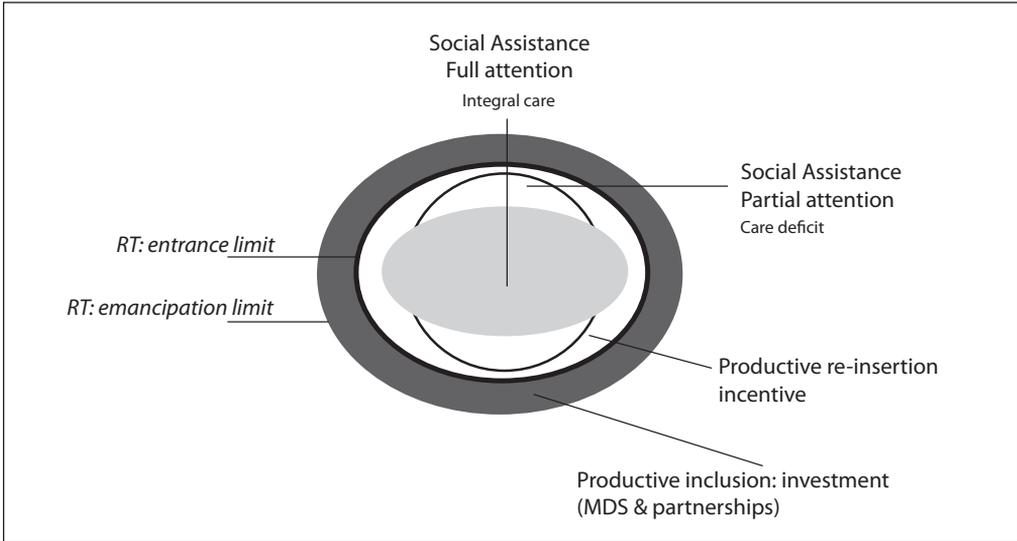


Source: Ministry of Social Development and Fight against Hunger, 2010.

In spite of the legal configuration of the social protection system, which comprises contributive and non-contributive policies (social insurance: contributive pensions; health: Unified National Health System and Social Assistance), the Ministry of Social Development and Fight against Hunger (MDS) is in charge only of the latter. Therefore, areas of the Ministry encompass productive inclusion policies and the conditional cash-transfer programme (Bolsa Família, or Family Grant) in its updated format. They also include previously conceived public policy systems: the Unified System of Social

Assistance (Sistema Único de Assistência Social, SUAS) and the National System for Food and Nutrition Security (Sistema Nacional de Segurança Alimentar e Nutricional, SISAN). The execution of most of these public policies is decentralized in cooperation with State governments and municipalities. The target populations reached by these policies and programmes are shown in figure 2.

In figure 2, there are two elliptical shapes that represent the population living in extreme poverty. The light grey ellipsis in the centre stands for the part of the population comprised of the whole

Figure 2 | Logical framework: access of poor and extremely poor populations to MDS programmes.

Source: Paes-Sousa, R., 2009, p. 390.

portfolio of MDS programmes. The round white shape represents the segment of the population whose access is still partial due to deficits of coverage concerning certain social assistance services. The white oval area (indicated by the words "Productive re-insertion incentive") stands for the poor target population, whose demand for social assistance is lower. In this case, although access to cash-transfer policies is comprehensive, it is necessary to provide access to governmental programmes of productive inclusion, housing, health and high-quality education.

The black oval line stands for the entrance limit (criteria based on income and vulnerability) to cash-transfer programmes and the external line shows the population at risk of impoverishment. As a consequence, there is demand, repre-

sented by the dark grey (outermost oval) area, for anti-poverty policies, such as incentives for family farming. Conditional cash-transfer beneficiaries also need this type of support since, after some permanence in the programme, there seem to be slight increases in family income, which could possibly make the families ineligible for the benefit. Owing to such cases of vulnerability and instability, there must be specific policies to promote sustainability and empowerment to counter unfavourable economic environments.

UNIFIED SYSTEM OF SOCIAL ASSISTANCE

For decades and before the conception of a systemic model, the social assistance policy consisted of various types of facilities and initiatives developed around the country in a complementary, compensatory fash-

ion. In this sense, much of the work was done without consistent planning or a national project for broad coverage since municipalities, State governments and private actors organized their activities according to emerging needs and demands. As a consequence, these dispersed actions resulted in a fragmentary sector that operated policies at times classified as palliative assistencialism (Sposati, 2009). It was still necessary to build and strengthen a conceptual model in which a universalized social protection system would enable the articulation among the policies and actors.

With the 1988 Constitution, these initiatives were to be integrated into a national social assistance policy. Thereupon, many legislative actions focused on institutionalizing social assistance, especially the Organic Law of Social Assistance (Lei Orgânica de Assistência Social, LOAS), enacted in 1993. This specific law established the competencies of the federal, State and municipal levels regarding the implementation of a participatory, democratic management model and compliance with standards for social assistance benefits and services. This landmark, along with the ongoing experience of the Unified National Health System, was seminal to the decision to build a unified system of social assistance.

In 2004, there were intensive negotiation and social mobilization towards the consolidation of a national policy document, the National Social Assistance

Policy (Política Nacional de Assistência Social, PNAS). This discussion acted as a catalyst for the National Council for Social Assistance (CNAS), empowered by the new political perspectives, to approve a resolution establishing the Unified System of Social Assistance (SUAS) in 2005.

The whole process was a big step from the perspective of creating public structures for planning and executing the Constitutional obligation of protecting poor people through a holistic system of social protection. As a result, the system has consolidated social assistance as a State policy towards the guarantee of social rights.

Nowadays, social assistance services are organized and provided according to different levels of complexity, especially in public facilities where reference and counter-reference (Social Assistance Reference Centre (Centro de Referência de Assistência Social, CRAS) and Specialized Social Assistance Reference Centre (Centro de Referência Especializado de Assistência Social, CREAS)) enable the development of programmes and projects, as shown in table 1.

NATIONAL SYSTEM FOR FOOD AND NUTRITION SECURITY

The implementation of the National System for Food and Nutrition Security (SISAN) started much before its legal establishment in 2006. In other words, about two decades of social mobilization

Table 1 | Levels of complexity of social assistance: Services and facilities.

Social Assistance Services	
Basic Social Protection	Special Social Protection
<ul style="list-style-type: none"> • Social Assistance Reference Centre (CRAS) <ul style="list-style-type: none"> - In 2010, 3,919 CRASs co-financed by MDS in 3,187 municipalities (70% of Brazilian municipalities); • Comprehensive Family Care Programme (Programa de Atenção Integral à Família, PAIF); • Socioeducational Services for Adolescents (ProJovem Adolescente); • Entrance door into the social protection network of SUAS. 	<ul style="list-style-type: none"> • Specialized Social Assistance Reference Centre (CREAS) <ul style="list-style-type: none"> - 2010: 1,235 CREASs in 1,014 municipalities; • Protection and specialized attention to families and individuals; • Child Labour Eradication Programme (Programa de Erradicação do Trabalho Infantil, PETI); • Programme for Fighting Sexual Exploitation of Children and Adolescents; • Social protection services to victims of violence, mistreatment and other violations of rights.
<p><i>Source: National Secretariat for Social Assistance (SNAS)/MDS, Brazil, 2010.</i></p>	

for an effective system of food and nutrition security were necessary before the reactivation of the National Council on Food and Nutrition Security (Conselho Nacional de Segurança Alimentar e Nutricional, CONSEA) and the Federal Law on Food and Nutrition Security became a reality.

The development of the system (SISAN) aims at promoting the human right to adequate food through the intersectorality of actions, public programmes and policies besides the articulation of social participation, with repercussions at the State and municipal levels.

Regarding the participation of MDS in

the implementation of the National Policy on Food and Nutrition Security, among other actions, it is worth mentioning:

- local public facilities to provide access to food and water by the low-income population (popular restaurants, food banks, community kitchens, cisterns);
- policies for food supply, land reform, school meals, nutrition education, etc.; and
- policies for the strengthening of family farming and agriculture (financing, technical assistance and guaranteed government purchase).

With the approval of a new Constitutional amendment in February 2010, the right to adequate food is part of the catalogue of fundamental guarantees, which reinforces the role of the State in strengthening the mechanisms and resources necessary to ensure food and nutrition security in Brazil.

CASH-TRANSFER PROGRAMMES

Bolsa Família Programme

The Bolsa Família (Family Grant) programme is a conditional cash-transfer programme that was launched in October 2003 and instituted by federal law. Its main objectives are to transfer income to

the poorest families so as to combat hunger and poverty as well as to promote these families' access to health, education and social-welfare public services.

Over the last several years, the Bolsa Família programme has turned out to be one of the most important strategic axes for the integration of policies and actions that are part of the Brazilian social protection network (fig. 3). The Unified Registry for Social Programmes of the Federal Government (Cadastro Único para Programas Sociais do Governo Federal, CadÚnico) is an articulated set of procedures, techniques and capacities for registering and updating socio-

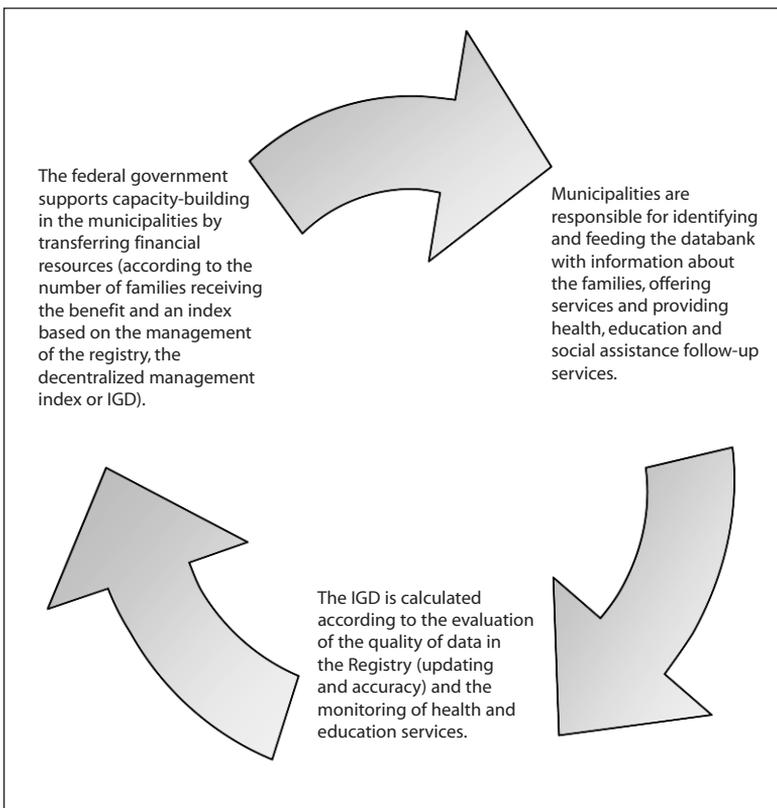


Figure 3 |
Bolsa Família:
Roles and
responsibilities in
the operation of
the Unified
Registry for Social
Programmes of
the Federal
Government
(CadÚnico).

Source: National Secretariat for Citizen Income (SENARC)/Ministry of Social Development and Fight against Hunger (MDS), Brazil, 2010.

economic information about families in poverty. It contains the database on families earning no more than half the Brazilian minimum wage per capita.

The purpose of the Unified Registry is to ensure that socio-economic data about the poor and extremely poor families are collected and fine-tuned by the municipalities so that the identification of poverty pockets and territorial challenges is used as a guideline for planning, implementing and monitoring public policies. It also enables support for the integration and articulation of other social programmes with Bolsa Família, aiming at the development of family capacities. Furthermore, through the construction of multidimensional indexes, it has been possible to measure poverty and vulnerability, pointing to target families eligible for social assistance follow-up.

Nowadays, families with per capita income below US\$80 – totalling around 12.4 million poor families (almost 50 million people) – have benefited in all 5,564 Brazilian municipalities. The Bolsa Família programme is notable for its low operating costs (only 5 per cent of the programme budget): expenditure in 2010 reached US\$7.7 billion (0.4 per cent of the GDP).

Besides income, some additional criteria have been defined in order to focus on certain features that may increase the vulnerability of the families, such as the number of children and youths between 16 and 17 years of age, who tend to drop out of school in order to work and support the families.

The choice of conditionalities attached to a cash-transfer programme is, above

Table 2 | Bolsa Família: Criteria for calculating benefits (US\$1~R\$1.7).

Type of Benefit	Amount	Criteria
Basic	US\$68	Families with per capita income up to US\$41; not attached to number of children, adolescents and youths.
Adjustable	US\$12.90	Families with per capita income up to US\$82.30; limited to 3 adjustable benefits for children or adolescents (younger than 15 years of age).
Adjustable for youths	US\$19.40	Families with per capita income up to US\$82.30; limited to 2 benefits for youths between 16 and 17 years of age who are attending school.

- The amount per family varies from US\$12.90 to US\$117.60 depending on family size and poverty level.
- The average monthly benefit paid to families is US\$54.

Source: National Secretariat for Social Assistance (SNAS)/MDS, Brazil, 2010.

all, a way to reinforce basic rights, such as education, health and social assistance services. The monitoring of these conditionalities enables an effective process of tracking down the most vulnerable fami-

lies, which should have follow-up priority. It is also seen as a means of reinforcing the importance of sharing responsibility between the families and the State.

Table 3 | Conditionalities monitored by the Bolsa Família programme.

Area	Conditionality	Target
Health	Following vaccination calendar, children's growth and development	Children under 7 years of age
	Pre-birth and nursing health care	Pregnant women and nursing mothers
Education	School registration and monthly attendance (minimum 85%)	Children and teenagers between ages 6 and 15
	School registration and monthly attendance (minimum 75%)	16- and 17-year-olds
Social protection	Socio-educational and community activities (Child Labour Eradication Programme)	Children up to 15 years of age

Source: National Secretariat for Citizen Income (SENARC)/MDS, Brazil, 2009.

Monitoring conditionalities is an intersectoral responsibility shared by the Ministries of Health, Education and Social Development. This process

involves a great deal of articulation and mobilization both vertically and horizontally. When non-compliance with conditionalities is found (fig. 4), it is mostly

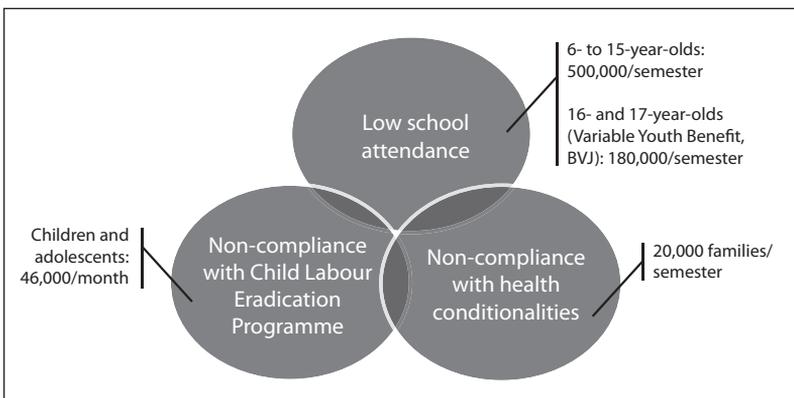


Figure 4 | Families meeting priority criteria for follow-up services.

Source: National Secretariat for Citizen Income (SENARC)/MDS, 2010.

interpreted by federal and local authorities as a sign that a family may be at risk or in need of additional social assistance services. The consequences for non-compliance with conditionalities are gradual, beginning with a “warning” followed by blockage, suspension and finally cancellation of benefits.

Emphasis has been put on the development of strategies to strengthen the articulation among social protection services and benefits in order to overcome situations of vulnerability and risk. In this sense, the Protocol for Integrated Management of Services, Benefits and Cash Transfers aims to provide social assistance follow-up services to beneficiaries of the Bolsa Família and the Benefit for the Elderly and Disabled in Poverty or Continuous Cash Benefit (Benefício de Prestação Continuada, BPC). Thus, whether there is non-compliance with conditionalities of the Bolsa Família programme or with the Child Labour Eradication Programme, for instance, the focus should be on diagnosing and treating the cause of vulnerability so as to break the intergenerational cycle of poverty and violation of rights.

Benefit for the Elderly and Disabled in Poverty

The Benefit for the Elderly and Disabled in Poverty or Continuous Cash Benefit (BPC) is a Constitutional right under the Social Assistance Policy included in the Unified System of Social Assistance. It is a poverty-targeted, non-contributive pension aimed at guaranteeing income

security for the elderly (over 65 years of age) and for the disabled, at any age, who are not capable of living independently or working.

Beneficiaries who fulfil the criteria are granted a monthly minimum wage (US\$283). From 2003 to 2009, coverage was extended to about 80 per cent of those qualifying for it. Nowadays, beneficiaries total 1.6 million elderly and 1.8 million persons with disabilities, in both cases belonging to poor families with a monthly per capita income lower than one fourth of the minimum wage (US\$66).

In 2010, the budget provided for the Continuous Cash Benefit (BPC) was US\$12 billion, representing 0.6 per cent of Brazilian GDP.

RECENT RESULTS REGARDING THE SOCIAL PROTECTION SYSTEM

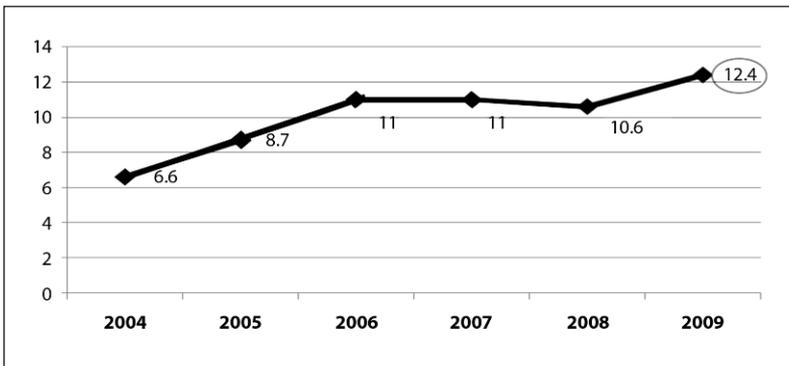
In evaluating the results of benefits and services, it is necessary to note that, while the measurement of the impact of cash transfers can be done by monitoring standard statistics and well-known variables, the same objectivity does not apply to the evaluation of services. Since there are no such known standards or acknowledged measures for services, it becomes somewhat more difficult to make comparisons. It is also early to measure the impact of these services since the implementation of massive coverage and quality standards is still in progress.

What can be said is that the social protection network, consolidated by the programmes described earlier, has had powerful effects regarding poverty reduction and food security for poor families in Brazil. Moreover, these results seem to be even more robust when the focus is on the impact of cash-transfer actions.

In this sense, the expansion of Bolsa Família (graph 1) and the Continuous

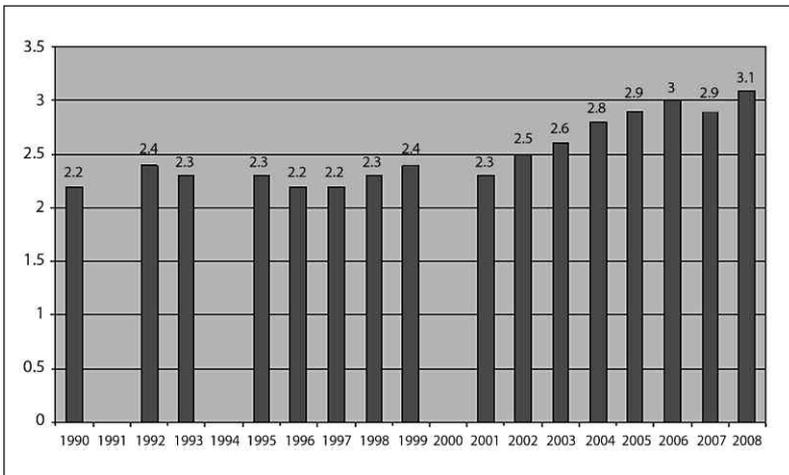
Cash Benefit (graph 2) has resulted in immediate and significant effects on the living conditions of the poor population. Families receiving the benefits have been directly affected, and results point to increased food and nutrition security and reduced poverty and inequality.

These programmes have had a great impact on the reduction of the risk of child labour as well as child malnutrition



Graph 1 | Evolution of Bolsa Família benefit coverage: number of families, 2004-2009 (in millions)

Source: National Secretariat for Citizen Income (SENARC)/MDS, Brazil, 2009.



Graph 2 | Expansion of the Continuous Cash Benefit (BPC): Elderly and persons with disabilities (in millions).

Source: National Secretariat for Social Assistance (SNAS)/MDS, Brazil, 2008.

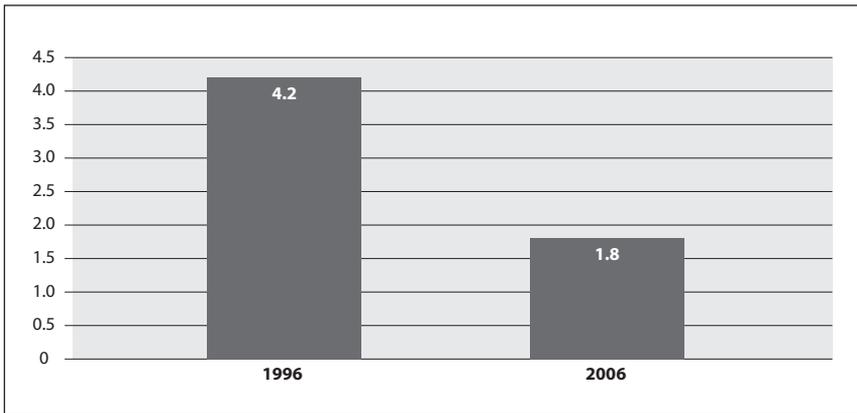
(graph 3). For instance, in the semi-arid region, participation in the Bolsa Família programme has reduced the risk of chronic malnutrition in children under five years of age by 30 per cent. The greatest benefit was seen for children between the ages of 6 and 11 months, for whom there was a 62 per cent reduction in the risk of chronic malnutrition.

As a result, 19.4 million Brazilians

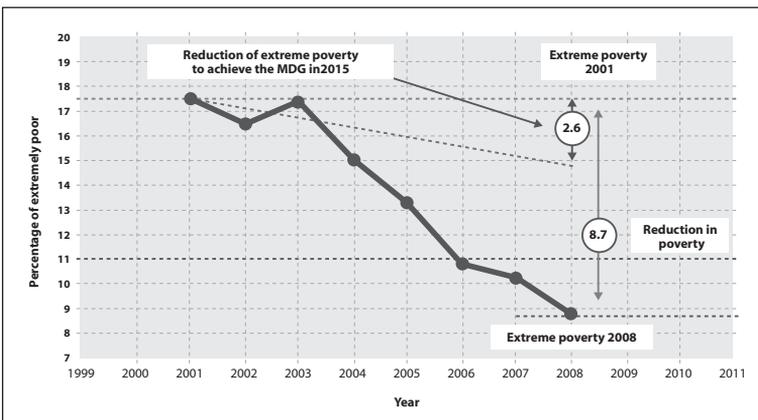
have overcome extreme poverty since 2003 (Fundação Getulio Uargas Center for Social Policies) (graph 4). Moreover, Brazil achieved Target 1 of the Millennium Development Goals ten years in advance and it has set higher standards: to reduce extreme poverty to one fourth and eradicate hunger by 2015.

There has also been a decrease in inequality, which dropped from 2001 to

Graph 3 | Percentage of children from age zero to four years with weight-for-age deficit, 1996 and 2006.



Source: National Survey on the Health and Demographics of Women and Children (Pesquisa Nacional de Demografia e Saúde da Mulher e da Criança, PNDS), 2006; Dimensions of the reproductive process and children’s health, Ministry of Health, Brazilian Centre for Analysis and Planning, Brazil, 2009.



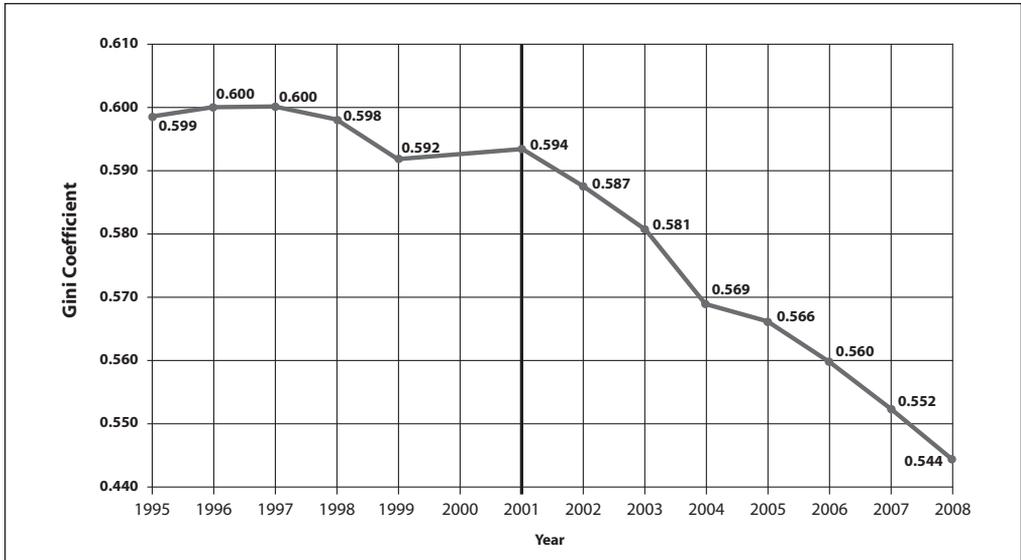
Source: Barros, R.P., Sobre a Recente Evolução da Pobreza da Desigualdade. Brasília: IPEA, 2009.

Graph 4 | Evolution of extreme poverty in Brazil, 2001-2008.

2008 (graph 5), with the income of the bottom 10 per cent growing six times faster than that of the top 10 per cent (Institute of Applied Economic Research, Instituto de Pesquisa Econômica Aplicada, IPEA).

According to Sergei Soares (2008), on average, the Gini index in Brazil has been falling 0.7 points per year, which is superior to the rhythm of a selected group of Organisation of Economic Co-operation and Development (OECD)

Graph 5 | Distribution of per capita household income according to the Gini index, 1995-2008.



Source: Estimates based on National Household Sample Survey (Pesquisa Nacional por Amostra de Domicílios, PNAD) from 1995 to 2008.

countries analysed according to the criterion of having built a consistent welfare system. The general conclusion of this study was that the speed with which inequality is falling is adequate, but the challenge will be to keep inequality falling at the same rate for another two or three decades (Soares, 2008, p.16).

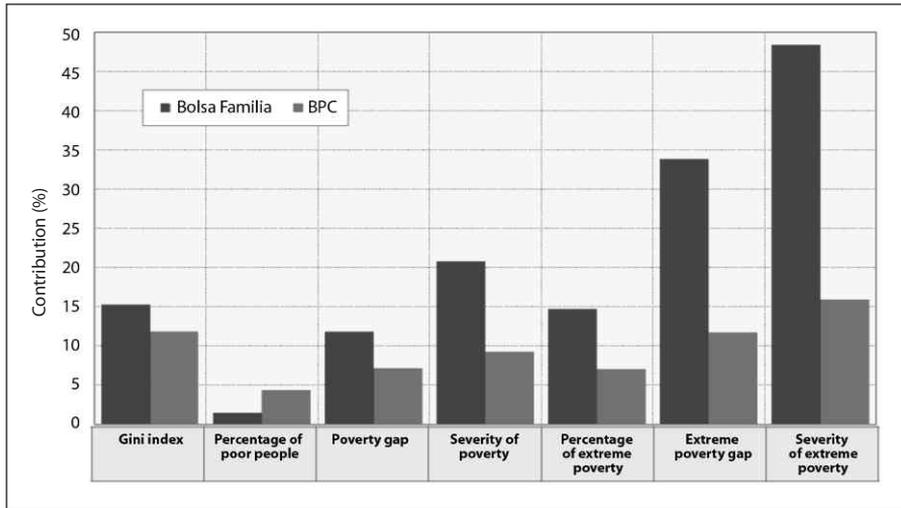
Evaluations have pointed out consistently that cash transfers have made relevant contributions to the reduction of inequity and poverty in Brazil (graph 6), especially when taking into consideration that one of the main objectives of the Bolsa Família programme is the immedi-

ate alleviation of poverty.

It is important to point out that social policies may be associated with two main externalities. First, they grant social rights for people who need assistance from the State and receive it through these public policies. In addition, they foster economic performance, injecting new money into some depressed regions that become dynamized by new demands for consumption and production.

This was one of the main reasons why the federal government decided to increase investment in social policies during the

Graph 6 | Contribution of Bolsa Família and Continuous Cash Benefit (BPC) to the reduction of inequity and poverty, 2003-2008.



Source: Estimates based on the National Household Sample Survey (Pesquisa Nacional por Amostra de Domicílios, PNAD), 2003-2008/Barros, R. P., Institute of Applied Economic Research (IPEA), Brazil, 2009.

2008 economic crisis. The Bolsa Família programme benefits were raised and its coverage increased and unemployment insurance was extended. In addition, the maintenance of the policy on raising the minimum wage was important. Sustainable economic growth through social inclusion and redistribution of wealth was maintained, increasing domestic markets.

In 2009, resources effectively invested in the Continuous Cash Benefit (BPC) and Bolsa Família totalled US\$17 billion – around 1 per cent of GDP. In this sense, cash transfers have shown an important economic redistributive effect: the smaller the per capita income of a given region, the greater the importance of transfers for the local economy. In the Northeast (the poorest region of Brazil), they represent 3 per cent of regional GDP. Since these social transfers raise the consumption capacity of families, they have an immedi-

ate multiplier effect on the economy.

It is clear, therefore, that the existence of a wide network of social protection and promotion played an important role in overcoming the crisis in Brazil. Poverty and inequality continued to drop in the six main metropolitan regions, besides the acknowledged dynamization of local economies.

In addition, it is important to point out that the Bolsa Família programme has increased consumption and aggregate demand in local economies. Furthermore, studies show that the programme does not discourage beneficiaries from working since 77 per cent of beneficiaries do have a job (Brazilian Institute of Geography and Statistics (Instituto Brasileiro de Geografia e Estatística, IBGE), 2008). On the contrary, the programme provides many people with the opportunity to look for a job

once again. Data have shown that 99.5 per cent of beneficiaries have not quit working after being granted the benefit (Brazilian Institute of Social and Economic Analyses (Instituto Brasileiro de Análises Sociais e Econômicas, IBASE), 2008). Thus, the Bolsa Família programme can be seen as an integrator of opportunities for inclusion.

The central player of Bolsa Família is the mother, who receives the benefit, so the programme also works as a tool for the empowerment of women. According to official data, 92.4 per cent of Bolsa Família beneficiaries nowadays are women. Impact evaluation studies have shown that the participation of women in decisions regarding the consumption of durable goods has increased by 10 per cent.

Another positive advance that complements the actions described above is the social and economic data gathered by the Unified Registry for Social Programmes of the Federal Government (CadÚnico). Through the Unified Registry, it has been possible to find information about the beneficiary families in order to offer customized literacy courses for adults, low-income housing (Minha Casa, Minha Vida Programme: Ministry of the Cities), subsidized electric energy (Luz para Todos Programme: Ministry of Mining and Energy), financial/banking inclusion and actions aimed at income-generation, professional qualification and insertion into the labour market (Civil Construction, Tourism: Proximo Passo Programme).

Further comprehension of the impact and results of all these programmes should emerge in the long term. It is expected

that these results will include the improvement of educational and health services, which will contribute to breaking the intergenerational cycle of poverty, understood now as a multidimensional issue that comprises not only income but also access to services and rights.

LOOKING FORWARD: CHALLENGES TO CONSOLIDATING THE SYSTEMS

Despite recent advances in Brazil, the number of poverty-stricken people is still high (around 30 million, 8.9 million of whom still live in extreme poverty, according to the MDG Report/Brazil, 2010). Inequality rates continue to be among the highest in the world (Gini coefficient 0.531 in 2008); the country still faces persistent illiteracy levels and unsatisfactory health indexes.

This situation persists mainly in the poorest regions, such as the Northeast of Brazil, where the percentage of poor people is twice as high as the national average (IBGE, 2008). Moreover, poverty in rural areas is three times higher than in urban centres, and the percentage of black or mixed-race people living in poverty is twice as high as that of white people.

In short, it is mandatory that the combination of economic growth, income distribution and social inclusion be maintained for several years in order to achieve desirable standards of social development. Qualitative changes in the focus of current policies might be necessary as well.

In practical terms, these social pro-

grammes should be reorganized on two fronts. The first should be the integration of cash transfers and benefits to achieve an effect on income distribution and poverty reduction in the short term. The second should be the improvement and standardization of social services in line with these programmes so as to obtain longer-term, effective results.

This reorganization should take place because, in sum, the political and academic communities are increasingly reaching the conclusion that even with greater success, distribution policies will reach their limits by the second decade of the twenty-first century. Government policies, if based only on benefits, may lose their effectiveness, becoming a hostage of their own success. An approach to services that has a special focus on quality must, therefore, be taken into consideration at this point since a new chapter in the design of social policies seems to have started. Thus, it is possible to state that during this second decade, socio-economic development will depend very much on greater integration of social protection policies, strengthening the design of multisectoral approaches to social development.

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ⁱⁱⁱ WHO, UNICEF, UNFPA and World Bank, *Global Health Observatory*, 2005.

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The Rural Social Insurance Programme

Edvaldo Duarte Barbosa

4

Brazil

Summary

- The Brazilian rural social insurance model is formally contributory. Yet, owing to the particularities of rural activity, contribution rules are not the traditional rules applicable to the urban system, thereby requiring a high level of subsidy.
- The model targets workers engaged in activities particular to the agrarian sector regardless of whether they live in rural or urban areas.
- The insured persons under this regime are salaried workers, producers who are physical persons and specially insured persons (family agricultural workers).

Financing

- For specially insured individuals, the amount of contributions collected is based on the commercialization of their production (2.1 per cent). This does not prevent them from contributing on a voluntary basis and as an individual contributor in order to obtain benefits higher than the minimum.
- The rural producer who is a physical person contributes on the basis of commercialized product (2.1 per cent corresponding to the employer's quota) and on the basis of income declared as an individual contributor (the personal quota). The value of this income will always be at least equal to the minimum wage and the contribution will be 11 per cent.
- Like the urban worker, the salaried rural worker contributes 8 per cent, 9 per cent or 10 per cent of his/her monthly income.
- The rural producer who is a legal person contributes 2.6 per cent of the value of the product commercialized.

Benefits

- Benefits have a minimum value of one official minimum wage.
- Retirement due to contribution time, old-age pension, disability pension, illness aid, maternity salary, accident aid, survivor's pension and reclusion aid.
- Old-age pensions at 60 years of age if male and 55 if female, given 15 years of rural work (for the specially insured) or 15 years of contributions (for rural producers who are physical persons and for salaried rural workers).

Specially insured family agricultural workers

- A person who falls in the category of "specially insured" must be a physical person who inhabits a rural estate or a neighbouring urban or rural agglomerate. He or she must work individually or in a family economy regime and may eventually be able to enlist

Summary (cont'd.)

the help of third parties for mutual cooperation reasons so long as: (a) he/she is a producer – a property owner, property user-owner, inhabitant, partner or sharecropper,¹ bailee or rural renter – who exploits agriculture within four fiscal modules, or is a latex gatherer or other vegetal extractor who makes these activities his/her main means of earning a living; (b) is an artisanal fisherperson or person employed in a similar activity who makes fishing his/her usual profession and means of earning a living; (c) is the spouse or child under 16 years of age (or child-equivalent) of the insured person as defined in (a) and (b) above and can provide proof of working with his or her respective family.

- With the introduction of the “specially insured” concept in 1992, the Rural Social Insurance system began guaranteeing universal access to it by both male and female rural workers under the regime for the specially insured.
- Rural workers under a family economy regime have been guaranteed the same treatment as that given to urban workers. With the exception of retirement due to contribution time, rural workers have access to the same benefits: old-age, disability and survivor’s pensions as well as a maternity salary, and accident, sickness and reclusion aid.
- In practice, social insurance rights have been extended to a particular group of workers regardless of their capacity to contribute to social security.

The differentiated treatment has resulted in a significant expansion of social protection among agricultural workers. In 2008, insurance coverage among agricultural workers reached 79.8 per cent while it was 65.9 per cent among workers employed in other economic sectors.

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INTRODUCTION

Brazil’s Rural Social Insurance (Previdência Social Rural), which was expanded and consolidated by the 1988 Federal Constitution, had a slow and gradual evo-

lution before it finally established itself as a true guarantor of protection for rural workers. These workers are subject to much greater social insecurity than urban workers, who have always had at least some bargaining power through their class organizations.

¹*meio outorgados* or *sharecropper*: a small-scale farmer whose land is not his/her property. There is usually an informal agreement between the land owner and the farmer so that part of the production is exchanged for the right to occupy and use the land, equipment, seeds and facilities.

Previdência Social Rural is formally a contributory programme. Yet, owing to the particularities of rural activity, it has contributory rules that are different from the traditional rules of the urban scheme, which entails a high degree of public subsidy. The model is geared towards workers who carry out activities particular to the agricultural sector regardless of whether they reside in rural or urban areas. Under this regime, the insured include salaried workers and individuals who are producers as well as individuals in the special insurance category (family agricultural workers²).

Each insured individual receives benefits specific to the contributory rules that apply to him or her. In the case of individuals under the category of "specially insured persons", contributions are collected on the basis of the value of their commercialized production. This, however, does not prevent them from being able to contribute voluntarily as individual contributors so as to obtain benefits above the minimum level. Rural producers who are physical persons³ contribute to social security based on the value of their commercialized production – corresponding to the employer's quota. Through the individual's quota, they also contribute based on the income declared, which will always be at least equivalent to the official minimum wage. Salaried rural employees

contribute on the basis of their monthly wages, in the same manner that urban employees do, whereas employers' contributions are a percentage of the value of commercialized production.

The concept of "specially insured persons" was introduced into legislation in 1991 with the intent of offering special treatment to a portion of rural workers who are involved in family economy regimes, thus extending social protection to the family as a whole. The pensions of people insured under this category are strongly tied to certain months of the year and to the type of agricultural product grown. Furthermore, the selling price of their products usually suffers oscillations due to the bargaining power of buyers (generally large food suppliers) and to the presence of intermediaries that also receive a portion of profits at negotiations. Given this unstable financial flux, specially insured persons have very low incomes; therefore, the additional resources necessary for the full functioning of the regime must be guaranteed by the State.

This social insurance model, which is contributory yet heavily subsidized by the State, was responsible for the payout of 7.9 million pensions amounting to R\$45.5 billion in 2009. In the same year, the contributions collected totalled only R\$4.6 billion, which resulted in the State

²These are family agricultural workers or artisan fisherpeople whose primary activity is agriculture/fishing and who make use of the labour of family members in this undertaking. When they do hire labour, they do so punctually and on a small scale (for no more than 120 workdays per year). The property on which these types of workers carry out their activities cannot be larger than four rural modules (units that vary depending on the region in Brazil).

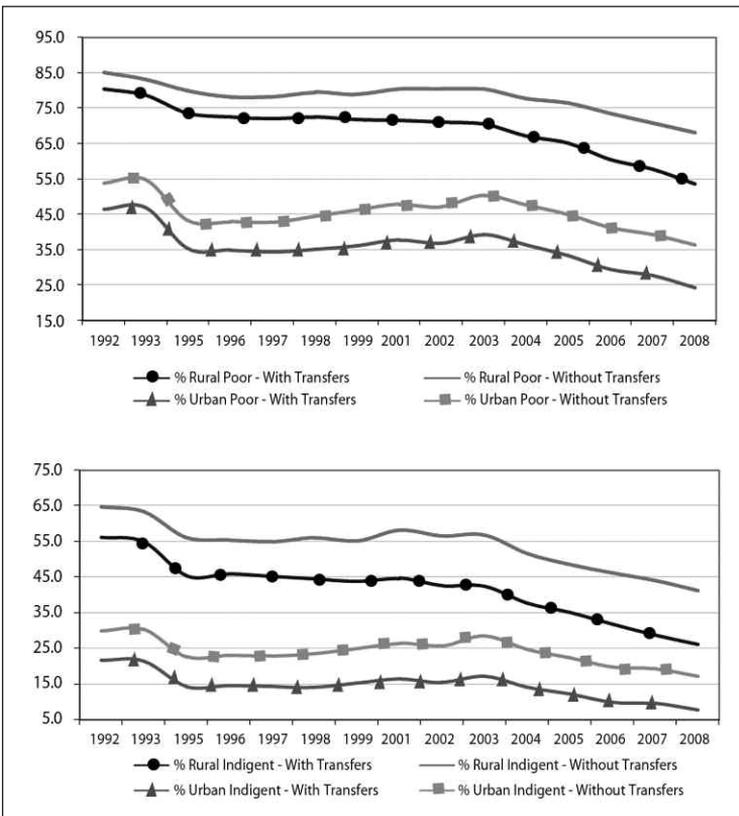
³Rural producers, who are physical (as opposed to legal) persons, are those who are self-employed and use a property area larger than four rural modules. They may or may not use labour from third parties. Rural producers are also considered to be those who are self-employed and use fewer than four modules of property but who hire the labour of third parties in quantities that are not permitted under the category of "specially insured persons".

needing to finance R\$40.9 billion – 1.3 per cent of GDP.

The social gains are already evident since they have been enabling elderly agricultural workers to have a dignified life. Moreover, the monthly pensions paid out by the social insurance system represent an impetus for increased activity in the service, goods and other sectors, especially for smaller and poorer towns.¹

Data from the National Household Sample Survey (Pesquisa Nacional por Amostra de Domicílio, PNAD) show that social welfare benefits are directly respon-

sible for the reduction in poverty and indigence⁴ in rural areas. Using the survey, it is possible to establish a comparison of the evolution of the poverty and indigence rates with and without the effect of social transfers in rural areas since 1992 (graph 1). It can be observed that under both circumstances, there is a reduction in the rates since 2001 and a tendency for the two curves to diverge. In 1992, the difference between the poor and indigent in rural areas who received transfers and those who did not was 4.5 and 8.6 percentage points, respectively. In 2001, that difference rose to 8.9 and 13.5 percentage



Graph 1 | Percentage of the population that is poor or indigent in rural and urban areas, with and without social transfers, 1992-2008.*

* Not including rural areas in the northern region, except Tocantins.

Source: National Household Sample Survey (PNAD)/Brazilian Institute of Geography and Statistics (IBGE), 2008. Preparation: Secretary of Social Security Policies (SPS), Ministry of Social Security (MPS).

⁴Individuals considered to be poor are those whose income is inferior to one half of the minimum wage while individuals considered to be indigent are those whose income is below one quarter of the minimum wage.

points, and, by 2008, it had reached 14.6 and 15.1 percentage points, respectively.

By 2008, 53.5 per cent of the rural population was still poor but this figure would have jumped to 68.1 per cent if there had been no social insurance transfers. In absolute terms, this represents a reduction of 4 million people. Similarly, 26.1 per cent of the rural population was indigent in 2008, but without social transfers, this percentage would have been 41.3 per cent, indicating a reduction of 4.1 million people.

Recognition that *Previdência Social Brasileira* (Brazilian Social Insurance) (urban and rural) contributes strongly to the reduction of poverty, especially among the elderly, is growing. This becomes more apparent in rural areas, given that pensions are the main sources of income for many rural families. As such, family structures themselves have undergone significant alterations: pensioners have acquired a better standard of living and they have gone from fulfilling the role of “dependant” to that of “provider” within their family.ⁱⁱ

BRAZIL, SOCIAL SECURITY AND THE SOCIAL PROTECTION FLOOR

Brazilian Social Insurance (*Previdência Social*), including Rural Social Insurance (*Previdência Social Rural*), is anchored in

the concept of social security. This concept was defined by the 1988 Federal Constitution as a coordinated group of actions initiated by the State and by society and destined to ensure rights relative to health, welfare and social assistance.

The 1988 Federal Constitution defines the “social protection” concept broadly, giving it several elements of a universal social protection floor – contributory and non-contributory benefits for the support of children, for the elderly, for adults without the capacity to work and for the unemployed, as well as implementing the Universal Health Care System (*Sistema Único de Saúde, SUS*) and thereby recognizing the right to universal health care. As such, this concept of social security joins the recent global initiative proposed by the United Nations in 2009. In response to the effects of the global economic crisis, the Initiative seeks to implement a social protection floor comprising four basic guarantees: access to basic health care for all; economic security for children; assistance for the unemployed and the poor; and economic security for the elderly and the disabled.

Brazil has significant income transfer programmes such as the *Bolsa Família* programme, which targets children. In 2009, *Bolsa Família* had a budget of R\$12.5 billion and benefited 12.4 million families. Brazil also offers the Benefit for the Elderly and Disabled in Poverty⁵ or Continuous Cash Benefit (*Benefício de Prestação Continuada (BPC)*), regulated by

⁵Means-tested benefits addressed to very poor older people, as well as disabled people (in this case, irrespective of age), whose per capita income falls below the threshold of one fourth of the minimum wage.

the Organic Law of Social Assistance, LOAS). In 2009, this programme spent R\$17.6 billion on 3.2 million benefits. Finally, the Previdência Social (Social Insurance) system includes the Previdência Rural Social (Rural Social Insurance) system, which transfers income, especially through its treatment of the category of “specially insured persons”.

Given the size of Brazil and the complexity of each of these areas of activity, different ministries are in charge of the implementation of the programmes: the Ministry of Social Development and Fight against Hunger (Ministério de Desenvolvimento Social e Combate à Fome, MDS) is responsible for cash-transfer programmes such as Bolsa Família; MDS, along with the Ministry of Social Insurance (Ministério da Previdência Social, MPS), is in charge of the Benefit for the Elderly and Disabled in Poverty (BPC);⁶ the MPS also oversees the Social Insurance system (Previdência Social); and the Ministry of Health (Ministério da Saúde, MS) implements health care as a universal right.

Although social policies are implemented by distinct ministries, they remain under the single command of the President of the Republic, who meets periodically with ministries involved in social affairs in order to evaluate the programmes. There is frequent communication between the ministries but, in truth, there is no forum for technical coordination nor a management application

accessible to all ministries involved in social security that would provide more agility in the taking of decisions. Perhaps this is precisely the element (still) absent from the Brazilian social protection floor (SPF) model: institutional space for the coordination of programmes that belong to the SPF.

CONTEXT

Brazil is located in eastern Latin America and has an area of 8,547,403.50 km². For administrative purposes, the country is divided into 26 States, one Federal District and 5,564 municipalities. The 1988 Federal Constitution establishes citizens' rights and obligations as well as the organization of the Brazilian State. There are three established powers: the executive, the legislative and the judiciary. The President functions as Head of State and Government and has a four-year term with the possibility of a one-term renewal.

The country has a population of approximately 193 million (IBGE 2008 estimate), 80 per cent of whom live in urban areas. The rural population is relatively small, which facilitated the widespread implementation of rural social insurance. The latest (2008) IBGE demographic projection indicates that the population's rate of growth is dropping and that life expectancy is increasing, which points to a rapid ageing of the population by 2050.

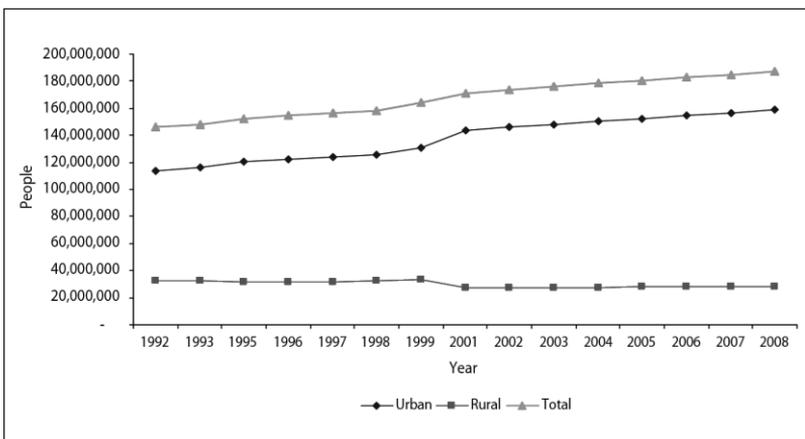
⁶The Ministry of Social Insurance (MPS) is responsible for operating payments and concession, but the Ministry of Social Development and Fight against Hunger (MDS) is in charge of its rules, decisions about its budget and management.

Previdência Social (Social Insurance) does not use the concept of “geographic residence” to determine whom it insures among rural inhabitants. For the purposes of the programme, rural workers are defined by their occupation, which must be particular to the rural setting regardless of where the activity is performed. As such, one can find urban inhabitants who are insured as rural workers and vice versa.

Brazil’s rural population has been waning since 1940 while its urban population continues to grow. The 1970 census was the first to indicate that the urban population had exceeded the rural population. Since then, the gap between the two has continued to widen, which indicates that the country is undergoing a rapid process of urbanization. In 2008, the urban population was 159.1 million, 39.8 per cent larger than it was in 1992. The rural population, on the other hand, was 27.8 million, dropping 13.5 per cent between 1992 and 2008 (graph 2). This

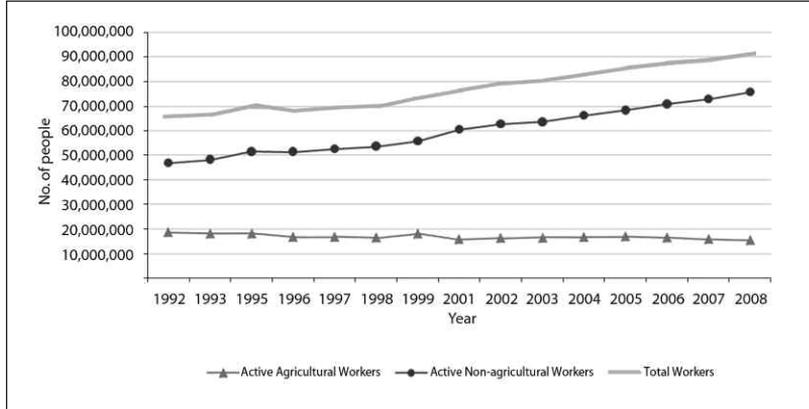
trend should continue in the coming years. Nonetheless, Brazil has and will continue to have a significant number of families working in small-scale farming, which demonstrates that rural social insurance will continue to play a relevant role in Brazilian social protection.

According to the Ministry of Labour and Employment (Ministério do Trabalho e Emprego, MTE),ⁱⁱⁱ the formal labour market in Brazil has been expanding and has had a direct impact on the development of social protection. Between 1995 and 2008, employment grew by 65.5 per cent, with significant results after 2003; the following five years would register an employment growth rate of 33.6 per cent. In 1995, the formal labour market in Brazil had about 23.8 million formal jobs. The total rose to 28.7 million in 2002 and reached 39.4 million in 2008. Thus, for the 1995-2008 period, 68 per cent of the jobs were created between 2002 and 2008.



Graph 2 |
Size of urban and rural populations, 1992-2008.

Source: National Household Sample Survey (PNAD), Brazilian Institute of Geography and Statistics (IBGE), 2008. Preparation: Secretary of Social Security Policies (SPS), Ministry of Social Insurance (MPS).



Graph 3 | Working population, by sector of employment (agricultural/non-agricultural), 1992-2008.

Source: National Household Sample Survey (PNAD), Brazilian Institute of Geography and Statistics (IBGE), 2008. Preparation: Secretary of Social Security Policies (SPS)/Ministry of Social Insurance (MPS).

Brazil has officially adopted an ample⁷ indicator for determining the level of social protection among the employed. The insured employed population between 16 and 59 years of age includes: contributors (active and insured individuals under the General Social Insurance Scheme (Regime Geral de Previdência Social, RGPS) as well as active and insured individuals under the regimes particular to military and civil servants); individuals belonging to the category of specially insured family farmers; and non-contributors who receive some continuous welfare or assistance benefit. In sum, the insured active population encompasses (a) those individuals who either contribute to some public welfare regime or are part of the “specially insured” category, or (b) those who, despite not contributing and not being “specially insured”, are already beneficiar-

ies of the Social Insurance or Social Assistance system.

It is important to highlight that the indicators of social insurance protection include both insurance benefits and assistance benefits paid as pensions to disabled individuals of any age who are unable to work and to the elderly (age 65 or older) whose income is classified as low (family income per capita lower than one fourth of the official minimum wage).

According to data from the 2008 National Household Sample Survey (PNAD), 63.4 per cent of the employed population (between 15 and 59 years of age) was socially protected in 1998. With a tendency to decline, this proportion dropped to 61.7 per cent in 2002. From 2003 onwards, however, the opposite trend began manifesting itself and the proportion reached 65.9 per cent in 2008.

⁷The National Household Sample Survey (PNAD) cannot accurately determine whether the interviewee is receiving a continuous assistance benefit or a social welfare benefit. This is owing to the fact that even the insured person often cannot distinguish between the two benefits, given that the assistance benefit is distributed by the social welfare agencies despite being paid by the Ministry of Social Development and Fight against Hunger (MDS).

Table 1 | Social insurance protection of the elderly,* 2008.

Category	Men	Women	Total
Retired	6,950,143	5,306,168	12,256,311
Pensioners	126,099	2,237,270	2,363,369
Retired and pensioners	220,707	1,397,096	1,617,803
Contributors but non-beneficiaries	678,869	273,703	952,572
Total protected (a)	7,975,818	9,214,237	17,190,055
Inhabitants (b)	9,214,542	11,824,542	21,039,084
Coverage (%) ((a)/(b))	86.6	77.9	81.7

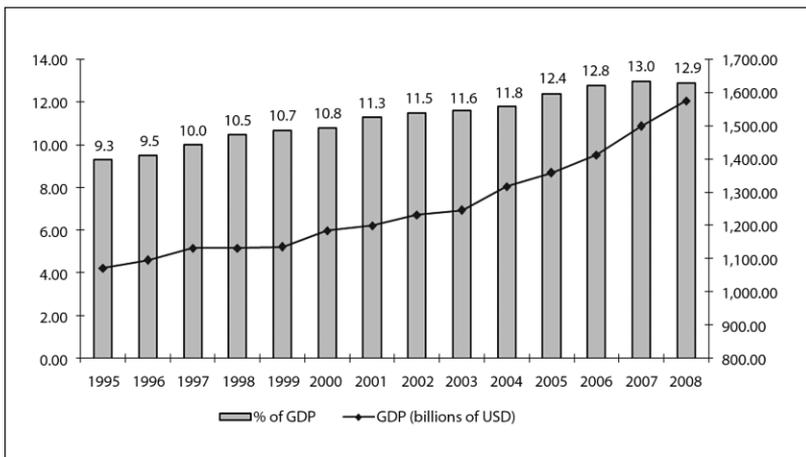
* The elderly comprise men and women who are 60 years of age and older.

Source: National Household Sample Survey (PNAD), Brazilian Institute of Geography and Statistics (IBGE), 2008.
Preparation: Secretary of Social Security Policies (SPS), Ministry of Social Insurance (MPS).

Previdência Social (Social Insurance) went from paying 19.5 million benefits in December 2000 to paying 27 million in December 2009 – an increase of 38.5 per cent. PNAD 2008 shows that, among the elderly population (above 59 years of age), social protection covered 81.7 per cent of the population (table 1), with the level steady since 1995, when it covered 80.1 per

cent of the elderly.

It is important to highlight that federal expenditure on social security in Brazil (including social insurance and social assistance) has been on the rise. As a percentage of GDP, social security expenditure increased from 9.3 per cent in 1995 to 12.9 per cent in 2009 (graph 4).



Graph 4 | Federal social security expenditure, as a percentage of GDP and in billions of US\$, 1995-2008.

Source: Institute of Applied Economic Research (IPEA). Preparation: Secretary of Social Security Policies (SPS), Ministry of Social Insurance (MPS).

EVOLUTION OF RURAL SOCIAL INSURANCE (PREVIDÊNCIA SOCIAL RURAL)

The law that is considered to be an initial marker of Brazil's social protection, the Eloy Chaves Law, was passed in 1923 and included only some categories of workers. By the 1950s, almost all urban workers had been included, which was not the case for rural workers. Among the various reasons given for the exclusion of rural workers from effective social protection, the main reason was, according to Schwarzer,^{iv} that they "did not represent a pressure group with sufficient capacity for political articulation and vocalization such that the populist-paternalist State would see it as a social group needing to be integrated and co-opted through the significant expansion of social programs' coverage".

The first attempt at formally including rural workers in the Previdência Social (Social Insurance) system took place in 1945 with the creation of the Institute of Social Services and the move to combine all the already-existing welfare institutions. However, this attempt at universalizing social welfare was not implemented owing to an insufficient budget. From then on, new efforts at extending social security to rural populations were made in 1955 with the creation of the Rural Social Service. This programme, which was financed by urban industrial companies, was destined to assist rural populations.

The effective inclusion of the rural

worker in insurance legislation took place in 1963 with the approval of the Rural Worker's Statute and the creation of the Fund for Social Insurance and Assistance to Rural Workers (Fundo de Assistência e Previdência do Trabalhador Rural, FUNRURAL). The FUNRURAL was financed by a contribution that the producer (or, given prior agreement, the buyer) paid based on the value of the first commercialization of rural products. It offered disability, old-age, survivor, maternity and sickness benefits as well as funeral assistance and medical care. Yet there was still a failure to implement rural social insurance at that time. This failure appears to have been tied to the programme's source of funding, which was based on the commercialization of rural products and which did not provide a sufficient financial base for the programme's execution, making taxation and the collection of contributions unsustainable.

In 1967, the Rural Worker's Statute was reformulated and the recently created National Institute of Social Insurance (Instituto Nacional de Previdência Social, INPS) was given charge of the entire financing structure of the FUNRURAL. The programme's benefits were limited to medical and social services and all cash benefits were suppressed. In addition, the contribution system, which was still based on the first commercialization of rural products, underwent some alteration. The contribution became the responsibility of the buyer rather than of the producer unless the latter processed the transformation of the actual product. Later, in 1969, the Basic Social Insurance

Plan (Plano Básico da Previdência Social) was created. It was meant to re-establish an array of monetary benefits but was not implemented because of a lack of financing regulation.

In 1971, the FUNRURAL became effectively operationalized through the creation of the Assistance Programme for Rural Workers (Programa de Assistência ao Trabalhador Rural, PRÓ-RURAL). Its financing structure is based on a buyer's contribution of 2 per cent of the commercialized value of rural products and on a complementary contribution from urban companies equal to 2.4 per cent of their payments to employees. The benefits provided were both unrelated and related to occupational accidents. In the case of benefits unrelated to an accident, the value given was equal to 50 per cent of the minimum wage and covered old-age pensions (at 65 years of age), disability pensions and survivor's pensions. In the case of benefits related to an accident, the value distributed rose to 75 per cent of the minimum wage and covered disability and occupational illness benefits. It is important to note that, despite the breakthroughs made by the FUNRURAL, the programme had a rather limited scope. It focused only on male family heads – its beneficiaries – and immediately excluded women from accessing old-age pensions unless they lived alone.

According to Schwarzer (2000) in his citation of Malloy (1976),^v PRÓ-RURAL represented a double break with the Bismarckian model's principles of contributory social insurance – the same principles that have characterized the

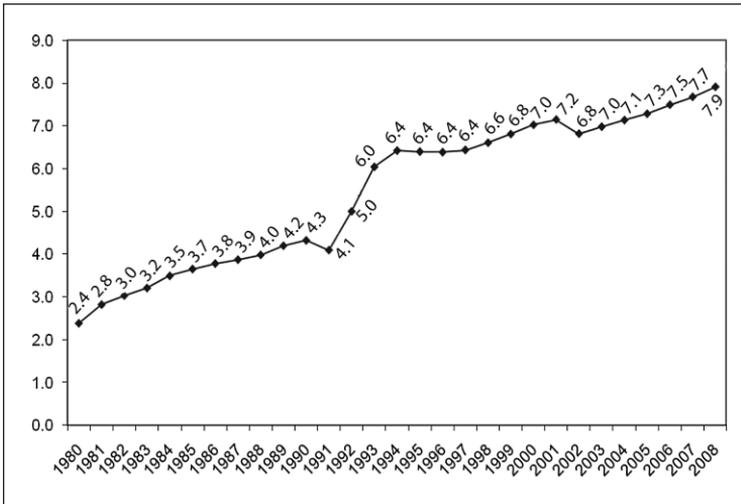
history of social security in Latin America during the twentieth century. There was a break with the notions that, first, a contribution must correspond to a benefit, and, second, that the resulting benefit should be based on the insured person's previous income pattern. Another differentiating element is that the programme introduces a redistribution of income from urban to rural areas. Through the contribution of urban companies to the financing of PRÓ-RURAL, there is a redistribution that counterbalances, at least partially, the rural-to-urban subsidy implicit in the urban system, where the employers' portion of social security contributions is reflected in the prices of goods that are also consumed in rural areas.

With the introduction of the 1988 Constitution, Previdência Social Rural (Rural Social Insurance) underwent profound modifications, which brought significant improvements for rural workers. Social protection was considerably extended by granting spouses the right to a pension regardless of whether or not their partner was a social insurance recipient. For male agricultural workers, the age of eligibility for old-age pensions dropped from 65 to 60 years. For female agricultural workers, the eligibility age was established at 55, a reduction of five years when compared to urban workers, for whom the eligibility age is 65 and 60 for men and women, respectively. The minimum amount received by rural pensioners was fixed at one minimum wage, which corresponds to the social insurance floor foreseen by the Federal Constitution. This pension amount can

nonetheless be higher for the rural salaried worker, who contributes based on his or her income, or for the voluntary contributor, who contributes on the basis of the value he or she declares.

This entire extension of rights was only established through Laws 8.212 and 8.213 in 1991 (Leis de Custeio e de Benefícios da Previdência Social), implementation of which began in 1992. These laws engendered a profound conceptual change in Previdência Social Rural (Rural Social Insurance). The new legislation

has been conducive to a great evolution in the granting of new rural benefits since 1992. In that year, the number of benefits distributed reached 5 million, and already in 1994, the benefits numbered 6.4 million. The historical rise continued, reaching 7.2 million benefits in 2001. In 2002, there was a drop in the observed number due to the replacement of the concept of "ongoing benefits" with the concept of "active benefits"⁸ but the upward trend resumed and 2008 ended with 7.9 million active benefits (graph 5).



Graph 5 | Evolution of the quantity of ongoing/active rural benefits, 1980-2008* (in millions).

*Data gathered in December of each year.

Source: Social Security Statistical yearbook.

Preparation: Secretary of Social Security Policies (SPS), Ministry of Social Insurance (MPS).

Thus, as of 1992, Previdência Social Rural (Rural Social Insurance) was effectively established in Brazil, granting universal access to its benefits to rural workers of both sexes who fit under the

"specially insured" category. Agricultural workers as well as their families are included in the programme under a category for the specially insured provided that they fulfil⁹ the following criteria:

⁸The concept of "active benefits" no longer took into account "suspended benefits", which engendered the drop observed in the year 2002.

⁹The criteria were modified by Law 11.718/2008. A clearer description of the specially insured person and the establishment of a maximum size for his/her rural property were introduced.

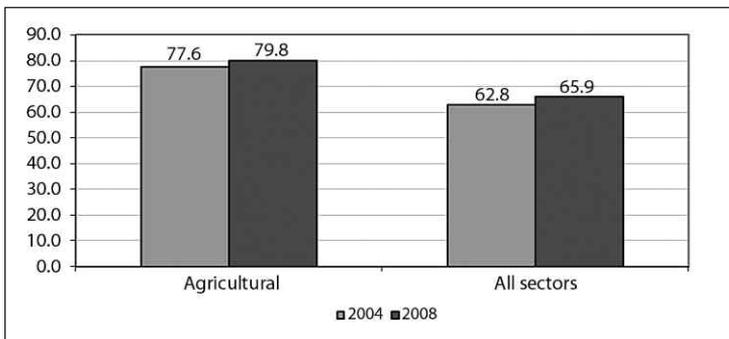
- He/she must be a physical person who inhabits a rural estate or a neighbouring urban or rural agglomerate. He/she must work individually or in a family economy regime and may eventually be able to enlist the help of third parties for mutual cooperation reasons so long as:

- he/she is a producer – a property owner, property user-owner, inhabitant, partner or share-cropper, bailee or rural renter – who exploits agriculture within four fiscal modules or is a latex gatherer or other vegetal extractor who makes these activities his/her main means of earning a living;
- he/she is an artisanal fisherperson or person employed in a similar activity who makes fishing his/her usual profession and means of earning a living;
- he/she is the spouse or under-16 child (or child-equivalent) of the insured person as defined in (a)

and (b) and can provide proof of working with his/her respective family.

Rural workers, including those who work under a family economy regime, have been guaranteed the same treatment as that given to urban workers. With the exception of retirement due to contribution time to social security, rural workers have access to the same benefits: old-age, disability and survivor's pensions as well as a maternity salary and accident, sickness and reclusion aid. In practice, rights have been extended to a particular group of workers regardless of their capacity to contribute to social security. This has, without a doubt, resulted in an expansion of social protection for agricultural workers. According to National Household Sample Survey (PNAD) data for 2008, welfare coverage was almost 80 per cent in the agricultural sector while it was 66 per cent in other economic sectors (graph 6).

As for the financing of rural social protection, one must keep in mind that it is a contributory system whose basis of contribution is distinct from that of urban



Graph 6 | Expansion of social protection for workers, by economic sector of activity, 2004 and 2008 (as a percentage).

Source: Preparation by General Coordination of Social Security Studies (Coordenação-Geral de Estudos Previdenciários, CGEP)/General Regime of Social Security (Departamento de Regime Geral de Previdência Social, DRGPS)/Secretary of Social Security Policies (SPS)/Ministry of Social Insurance (Ministério da Previdência Social, MPS) from PNAD 2004 and 2008 micro data, on workers ages 16 to 59, including those in the northern rural areas.

social protection. In the case of the specially insured, contributions are made based solely on the commercialization of products (2.1 per cent), which takes the place of the individual's quota. In the case of rural employers, legal and physical persons contribute 2.1 per cent and 2.6 per cent, respectively, of their owner's quota of commercialization. This form of financing does not imply that the specially insured person has restricted rights when it comes to accessing benefits. All that is needed to ensure rural workers' access to old-age pensions, at least at the minimum-wage level, is proof that rural activity was undertaken for a minimum of 15 years. This is a period equivalent to the minimum number of years during which the urban insured must contribute to be eligible for an old-age pension.

In June 2008, social insurance legislation was updated by Law 11.718, with the intention of facilitating the recognition of rights in rural areas. Broadly speaking, the Law: (a) detailed the concept of the "specially insured", specifying conditions for being included in this category; (b) expanded the concept of a "family group"; (c) allowed the specially insured person to undertake a remunerated occupation during off-seasons or between crop seasons without losing the status of "specially insured"; (d) authorized the short-term hiring of rural salaried workers; and (e) determined that in registering the specially insured person, family groups must be treated as a unit and information must be collected on the estate where the agricultural activity is undertaken.

Table 2 | Evolution of net social insurance revenue, social insurance expenditure and the social insurance balance, for urban and rural clients, 2007-2009 (in R\$ millions). – National Consumer Price Index (INPC)

Year	Clients	Total Contributions (a)	Insurance Benefits (b)	Result (a – b)
2007	Urban	154,498	168,804	-14,306
	Rural	4,819	41,515	-36,696
	Total	159,317	210,319	-51,002
2008	Urban	168,611	170,108	-1,497
	Rural	5,298	42,518	-37,220
	Total	173,909	212,626	-38,717
2009	Urban	179,946	182,680	-2,734
	Rural	4,632	45,512	-40,880
	Total	184,578	228,192	-43,614

Source: National Social Security Institute (Instituto Nacional de Seguro Social, INSS) cash flow, adjusted by the Management Information System for the Collection of the Brazilian Internal Revenue Service (*Sistema de Informações Gerenciais da Arrecadação da RFB*).

Preparation: Secretary of Social Security Policies (SPS), Ministry of Social Insurance (MPS).

With respect to salaried rural workers, a special emphasis was placed on the formalization of their activity, given that these types of workers are frequently hired temporarily without any form of contract and are thus exposed to all kinds of risk. Law 11.718/2008 simplified the hiring of rural workers for small-scale activities. It ceased requiring that the rural employer and physical person hire rural workers for at least two months and began allowing the small-scale producer to use salaried manual labour for up to 120 workdays per year without losing his/her insurance status. For the hired (salaried) rural worker, many of whom are temporary (known in Brazil as “bóias-frias”, or cold grub), the Law established special conditions for determining the number of contributions required in order to gain access to non-contributory benefits. These conditions demand that a multiplier be used in the following manner: from 2011 to 2015, each month of attested employment will be multiplied by three but will not surpass 12 months. From 2016 to 2020, the duration of attested employment will be counted as double.

DIFFICULTIES ENCOUNTERED IN THE RURAL SOCIAL INSURANCE MODEL AND MEASURES TAKEN TO OVERCOME THEM

In the course of recent years, Previdência Social Rural (Rural Social Insurance) has begun to show some need for operational or legal adjustments that are important or

indispensable for its future sustainability. The main need relates to the difficulty in determining who is a specially insured person (family agricultural worker) for lack of a specific set of records such as those that already exist for urban workers. This derives from the fact that the right to benefits is not necessarily based on the direct collection of contributions. As a result, it is very rare for workers to present themselves at State agencies for the purpose of identifying themselves as specially insured persons; this usually happens only when they need to claim an actual benefit.

To minimize this difficulty, in 2006 the Ministry of Social Insurance (MPS) created a working group tasked with proposing a record-keeping system for this type of insured person. The lack of specific documentation for these individuals actually hinders the recognition of the rights of insured persons, given that it makes the benefit provider uncertain of their eligibility. The paper presented by the Working Group proposed the creation of a special declaration form for the specially insured, which could be included with a mandatory declaration form that already exists and that would require periodic updating. The record-keeping system would need to have a way to tie the individual to his/her family, to keep a historical record of the individual as a specially insured person as well as of his/her family's activity, and to identify the sale of produced goods to a legal person.

To help to implement the Working Group's proposals, the MPS and the

National Social Security Institute (Instituto Nacional de Seguro Social, INSS) drew up various technical cooperation agreements with government entities and bodies that have a direct or indirect relationship with specially insured persons. The goal was to identify these individuals and to determine the nature of their activity. The agreements were meant to give legal coherence and robustness to records by promoting the cross-referencing of information between several public bodies, among which: the Ministry of Agrarian Development, the Ministry of Environment, the Ministry of Defence, the Ministry of Justice, the Ministry of Finance, the National Foundation of the Indian, and the Special Secretariat for Policies Promoting Racial Equality. The Enterprise for Technology and Information on Social Insurance (Empresa de Tecnologia e Informações da Previdência Social, DATAPREV) is in charge of the full development of the record-keeping tool for specially insured persons. The tool is then tested and ratified by the National Social Security Institute.

Another difficulty encountered concerns the control over the collection of rural contributions. Despite being, by nature, significantly inferior to the amount necessary to pay benefits, these contributions are still the object of a high level of fraud. Law 8.212 of 1992 introduced the legal mechanism of subrogation, which is the transference of the obligation to pay the contribution from a given contributor to another. This is an option only for the specially insured per-

son, given the economic insecurity of this category and the great fragmentation characterizing small-scale rural production in Brazil. The category of "specially insured person" does not justify investing in a fiscal structure tailored to this sector.

It so happens that Law 8.540 of 1992 extended the option of subrogation to rural producers who are physical persons. Giving these producers the same treatment as that given to specially insured persons is a move that does not seem to match the goal of the original legislation because specially insured individuals have a significantly lower production volume and face many more difficulties in selling their production than do rural producers. It should be highlighted, however, that even though this programme includes rural producers, it is seen by many as a breakthrough. This is thanks to the fact that the programme facilitates taxation, which now becomes concentrated in the group of rural production buyers – a cohort much smaller in number than the group of specially insured individuals and rural producers who are physical persons.

Measures under way that should reduce the detected problems include: the establishment of a set of records for the identification of the specially insured (family agricultural workers), the expansion of the "family group" concept, the identification and association of the family with the size-limited rural estate for the purpose of fitting individuals in the "specially insured" category, and the possibility for the specially insured to perform an activity during off-season or between crop seasons without the loss of specially-

insured-person status. These measures should ensure that the actions of the insurance-benefit provider are more precise and they should make it easier to recognize the potential beneficiary's rights, reduce fraud and exercise greater control over the payment of benefits.

In 2007, the Ministry of Social Welfare created the National Forum for Social Insurance (Fórum Nacional de Previdência Social, FNPS), with the objective of organizing and structuring discussions between representatives of various societal groups on social insurance and its medium- and long-term sustainability. In what pertains to Previdência Social Rural (Rural Social Insurance), the FNPS recognized the strategic importance of the social insurance policy targeting rural workers and declared that:

- The different criteria for contribution and for gaining access to insurance benefits used for the special, rural insured person should be kept;
- Given the particularities of rural activity, public policies targeting rural workers and measuring their impact on urban-rural inequalities should be retained. In addition, the FNPS called on the National Social Insurance Council (Conselho Nacional de Previdência Social) and the National Social Security Council (Conselho Nacional de Seguridade Social) to carry out studies and periodic evaluations of the working conditions and demographics

of rural labour, testing the possibility of converging the eligibility age of urban and of rural workers for retirement pensions;

- It also recommended the creation of mechanisms that would promote and facilitate the formalization of work contracts involving salaried rural workers, particularly those who work in short-term activities; and
- Finally, given that in rural areas there is a predominance of seasonal work during off-season, the FNPS advised that contributory and/or non-contributory mechanisms should be instituted so as to allow salaried rural workers to count the entire 12 months of each year towards welfare benefits.^{vi}

FINAL CONSIDERATIONS AND FUTURE CHALLENGES

Brazil's Previdência Social Rural (Rural Social Insurance) plays an important role as an integral element of a basic social protection floor targeting workers with little or no contributory capacity. Its monthly expenditure has greatly improved the lives of these workers, namely, the elderly, and has contributed to the economic development of Brazilian municipalities, as several recent studies have found. The programme is being brought up to date. It is implementing a set of records for the identification of the specially insured and their families, which should provide the social insur-

ance system with a more detailed understanding of its rural insured individuals. It should also compel faster recognition of legal rights based on an individual's records – such as is already being provided for urban clients. With the purpose of extending its coverage, Previdência Social (Social Insurance) is now targeting field workers, who have been identified as extremely vulnerable actors in labour relations, given the almost consistently temporary nature of their activities.

The recognition that Previdência Social Rural (Rural Social Insurance) is an important social protection tool makes the need to guarantee its sustainability for future generations increasingly evident. The path towards the future is already being trod. It entails a better knowledge of the rural worker and of his/her productive activity and a focus on those workers who are most insecure, whether they are small-scale land-owners or salaried workers. Another aspect that should be strengthened for Previdência Social (Social Insurance) as a whole is the extension of social-protection education programmes and their inclusion in Brazil's educational curriculum. The goal here is to create citizens who are knowledgeable about the importance of social protection for their lives and for society as a whole.

ⁱ Costanzi, E. and Barbosa, R., "Previdência Social e Redistribuição de Renda Intermunicipal", *Informe de Previdência Social*, vol. 21, No. 4, April 2009.

ⁱⁱ Camarano, A. Brazilian population ageing: Differences in well-being between rural and urban areas. Paper presented at United Nations Research Institute on Social Development meeting on ageing, development and social protection, Madrid, April 2002.

ⁱⁱⁱ Data from the *Annual Social Information Report (Relação Anual de Informações Sociais, RAIS)*.

^{iv} Schwarzer, Helmut (2000). Impactos socioeconômicos do Sistema de aposentadorias rurais no Brasil — Evidências empíricas de um estudo de caso no estado do Pará. Brasília: IPEA, Texto para discussão nº 729/Junho de 2000, p. 7 (available at: http://www.ipea.gov.br/portal/index.php?option=com_content&view=article&id=3998:td-729-impactos-socioeconomicos-do-sistema-de-aposentadorias-rurais-no-brasil-evidencias-empiricas-de-um-estudo-de-caso-no-estado-do-para&catid=170:presidencia&Itemid=2).

^v *Idem*, p. 10.

^{vi} Fórum Nacional de Previdência Social, Summary of activities undertaken (Síntese das atividades desenvolvidas). Final document produced 31/10/2007 (available at: http://www.mps.gov.br/arquivos/office/4_081010-120045-048.pdf).



Burkina Faso

Population ⁱ	15,233,884
Age structure	
• 0-14 years (%)	46.2
• 15-64 years (%)	51.8
• 65 years and over (%)	2.0
Infant mortality rate (per 1,000 live births) both sexes ⁱⁱ	92
Life expectancy at birth (years) female	54.3
Life expectancy at birth (years) male	51.7
Maternal mortality ratio (per 100,000 live births) ⁱⁱⁱ	700
GDP per capita	
• Current US\$ ^{iv}	522
• PPP (current international \$) ^v	1,160
• Constant local currency	190,224
Size of informal economy ^{vi}	87.3%
Human development index (HDI) rank ^{vii}	177
HDI poverty indicators – Human poverty index rank	131

Building a Social Protection Floor

5

Burkina Faso

Marie Eugénie Malgoubri Kyendrebeogo

Inousa Ouiminga

Olivier Louis dit Guérin

Summary

2001: Start of brainstorming process - The idea of a national policy on social protection is launched, which resulted in a document, National Policy for Social Protection in Burkina Faso (2003). The document outlined a very broad set of needs without focusing on precise, prioritized and realistic objectives.

2008: Start of the universal health insurance project.

2009: The authorities progressively became aware of the need for a national policy on social protection that would frame all the various initiatives. That is how Burkina Faso came to take an interest in the concept of the social protection floor and initiated a process for mainstreaming and consolidating initiatives to promote access to basic social services for all, particularly the poorest and most vulnerable. The country took steps in September 2009, through the Prime Minister, to request that the United Nations Social Protection Floor Initiative support the Government in launching a process to build a social protection floor in Burkina Faso.

2010: Establishment of an inter-ministerial committee responsible for driving efforts to develop a national policy on social protection that sets out a road map presenting the global vision on social protection in Burkina Faso and sets its objectives, its priority areas and its monitoring and evaluation mechanisms. The inter-ministerial committee must coordinate efforts to build a global, streamlined national policy.

Steps in the process of building a national policy based on a social protection floor:

1. Build capacity of national actors;
2. Design a global vision for social protection;
3. Create synergy among the respective programmes;
4. Agree on the criteria for defining poverty and vulnerability and put in place efficient targeting mechanisms;
5. Put in place a statistical information system on social protection, building on robust monitoring and evaluation mechanisms; and
6. Develop innovative mechanisms for increasing financing for the social protection sector.

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INTRODUCTION

This case study gives an account of the efforts under way to implement a national process for building a social protection floor in Burkina Faso. It seeks to present the context and basis for building the floor, not to describe the components of a social protection floor, which are yet to be defined.

Owing to the numerous external crises (the Ivorian crisis and the food, energy, financial and economic crises) that Burkina Faso has suffered over the past decade, there have been a reinforcement and a multiplication of social protection programmes, particularly social safety nets. Social protection has increasingly become a priority in sectoral and national policies and strategies. However, there is still no consolidated national policy on social protection that integrates the numerous provisions and programmes of ministries, bilateral and multilateral partners, and local and international non-governmental organizations (NGOs). In 2009, Burkina Faso subscribed to the concept of the social protection floor and initiated a process for mainstreaming and consolidating initiatives to promote access to basic social services for all, particularly the poorest and the most vulnerable.

This case study, presenting the implementation of the process, begins with a concise description of the current social and economic development context in Burkina Faso and the rationale for social

protection. This is followed by an overview of the existing social protection environment. The focus then shifts to the basis of the ongoing process for establishing a social protection floor as well as the challenges to be addressed. The case study concludes with the next steps for the way forward.

CONTEXT

Burkina Faso experienced solid, albeit irregular, growth after the devaluation of the West African CFA franc in 1994 (averaging 6 per cent per year from 1994 to 2008). The gross domestic product (GDP) per capita (at 2000 US\$) increased in an irregular manner, climbing from about US\$214 in 1995 to US\$260 in 2007 (or US\$430 in real terms in 2007).^{viii} This GDP per capita, however, remains relatively low and represents barely half the GDP average in sub-Saharan Africa.^{ix} Burkina Faso is a landlocked country with practically no natural resources and falls among the least developed countries in the world.

While the country boasts good macroeconomic management, which has earned support from the International Monetary Fund (IMF) and the World Bank, it still depends heavily on foreign aid. The economy remains highly vulnerable to weather conditions and external shocks, particularly the price of cotton, energy and foodstuffs; the fluctuating rate of the dollar; and natural disasters. Looking at the secondary and tertiary

sectors, which contribute 25 per cent and 45 per cent, respectively, to the GDP, one notes that the secondary sector is exhibiting a stagnating trend while the tertiary sector shows a predominance of the informal sector and services. This means that little structural change has taken place in the economy. A direct consequence of these trends is the low availability of human capital, among other things, and the high cost of factors of production. These factors put a strain on the country's level of competitiveness and limit the growth of a vibrant private sector that can create jobs for women and young people in particular.^x

Burkina Faso has a total population of over 15 million,^{xi} 52 per cent of whom are female and over 52 per cent are children, and a high population growth rate, estimated at 3.1 per cent per annum. The majority of the population (77 per cent) is based in the rural areas and depends on agriculture for a living.

The economic growth experienced in the country is having a limited and delayed impact on poverty reduction, however. The World Bank estimates that the poverty level rose after the shocks that hit the country, as shown in table 1.

Poverty is seen mostly in the rural areas. The poor are few in number in the sectors currently driving economic growth and highly present in the agricultural sector, which relies predominantly on food crops.^{xii}

The National Strategy for Risk Management and Social Protection (SNGRPS, 2006, which was never adopted) described poverty in 2005 as follows: "Poverty is primarily a rural phenomenon. It is tied to distance and seclusion. It is strongly associated with household size. Hence, one more child in rural areas may translate into a drop of 18% to 30% in spending per head, depending on the age of the child. This phenomenon is far less severe in urban areas, where the impact on the drop in consumption stands at barely 1.4%. Poverty considerably lowers the level of education. A household where the head has completed primary school has a level of consumption that is 13% higher in rural areas and 22% higher in urban areas than a household whose head did not attain this level. The occupation of the household head has a significant impact on household spending per head. Hence, a household where the head works in the service sector has a level of spending per head that is 30% higher than that whose head

Table 1 | Trends in the poverty rate, 1998-2009 (as a percentage).

Year	National	Rural	Urban
1998	45.3	51.0	16.5
2003	46.4	52.4	19.9
2006	42.1	48.2	16.8
2007	42.6	48.6	18.6
2008	42.8	48.9	20.3
2009	43.2	48.8	20.6

Sources: 1998, 2003, Enquête intégrale sur les conditions de vie des ménages (EICVM), Institut national de la statistique et de la démographie (INSD); Priority Action Programme (PAP)-Poverty Reduction Strategy Paper (PRSP) report 2007, 2008, 2009.

works in the agricultural sector."^{xiii}

The findings from participatory surveys conducted in 1998 and 2003 on perceptions of the dimensions of well-being, poverty and access to basic social services in urban and rural areas show that poverty – particularly economic poverty – is seen as the inability of the individual to satisfy basic needs, especially in terms of feeding, employment or income-generating activities and health. Poverty among groups of persons is seen as the lack of favourable natural factors, hunger and epidemic situations. Moreover, the lack of a secure environment (public security), socio-economic infrastructure (schools, markets, dispensaries, etc.), and access to certain areas, coupled with poor means of transport, further aggravates this notion of collective poverty that is felt by communities.

The incidence and severity of poverty are felt more by women than by men (52 per cent compared to 48 per cent). Women are more vulnerable and have limited access to land, decision-making, factors of production and cattle. The 2003 household survey showed that the household poverty rate had increased by 11 per cent in female-headed households.

Furthermore, young people are severely affected by unemployment, job scarcity, illiteracy and the lack of qualifications. The working-age population (15 to 65 years) represents 51.8 per cent of the total population, 46 per cent of whom are men and 54 per cent are women. This working-age population, based primarily in the rural areas (73 per cent), is poorly

educated: 23.2 per cent have attained an average educational level. The employment situation, shown by the findings of the study, "Employment and poverty trends in Burkina Faso 1998-2007"^{xiv}, was characterized in 2007 by:

- an employment rate of 80.9 per cent;
- the predominance of the agricultural sector (79.5 per cent of the workforce) and the urban informal economy (7.8 per cent);
- the predominance of informal employment in towns (46.9 per cent of the population 15 years of age and older);
- the burden of unemployment (8.6 per cent) in the urban setting, which is four times higher than in the rural setting (2.2 per cent);
- visible underemployment that affects one quarter of the workforce, double the proportion in rural areas (26.7 per cent) compared to that in urban areas (13.7 per cent); and
- an increase of 12.5 per cent in labour productivity between 1998 and 2007, with an average annual growth rate of 1.4 per cent, which is still inadequate for addressing the barriers to a drop in under-employment.^{xv}

THE CURRENT SOCIAL PROTECTION FRAMEWORK

In the context described in the previous section, the promotion of basic social

services (health, education, potable water, nutrition, hygiene and sanitation) was positioned as a key priority for development in Burkina Faso as far back as the first generation of Poverty Reduction Strategies (PRSs) and social protection was added to the second Poverty Reduction Strategy Paper (PRSP) in 2006.

Since independence, Burkina Faso has been progressively putting in place a set of social security measures and programmes focused on social insurance, social security safety nets and social services. This architecture has been reinforced over the last several years to deal with the energy, food, economic and financial crises.

SOCIAL INSURANCE

Social security measures cover only salaried workers in the public and private formal sectors and their dependants. Workers in the private sector are covered by the National Social Security Fund (Caisse nationale de sécurité sociale, CNSS) (table 2), which is a public social insurance fund, placed under the supervision of the Ministry of Labour and Social Security (Ministère du travail et de la sécurité sociale, MTSS). This regime covers only the three branches that make up the minimum standards defined by International Labour Organization (ILO) Convention 102,¹ including pen-

sion allowance, disability allowance and survivors' pension, occupational hazards and family allowances.

The National Social Security Fund has great potential for protecting workers employed in the formal private sector, but it faces a certain number of difficulties, such as its high operational costs and low transformation rate for social security contributions. The highly informal character of economic activities also reduces its capacity to penetrate the labour market.

The Independent Pension Fund for Civil Servants (Caisse autonome de retraite des fonctionnaires, CARFO), whose services include pension allowance, disability allowance and survivors' pension, provides coverage for public servants, magistrates, and servicemen and servicewomen (table 2). These public servants benefit also from family allowances from the national budget.

Coverage of the risk of sickness, which is a need that has been expressed clearly by the social partners, is not taken into account by these measures. This coverage should be provided by the Office for Workers' Health (Office de santé des travailleurs), whose social security benefits are barely operational. In addition, as part of its national policy on social security, the Ministry of Labour and Social Security places a particular emphasis on developing

¹International Labour Organization (ILO) Convention No. 102: Social Security (Minimum Standards) Convention, 1952: Lays down the minimum standard for the level of social security benefits and the conditions under which they are granted. It covers the nine principal branches of social security: medical care, sickness, unemployment, old age, employment injury, family, maternity, invalidity and survivors' benefits. To ensure that it could be applied in all national circumstances, the Convention offers the possibility of ratification by accepting at least three of its nine branches and of subsequently accepting obligations under other branches, thereby allowing Members of the ILO to progressively attain all the objectives set out in the Convention.

Table 2 | National Social Security Fund (CNSS) and Independent Pension Fund for Civil Servants (CARFO) coverage.

	CNSS (2007)		CARFO (2008)	
	Number of persons insured	Number of beneficiaries	Number of persons insured	Number of beneficiaries
Compulsory pension plan				
- Salaried workers in the public sector			86,700	
- Salaried workers in the formal private sector	190,419			
- Employers	24,969			
Compulsory pension plan				
- Industrialists, entrepreneurs and professionals	1,231			
- Houseworkers	7,618			
Pensions				
- Old age		12,348		14,700
- Widows/widowers		11,497		11,700
- Orphans		10,730		
- Disability		129		State budget
Occupational accidents and occupational illnesses				
		1,512		Non-operational
Family and maternity allowance				
- Beneficiaries		46,438		State budget
- Spouses of beneficiaries		50,639		
- Children of beneficiaries		147,580		

Source: S. Soulama, Review of the social protection measures in Burkina Faso, October 2008.

mutual health insurance funds to provide insurance coverage to workers in the formal sector and those in the informal sector who are based in the urban and rural areas. For this latter group, a number of experiments have been developed across the entire country since the 1990s. Working on the basis of micro health insurance prac-

tices, these mutual health insurance funds ensure 100 per cent coverage that is based on direct billing and direct payment mechanisms for primary health care and, in some cases, for secondary care. The viability of these mutual health insurance funds, which usually have about 1,000 beneficiaries on average, is still shaky owing to the lack of

technical capacities for management and their very limited coverage (table 3).

Confronted with the weakness of mutual health insurance funds, the Ministry of Labour and Social Security has embarked on a universal health insurance project. The project was planned during the elaboration of PRSP 2² and adopted during the Cabinet Meeting on 4 August 2008. A national steering committee, including representatives of the technical ministries concerned, social insurance agencies, health facilities, mutual health insurance funds, partners and civil society, is currently seeking ways and means of putting in place a coherent health insurance system

that will provide wide access to health care for communities by 2015, with the support of ILO, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO). The work plan of this committee shows that the activities of this universal health insurance fund will begin in 2011 (table 4).

Table 3 | Data on mutual health insurance funds, 2005.

Mutual Health Insurance Funds	Number of Mutual Health Insurance Funds	Number of Beneficiaries
For the formal sector	25	41,800
For the urban and rural informal economy	119	18,900

Source: Report on the Study on Modes of Community Financing of Health in Burkina Faso, Ministry of Health, August 2005.

Table 4 | Key stages planned for developing universal health insurance.

Stage	2009/2010	2011	2013	2015
	Studies and Building of the System	Launch of Health Insurance	Intermediate Stage – First Evaluation	1st Stage of Maturity
Planned rate of coverage				
- Formal sector		30%	80%	100%
- Informal economy		5%	10%	30%
Planned number of beneficiaries		1,678,800	4,311,000	7,748,000

Source: Permanent Secretariat of the universal health insurance project. Outcomes expected in the 2009 work plan. These outcomes will change after feasibility studies are carried out.

²PRSP 2003-2010, p. 53: "The State should plan to set up an insurance system encompassing all poor people. Indeed, it is necessary to design systems that prevent poor people from paying for health services from their pockets by increasing the volume of prepayments through a general taxation system, compulsory contributions for health insurance or voluntary initiatives, and by providing subsidies to the poorest groups."

SOCIAL SECURITY SAFETY NETS

A diverse range of social security safety net programmes has been identified and analysed as part of a review carried out by the United Nations Children's Fund (UNICEF) and the World Bank (2010). The social security safety nets mentioned here refer to the non-contributory social transfer mechanisms targeting poor and vulnerable individuals or households in support of consumption and/or access to basic social services. Ten major categories of programmes have been identified and are summarized in table 5.

While many social protection projects have been developed in support of national policies for promoting access to education, these are sometimes isolated and limited. However, in addition, several national universal social protection policies that support the objectives of the Ministry of Basic Education and Literacy (MEBA) have been put in place to increase the enrolment rate and reduce inequalities while also promoting investments in service delivery.

These programmes focus on:

- removing primary school fees to promote access and reducing other costs of access to primary school for girls in order to reduce the gap between girls and boys;
- distributing school textbooks to all pupils in public and private primary schools in order to improve the quality of education and minimize the burden on households;
- granting scholarships to pupils

from the poorest homes; and

- providing school canteens that are one of the largest social protection programmes in the country, aimed at improving the quality of learning, school results at the basic education level, and the health and nutritional situation of pupils as well as promoting investment in human capital.

Several national social safety net programmes are under way to promote access to health services for all in synergy with programmes for improving the quality and availability of health services. These programmes deal with the following:

- In 2006, the Government of Burkina Faso adopted the policy of providing subsidies to cover 80 per cent of the cost of emergency obstetric and neonatal care for all and 100 per cent for the poorest women (at a total cost of 30 billion CFA francs (US\$63.9 million) for the period from 2006 to 2015). The policy has had a substantial impact on increasing access, particularly for the poorest groups. However, the application of the 100 per cent exemption for the poorest women has faced some problems relating to targeting, communication, financial compensation, etc. Exemptions are implemented to provide free treatment for meningitis and measles in the event of an epidemic, free treatment against severe malaria among children below the age of five

Table 5 | Summary of social safety net programmes, 2004-2009.

Programme	Agency	Type and Number of Beneficiaries
Food sales at a reduced price	National Society for the Management of Stocks for Food Security (Société nationale de gestion de stock de sécurité alimentaire, SONAGES), National Council for Emergency Relief and Rehabilitation (Conseil national de secours d'urgence et de réhabilitation, CONASUR)	Communities in areas exposed to food insecurity; 18,400 households in 2008
Food distribution	Catholic Relief Services (CRS)	Vulnerable persons such as those living with HIV, elderly persons
Food for education/ Infrastructure	World Food Programme (WFP)	30,800 women and 31,400 men in 18 provinces
Malnutrition treatment	NGOs, Food and Agriculture Organization of the United Nations (FAO), UNICEF, WFP, Ministry of Health	Vulnerable groups
School canteens	CRS, Ministry of Basic Education and Literacy (Ministère de l'enseignement de base et de l'alphabétisation, MEBA), Ministry of Secondary and Higher Education and Scientific Research (Ministère des enseignements secondaire, supérieur et de la recherche scientifique, MESSRS), WFP	All pupils in beneficiary schools; in principle, all public schools are potential beneficiaries
Food and fuel subsidies	Ministry of Economy and Finance (Ministère de l'économie et des finances, MEF)	Consumers – especially in big cities – of petroleum products and certain food items (in 2008 only)
Cash transfers	National AIDS Council (Conseil national de lutte contre le sida et les infections sexuellement transmissibles, CNLS-IST)	Vulnerable children in the Nahouri and Sanmatenga provinces; 3,250 beneficiary households (pilot programme 2008-2010)
Food vouchers	CRS, WFP, Ministry of Social Action and National Solidarity (Ministère de l'action sociale et de la solidarité nationale, MASSN), Burkinabe Red Cross Society (Croix-Rouge burkinabé)	195,000 poor people in Bobo and Ouagadougou
Subsidies and exemptions from health costs	NGOs, Ministry of Health, National Solidarity Fund (Fonds national de solidarité, FNS)	80 per cent subsidy for delivery in health centre (national); exemptions for pregnant women, children under 5 years of age, needy persons, people living with HIV in 4 pilot districts; limited exemptions for indigents (national)
Public works	Swiss Association for International Cooperation (Helvetas)/Ministère des infrastructures et du désenclavement (MID)	NGO project in communities in 4 provinces in the Eastern region

Source: K. Savadogo, Review of social security safety nets in Burkina Faso: Inventory and analysis of existing social security safety net programmes, Draft report, March 2010.

years, and free consultations on preventive care for children below five and pregnant women.

- Project initiatives to deliver free care are under way in some health districts to help vulnerable groups (pregnant women, children between 0 and 5 years).

Two innovative cash-transfer (or quasi-cash-transfer) programmes are being implemented as pilot experiences for reducing food insecurity and poverty in the country:

- the social transfer programme for orphans and vulnerable children in Nahouri Province. This programme, led by the National AIDS Council (Conseil national de lutte contre le Sida et les infections sexuellement transmissibles, CNLS-IST), with support from the common basket fund and the World Bank, aims to test various cash-transfer mechanisms for poor households to measure their impact and identify a mechanism that can be replicated at the national level; and
- a mechanism for using food vouchers to reduce vulnerability and food insecurity in urban areas (Bobo and Ouagadougou), which is being tested by the World Food Programme (WFP) for the poorest households. It is also intended to make up for the drop in their purchasing power after the sharp increase in basic foodstuff prices in 2007 and 2008, although living standards have declined further since then.

Furthermore, the rise in the prices of foodstuffs and petroleum products also led the Government to implement blanket subsidies for certain food items and for fuel by cutting taxes. These subsidies amounted to 4,263 billion CFA francs (US\$9,076 million) in 2008 (March to October) for food items and 8,608 billion CFA francs (US\$18,327 million) in 2008-2009 for petroleum products.^{xvi}

Finally, another poverty reduction programme is based on the labour-intensive public works approach. The rural roads programme, conducted by Helvetas in the Eastern region, is an important source of learning in this respect.

SOCIAL WELFARE SERVICES

Support for social welfare services is a priority for the Ministry of Social Action and National Solidarity (MASSN), which organizes awareness campaigns in this regard and welfare services for disabled persons, refugees and disaster victims, children in particularly difficult situations, socially excluded groups, etc. Several NGOs and decentralized structures also provide social welfare services.

EMPLOYMENT AND LABOUR MARKET INTEGRATION SERVICES

The National Employment Policy, adopted in 2006 at a tripartite workshop, seeks to increase opportunities for decent work, especially for young women and young men who are going into the labour market, in order to reduce poverty in Burkina Faso. One of the strategies in this policy is to broaden and improve access

Table 6 | Results of employment promotion programmes.*

Indicator	Responsibility	2008	2009
Number of jobs created	FAPE	82	267
	FASI	202	202
	FAIJ**		1,214
Number of jobs consolidated	PNV		885
	FAPE	312	208
	FASI	2,094	1,892
	FAIJ		1,214

* New targets set by the Project for Combating Youth Unemployment.
 ** Direct and indirect jobs.
 Source: Public Expenditure Review (Revue des dépenses publiques), Ministry of Employment and Youth (Ministère de la Jeunesse et de l'emploi, MJE), Report, March 2010.

to employment through vocational training and to ensure that such training can provide better responses to the real needs of the labour market.

In this respect, a number of support funds have been put in place (some since 1998) to:

- promote the creation of businesses and income-generating activities: the Youth Initiatives Support Fund (Fonds d'appui aux initiatives des jeunes, FAIJ), the Informal Sector Support Fund (Fonds d'appui au secteur informel, FASI) and the Employment Promotion Support Fund (Fonds d'appui à la promotion de l'emploi, FAPE); and
- improve employability: the Vocational Training and

Apprenticeship Support Fund (FAFPA).

The results of various employment promotion programmes are presented in table 6.

As part of efforts to operationalize the National Employment Policy action plan, the Ministry of Employment and Youth is proposing to reinitiate a public works programme. A multisectoral working group has been set up to identify the projects that will be implemented.

DEVELOPING A NATIONAL POLICY ON SOCIAL PROTECTION: PROGRESS MADE AND CHALLENGES ENCOUNTERED

THE IMPLEMENTATION PROCESS

Evolution of the Policy

Current thinking on social protection in Burkina Faso is the fruit of a long process initiated at the beginning of the millennium. The country embarked, in December 2001, on developing a national policy on social protection. Those efforts culminated in the preparation of a document (National Policy for Social Protection in Burkina Faso, February 2003) based on the work of four multisectoral committees (insurance and social assistance;

health risks; economic risks; national framework for consultation on social assistance) that was to serve as background material for a national forum to formulate a bill on social protection. However, while this document demonstrated a real awareness of the issues involved in social protection, it was inadequate for developing a national policy. The document outlined a very broad set of needs without focusing on precise, prioritized and realistic objectives. Nevertheless, this national consultative process ought to have provided a framework of reference for developing sector-based approaches by the respective ministries, including those summarized here.

Development of Sectoral Approaches for Social Protection

Ministry of Labour and Social Security

The brainstorming process, initiated in 2001, resumed in 2006 under the auspices of the Ministry of Labour and Social Security (MTSS), which supervised an inter-ministerial process aimed at developing a national policy on social protection. The subsequent policy document, National Policy for Social Protection (January 2007), proposed an interesting multisectoral approach in which social protection was considered to be an investment, not a form of help. This document was not validated at the national level, and the various ministerial strategies that were being developed from it failed to offer a comprehensive

and coherent vision of social protection. However, it served as a reference for the actions of the MTSS in developing a draft National Labour Policy in 2010, whose strategic goal 3, "Contributing to building a social protection floor", aims to "promote a global and coherent social protection policy that makes it possible to extend the range of services offered by the national mechanism for social protection, to improve the quality of these services and expand coverage to all workers".^{xvii}

Ministry of Social Action and National Solidarity

The Ministry of Social Action and National Solidarity, set up in 2006, developed a policy document for social action, National Policy on Social Action (La politique nationale d'action sociale, PNAS), in 2007. The general objective of this policy is to ensure, by 2015, the social promotion of specific and marginalized social groups and to create favourable conditions for consolidation and solidarity among the population. Adopted on 23 July 2007 (Decree n° 2007-480/PRES/PM/MASSN), this policy defines government action in the area of social action, promotion and solidarity.

Ministry of Health

The Government developed a national health policy document in 2000 that set forth the nation's major orientations on health, with the goal of improving the state of health of the population. This

policy was developed along with the National Health Development Plan (Plan national de développement sanitaire, PNDS), which covers the period from 2001 to 2010. One of the objectives of this plan was to improve financial access to health services for the people and implement programmes such as subsidizing care (i.e., obstetrical services) or implementing exemptions (i.e., for the treatment of "social" diseases such as tuberculosis).

Ministry of Basic Education and Literacy

The policy on "Education for All" aims to provide free education for all children between 6 and 16 years of age (Framework Law adopted in 1996) by abolishing registration fees in public primary schools and providing free basic school supplies in public and private schools. These measures were introduced in all provinces from the 2007/2008 academic year and have led to an increase in the enrolment rate, particularly for girls.

National Policies and Strategies

The existence of a diverse range of sectoral strategies for social protection attests that the authorities are interested in implementing measures and programmes for this purpose. These sectoral approaches have still not been put together and coordinated in a global national policy on social protection, but they are taken into account in national strategies.

The Vision in "Burkina 2025"

Expanding social protection is a key element of the development strategy in the vision set out for the nation in "Burkina 2025".^{xviii} According to this vision, the country cannot attain economic development without strong national solidarity, redistribution of wealth to provide access to quality education and health for all, and a fight against social discrimination.

Strategies for Poverty Reduction

In 2000, Burkina Faso was the first country in the subregion to implement a poverty reduction strategy (poverty reduction strategy framework (PRSP) 2000-2003) that focused on the social sectors (particularly education and health) and the acceleration of economic growth. The second-generation PRSP in 2003 (PRSP 2004-2006, extended up to 2010) expanded coverage to other sectors, including making social protection one of the priorities under the second goal: "Ensure access to basic social services and social protection for the poor".

Looking at the results of the PRSP annual review exercise in 2010, which observed that while some marginal progress had been made in poverty reduction, the crises hitting Burkina Faso had accelerated and worsened over the last three years, the third-generation PRSP currently being developed, titled "Accelerated Growth and Sustainable Development Strategy 2010-2015" (Stratégie de croissance accélérée et de

développement durable (SCADD) 2010-2015), will have to reinforce the emphasis placed on social protection.

The Government's 2009-2010 Action Plan for Addressing the Impact of the Financial and Economic Crisis on the Economy of Burkina Faso

The action plan for addressing the impact of the financial and economic crisis on the country's economy, adopted at the end of 2009, seeks particularly to implement social safety net programmes and innovative mechanisms for reducing the burden of the crisis on households.

Building a Streamlined National Policy

Burkina Faso Subscribes to the Global Social Protection Floor Initiative

The persistence of poverty and vulnerability, aggravated by external shocks, led the authorities to intensify existing social safety net programmes after 2000 and to develop new ones, with the support of partners in some cases, so as to provide short-term responses to the crisis and especially to build mechanisms for eradicating poverty over the long term while also improving the economic welfare of the poorest and the most vulnerable groups.

As the number of these programmes increased, including the adoption in 2008 of a universal health insurance project, the authorities progressively became aware of the need for a national policy on social protection that encompasses these

various initiatives. This was how Burkina Faso came to take a keen interest in the adoption, by the United Nations System Chief Executives Board, of the global Social Protection Floor Initiative in April 2009 and then took steps in September 2009, through the Prime Minister, to request that the Initiative support the Government in launching a process to build a social protection floor in Burkina Faso.

Formation of an Inter-ministerial Committee

The context described above led the Government to establish an inter-ministerial committee responsible for driving efforts to develop a national policy on social protection. This inter-ministerial committee, instituted officially in February 2010,^{xix} set out with the immediate goal of creating a road map that presents the global vision on social protection in Burkina Faso and setting its objectives, its priority areas and its monitoring and evaluation mechanisms. The road map will make it possible to embed social protection as one of the priority areas of the Accelerated Growth and Sustainable Development Strategy (SCADD) that is being developed.

Furthermore, the inter-ministerial committee has the task of coordinating efforts to develop a global, streamlined national policy on social protection, drawing on a set of guarantees that aim to promote access for all to basic social services and on social transfer mechanisms.

This committee is made up of the Permanent Secretaries of the various ministries, a representative of the Prime Minister, representatives of technical and financial partners, civil society, the association of municipalities and the association of the regions.

Placed under the chairmanship of the Permanent Secretary of the Ministry of Economy and Finance, the committee has an executive secretary and specialized commissions, one of which is responsible for social safety nets and the other for social insurance.

Establishment of a Working Group of Technical and Financial Partners on Social Protection

Following the request for a social protection floor made by the Prime Minister to the global Social Protection Floor Initiative, a meeting framework for partners working on social protection was organized in a working group at the end of 2009 in order to synergize the support that is going to be provided to the Government.

This working group includes United Nations agencies (ILO, UNICEF, WFP, WHO, etc.), the IMF, the World Bank, the European Union and bilateral partners (Canada and the Netherlands) as well as NGOs, which come together regularly and synergize their actions for capacity-building and support to the inter-ministerial committee monitoring the national policy on social protection.

Building Capacity and Promoting National Dialogue

The process of developing a national policy based on a social protection floor began with capacity-building for national actors. In January 2010, the Ministry of Social Action and National Solidarity, the Ministry of Economy and Finance and UNICEF, with the support partners, organized a week-long training workshop on social protection and, more specifically, on social safety nets and the universal health insurance project. This workshop, which brought together the main ministries (12) involved in social protection, was the first opportunity to coordinate and discuss the approaches and programmes of the various ministries and sectors and to identify the stages and actions that need to be carried out in order to consolidate, improve and institutionalize social protection.

After a review of social safety nets by UNICEF and the World Bank, the Ministry of Economy and Finance, together with other ministries (the Ministry of Labour and Social Security, the Ministry of Social Action and National Solidarity, the Ministry of Basic Education and Literacy and the Ministry of Health) and with the support of UNICEF and partners, organized a national technical workshop on social protection in April 2010. The objectives of this workshop were to:

- present the general principles of social protection, its development at the global level and in sub-Saharan Africa, and its potential

role in Burkina Faso;

- share information on the state of the existing social protection programmes in Burkina Faso, their achievements, gaps, challenges and opportunities;
- examine the strategic framework for social protection in Burkina Faso and how it compares to experiences internationally; and
- facilitate the participation of the Government, international partners and civil society in articulating a national vision of social protection.

This workshop may be considered as the common point of departure to building a national consolidated policy on social protection in which the Government, international partners and civil society share the same vision of the opportunities and challenges for expanding the social protection system in Burkina Faso. It concluded that:

- there was a need for Burkina Faso to define its own vision of social protection;
- social protection is important for overcoming the slowdown in growth and reducing poverty;
- a national framework for coordinating and directing interventions must be put in place; and
- it is important to develop a road map containing a global vision of social protection in Burkina Faso, its definition, objectives, key activity areas, and mechanisms for monitoring and evaluation.

CHALLENGES

The review of social safety nets by UNICEF and the World Bank (2010) briefly mentioned earlier made it possible for stakeholders to realize that:

- the pilot programmes and projects are scattered and do not benefit from the synergies that could develop among them;
- the vast majority of programmes provide assistance to the poor and vulnerable groups on a one-off basis without prospects for sustainability;
- coverage of all poor persons is not systematic since initiatives are conducted sometimes using the project approach to focus on a locality;
- on the whole, the establishment and financing of social safety net programmes are dependent on funding from external sources; and
- the State should serve as the actor that organizes and consolidates/sustains the various components of social safety nets.

In addition to these findings, there are difficulties encountered by certain programmes, such as the difficulty in acquiring and distributing school textbooks during efforts to promote access to education and the difficulties in targeting the poorest individuals and households and mobilizing resources.

This overview of social protection also makes it possible to underline that:

- the number of institutional and local actors and development partners involved in social protection initiatives is high; and
- synergy is lacking among the various components of social protection: social insurance, social safety nets and social welfare services.

From these realizations and findings, it is evident that the construction of a social protection floor in Burkina Faso cannot become a reality unless several existing challenges – which are institutional and technical, on the one hand, and economic and financial, on the other – are addressed.

Institutional and Technical Challenges

Coordinating and Streamlining the Interventions of Ministries

Several ministries have been involved in activities for social protection. Some agreement and robust consultation among these ministries would be necessary in the decision-making process to set priorities for the key components (depending on the socio-economic context) and to ensure smooth implementation at the national level.

Securing Coherence in National Policies

Without a consolidated national policy, decisions to mobilize funds for key sectors are made in commissions or during the various often-thematic round tables between donors and the government,

whereas the social protection floor is a combination of these thematic areas and must be considered as a crosscutting issue.

Producing Baseline Information to Inform Decision-making

There are no global statistical data on social protection. This makes it imperative to carry out an in-depth review of programmes so that relevant instruments can be selected in the national context.

Another important challenge to tackle is that of defining vulnerability and devising methods for targeting the communities that benefit from programmes.

Economic and Financial Challenges

No mechanism has been put in place to monitor social protection expenditure at the national level. As a part of the methodology for implementing the social protection floor, which has been developed by the agencies and partners that are members of the global Initiative,^{xx} ILO initiated a process to review social protection expenditure and performance in order to develop a social budget. This work, done in partnership with the Ministry of Labour and Social Security and the Ministry of Economy and Finance, follows the review of social safety nets conducted by UNICEF and the World Bank and will help to generate an overall statement on current social protection expenditure by the end of 2010.

Excluding the cost of the temporary general food and fuel subsidies, which

largely benefited the better-off groups, the average annual budget allocated to social safety net programmes between 2005 and 2009 amounted to approximately 0.6 per cent of the GDP. This increased from 0.3 per cent in 2005 to 1 per cent in 2009^{xxi} since the State was expected to intensify social protection programmes after the energy and food crises and to provide humanitarian assistance and aid to the flood victims in 2009.

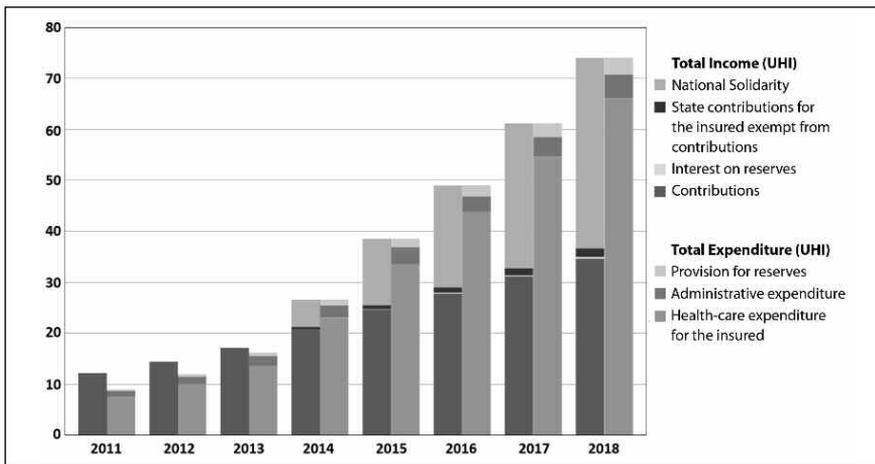
The crises faced by Burkina Faso have eroded people’s economic well-being and social indicators. They have also strained the country’s macroeconomic and budgetary situation. In this context, promoting universal access to a minimum social protection package calls for innovative ways of financing, based on collectivizing risks and rationalizing national resources.^{xxii} For example, the estimated costs (UNICEF and World Bank review, 2010) of national cash transfer programmes for the following two

target groups to transfer 14,000 CFA francs per year would amount to the following:

- for children below 5 years of age: 1 per cent of GDP (3.6 per cent of the national budget); and
- for the poorest tenth of the population: 0.6 per cent of GDP (2 per cent of the national budget).

The first financial simulation of universal financial insurance – done by the national steering committee, with the support of ILO and WHO³ – projected insurance costs for the State up to 2018 (see graph below), where these represent 0.6 per cent of GDP (about 3 per cent of the national budget) for coverage of 60 per cent of the population^{xxiii} (transfers from the State to subsidize the contributions of households from the informal economy and coverage of the poorest tenth for public primary and secondary health care). In this simulation, universal health insurance

Trends in universal health insurance (UHI) expenditure and cash inflows – 1st Simulation (SimIns) (in billions of CFA francs, constant prices 2008).



³Using the SimIns health financing policy tool developed by WHO and the German Agency for Technical Cooperation (GTZ).

expands first in the formal sector (compulsory contribution regime) in order to establish the insurance operations and make it possible afterwards to expand coverage to the informal economy (semi-contribution regime). State transfers (national solidarity) become necessary as the insurance coverage expands.

These first estimates, to which it is necessary to add the costs of transfers for other social protection programmes, already give an indication of the challenges to be addressed by Burkina Faso, which has little tax room and a tight budget margin. Real choices will have to be made in setting priorities for needs and committing national resources. Even if the State can count on foreign sources of funding, the viability and durability of the guarantees that it offers will be based, first and foremost, on its national resources. Having a social budget, as part of the support provided by the global Social Protection Floor Initiative, will give the State an important tool for decision-making.

THE NEXT STAGES OF THE PROCESS OF BUILDING A SOCIAL PROTECTION FLOOR

What came out of the review of social safety nets and the discussions generated during feedback at the national technical workshop on social protection (April 2010) was that the system for providing social safety nets in Burkina Faso needs to be reorganized. Although there is no organized system, surveys show that

social demand for protection is high. In the area of food security, for example, nearly 20 to 30 per cent of the population suffers from severe or moderate food insecurity. These are usually households that regularly face risk factors that maintain them in or push them into chronic poverty. In such a case, social safety nets can help them in periods of food scarcity or economic crisis and serve as an instrument for lifting themselves out of chronic poverty.

Ideally, the system will be made up of several programmes that are complementary and work in synergy with other social policies. For example, the system of the following three programmes reflects this rule:

- a public works programme targeting poor households that are able to work;
- a cash transfer programme targeting poor households that are unable to work in areas that are well covered by food markets; and
- a food transfer programme targeting poor households unable to work in remote and poorly served areas.^{xxiv}

This system will also build on the policies and legislation and complement social insurance regimes, particularly universal health insurance, to promote universal access to basic health care and build synergies with basic social services.

To develop this social protection floor, it is necessary to first put in place and reinforce immediate responses to the crisis and then to move on to meticulous

planning and strategizing for the long term. Considering that the challenges to be addressed are huge, efforts made towards building a coherent, streamlined national policy will have to build on:

- strong and lasting political will;
- national consensus; and
- technical evidence.

The stages for pursuing a process to implement a social protection floor, based on ongoing initiatives, are summarized in table 7. On the whole, these activities aim to:

- embed social protection as a key priority in the Accelerated Growth and Sustainable Development Strategy (SCADD);
- design a global vision for social

protection in Burkina Faso and develop a national policy on social protection and its action plan;

- build synergy between the respective programmes (both current and new) for social safety nets and the broader policies for poverty reduction stated in the SCADD;
- implement the universal health insurance system;
- agree on the criteria for defining poverty and vulnerability and put in place efficient targeting mechanisms;
- put in place a statistical information system on social protection, building on robust monitoring and evaluation mechanisms; and
- develop innovative mechanisms for increasing financing for the social protection floor.

Table 7 | Stages for building a social protection floor in Burkina Faso.

Type of Activity	Activities Ongoing/Planned and Actors
Raising awareness	<ul style="list-style-type: none"> • Jan. 2010 – Training in social protection (UNICEF, Ministry of Social Action and National Solidarity (MASSN) and Ministry of Economy and Finance (MEF)).
National Social Protection Floor Task Force	<ul style="list-style-type: none"> • Feb. 2010 – Setting up of an inter-ministerial steering committee for the policy on social protection and working groups (MEF and technical ministries). • April 2010 – National technical workshop on social protection (MEF and UNICEF, with Ministry of Labour and Social Security (MTSS) and MASSN). • April 2010 – Production of a strategic background document on social protection (UNICEF for MEF).
	<ul style="list-style-type: none"> • 2010 – Elaboration of a road map for social protection as a part of efforts to review the Poverty Reduction Strategy Paper and include social protection as a priority in the Accelerated Growth and Sustainable Development Strategy (SCADD) proposed in the national workshop and to be finalized in June 2010 (Committee). • 2011 – National forum on the national strategy for social protection (Inter-ministerial Committee).

Table 7 | Stages for building a social protection floor in Burkina Faso (cont'd.).

Type of Activity	Activities Ongoing/Planned and Actors
Social protection stocktaking	<ul style="list-style-type: none"> • May 2010 – Review of social safety nets in Burkina Faso (UNICEF, World Bank). • 2010 – Start of stocktaking of social protection expenditure and performance (ILO/European Union, MEF, MTSS). • 2010 – Study on the impact of WFP food voucher programme (WFP). • 2010 – National AIDS Council (CNLS-IST) and World Bank study on the impact of the cash transfer programme. • End of 2010/beginning of 2011 – Update of the poverty and vulnerability profile (National Institute for Statistics and Demography).
Elaborating measures	<ul style="list-style-type: none"> • October 2010 – Finalization of the SCADD (MEF). • 2011 - Identification of pilot projects (costs, coverage, implementation and evaluation measures) (Inter-ministerial Committee).
Analysis	<ul style="list-style-type: none"> • 2010 – Research on methods for targeting the poor (WFP, World Bank, etc.). • 2010 – Feasibility studies on social net options, labour-intensive public works (LIPW), etc. (Inter-ministerial Committee and technical and financial partners (partenaires techniques et financiers, PTF). • 2011 – Social budgeting (Committee, MEF, PTF). • 2011 – Finalization of feasibility studies and implementation of the health insurance project (National Steering Committee, ILO, UNAIDS, WHO).
Implementation	<ul style="list-style-type: none"> • End of 2010 – Elaboration of the national action plan for social protection (Inter-ministerial Committee). • 2011 – Scaling up or start of projects .
Monitoring	<ul style="list-style-type: none"> • 2011 – Putting in place a complete and coherent statistical information system on social protection (Inter-ministerial Committee).

ⁱ World Bank, *World Development Indicators* 2008.

ⁱⁱ WHO, Global Health Observatory, 2008.

ⁱⁱⁱ WHO, UNICEF, UNFPA and World Bank, Global Health Observatory, 2005.

^{iv} World Bank, *World Development Indicators* 2008 and *Global Development Finance* 2008.

^v Ibid.

^{vi} National Strategy for Risk Management and Social Security, February 2006.

^{vii} UNDP, *Human Development Report* 2009.

^{viii} World Bank, *Africa Development Indicators* 2007, and *World Development Indicators* 2008.

^{ix} World Bank, *Country Economic Memorandum*, vol. 1, November 2009.

^x United Nations Country Team, Burkina Faso United Nations Development Assistance

Framework (UNDAF) 2011-2015, March 2010.

^{xxiv}K. Savadogo, 2010, *ibid.*

^{xi}World Bank, 2008. The projections from the National Institute for Statistics and Demography (Institut national de la statistique et de la démographie, INSD) show 15,730,977 inhabitants in 2010.

^{xii}Burkina Faso UNDAF 2011-2015, March 2010.

^{xiii}National Strategy for Risk Management and Social Security, February 2006.

^{xiv}*Ibid.*

^{xv}Ministry of the Economy and Finance, *Progress and Achievements of Burkina Faso 2000-2009*, April 2010.

^{xvi}K. Savadogo, Review of social security safety nets in Burkina Faso: Inventory and analysis of existing social security safety net programmes, draft report, March 2010.

^{xvii}MTSS, Draft National Labour Policy, May 2010.

^{xviii}National Prospective Study "Burkina 2025", Outlook and Planning Council (Conseil national de la prospective et de la planification stratégique, CNPPS), 2005.

^{xix}Ministerial Order n° 2010-051/MEF/SC/DGEP, instituting and making provision for the operationalizing of an interministerial committee to monitor the national policy on social protection, 25 February 2010.

^{xx}Social Protection Floor Initiative, Manual and Strategic Framework for Joint United Nations Country Operations, ILO and WHO, Geneva, November 2009.

^{xxi}World Bank, 2010, "Burkina Faso: Social safety nets", in *Social Protection in Burkina Faso: Current situation and future prospects*.

^{xxii}*Social Protection in Burkina Faso: Current Situation and Future Prospects*.

^{xxiii}Universal Health Insurance (UHI) Permanent Secretariat, ILO and WHO, Financial simulation of the national health insurance system, draft, May 2010.



Cambodia

Population ⁱ	14,562,008
Age structure	
• 0-14 years (%)	34.1
• 15-64 years (%)	62.5
• 65 years and over (%)	3.4
Infant mortality rate (per 1,000 live births) both sexes ⁱⁱ	69
Life expectancy at birth (years) female	62.8
Life expectancy at birth (years) male	59.2
Maternal mortality ratio (per 100,000 live births) ⁱⁱⁱ	540
Public social protection expenditure (% of total public expenditure) ^{iv}	32
Informal economy (%) ^v	72.8
GDP per capita	
• Current USD ^{vi}	711
• PPP (current international \$) ^{vii}	1,951
• Constant local currency ^{viii}	1,968,651
Unemployment rate (%) ^{ix}	1.68
Human development index (HDI rank) ^x	137
HDI poverty indicators – Human poverty index rank	87

The National Social Protection Strategy for the Poor and Vulnerable: Process of Development



Vathana Sann

Summary

- Rationale behind the strategy: to accelerate progress towards the Cambodian Millennium Development Goals so as to reduce poverty and inequality, and to achieve socio-economic security for the population and bring coherence to policy formulation and implementation;
- The Strategy prioritizes the development of effective and sustainable social safety nets for the poor and vulnerable and establishes the framework for sustainable and comprehensive social protection for all Cambodians over the long run (including contributory and non-contributory schemes);
- The Council for Agricultural and Rural Development (CARD) is the governmental body mandated to coordinate and develop the social protection framework.

Five objectives and key interventions (based on the vulnerability and gap analysis and consultation process in 2009 and 2010):

1. The poor and vulnerable receive support to meet their basic needs, including food, sanitation, water and shelter in times of emergency and crisis.
2. Poor and vulnerable children and mothers benefit from social safety nets to alleviate poverty and enhance the development of human capital by improving nutrition as well as maternal and child health, promoting education and eliminating child labour, especially its worst forms.
3. The working-age poor and vulnerable benefit from work opportunities to secure income, food and livelihoods while contributing to the creation of sustainable physical and social infrastructure assets.
4. The poor and vulnerable have effective access to affordable, quality health care and financial protection in case of sickness or illness.
5. Special vulnerable groups, including orphans, the elderly, single women with children, people living with disabilities, and people living with HIV and tuberculosis, receive income, in-kind and psycho-social support, and adequate social care.

Instruments for social protection:

- Cash and in-kind transfers and fee exemptions;
- Public works programmes;
- Social welfare services.

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INTRODUCTION

Having emerged from three decades of instability, Cambodia has had an impressive record of sustained growth and poverty reduction. Yet Cambodians still face many serious forms of vulnerability, notably regarding weather-dependent agriculture, idiosyncratic shocks, and un- and under-employment. The coverage of existing social protection programmes for the poor and vulnerable is very limited, and the presence of important sources of vulnerability (such as malnutrition, health shocks and poor quality of education) that remain inadequately addressed lead poor households into further destitution.

To promote equitable growth in the near-to-medium term, an effective and affordable social protection system should be developed that supports the poor and vulnerable in coping with major sources of vulnerability while at the same time promoting human development. In the near future, priority should therefore be given to the development of effective and affordable social protection programmes for the poor and vulnerable that achieve these goals.

An effective social protection system also promotes equitable growth and the government's ability to reform. To the extent that it encourages prudent risk-taking and enhances opportunities for the poor, social protection can be beneficial for economic growth. Social protection can also help governments to embark on reforms that have long-term benefits in economic efficiency but high short-term social and political costs by providing

effective compensation to those negatively affected by the reform.

CONTEXT

In the last three decades, Cambodia has changed its political regime more frequently than any neighbouring countries. Cambodian society – especially its social infrastructure – also has experienced major changes and challenges. The Government managed to stabilize the famine situation prevailing in 1979 and made slow but steady gains in reconstructing schooling and basic health care. The population was organized into “solidarity groups”. This collectivization ensured equal access to the scarce male labour and draft animals available in 1979-1980, but as the economy recovered, it came to be seen as a hindrance to growth. Spontaneous de-collectivization, formalized through liberalization and land distribution in 1989, improved output and was welcomed by most although vulnerable groups lost important forms of social security (Frings, 1993).

Great achievement in terms of infrastructure and human rehabilitation and development is tremendously significant. Cambodia had been embarking on a transition from war to peace, especially from one ruling party to multi-party politics, and from an isolated and planned economy to a free-market economy integrated into international trade. Since the Paris Peace Agreements in 1991, free and fair elections have been conducted. Since 1993, Cambodia has been transformed from a post-conflict society into a normal developing country.

POVERTY PROFILE OF CAMBODIA

The last decade in Cambodia has been characterized by high rates of sustained economic growth, averaging 7 per cent growth in gross domestic product (GDP) per year between 1997 and 2007. Over the same period, per capita income doubled from US\$285 to US\$593 per year (GDP in 2008 was \$711). Such growth has raised living standards and reduced poverty, which fell from an estimated 45 to 50 per cent of the population in 1994 to 35 per cent in 2004 and 30 per cent in 2007. Rising incomes and improved public services have contributed to improving human development indicators. Rapid growth and poverty reduction were accompanied by structural transformations: integration into the regional and global economy, a gradual shift of employment from agriculture to manufacturing,

and migration from rural to urban areas.

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Table 1 | Cambodian population index and projections.

Demographic Indicator	1970	1980	1990	2000	2008*	2010	2020	2030
Midyear population (*1,000)	7,396	6,888	9,345	12,396	13,395	14,753	17,601	20,183
Growth rate (%)	-0.7	2.5	3.6	1.8		1.8	1.6	1.1
Total fertility rate (births/woman)	6.5	7.4	6	3.7		3	2.7	2.4
Crude birth rate/1,000 population	43	58	47	27		26	23	18
Life expectancy at birth (years)	38	37	52	59		63	66	69
Infant mortality rate/1,000 births	199	228	144	82		53	38	27
Under-5 mortality rate/1,000 births	274	327	185	104		67	47	33
Crude death rate/1,000 population	24	28	15	9		8	7	7

* Data from 2008 general census.

Source: National Institute of Statistics.

Table 2 | Profile of the poor.

Stage	Quintile				
	Poorest	Next Poorest	Middle	Next Richest	Richest
Owned agricultural land is secured by a title (%)	15.6	21.6	24.5	25.3	28.6
Distance to nearest all-weather road (km)	5.2	3.7	3.3	3.1	1.9
Distance to permanent market (km)	10.8	9.6	8.1	7.1	4.2
Households with water pump (%)	3	8	9	12	13
Plots with access to irrigation in dry season (%)	6	10	12	13	12
Dependency burden (elderly and children per 100 economically active adults)	96.9	84.5	76.6	64.9	54.3
Literacy, adults, age 15 and older (%)	29.3	38.3	43.2	51.1	60.8
Education (average school grades completed by adults)	2.8	3.5	3.9	4.6	6.3

Source: Cambodia Socio-Economic Survey (CSES) 2004.

Poverty incidence largely remains a rural phenomenon. Despite impressive poverty reduction, one of three individuals continues to live below the poverty line. While poverty rates decreased in both urban and rural areas, inequality and the urban-rural divide increased between

1993-1994 and 2007. Less than 1 per cent of the population in Phnom Penh was deemed to be poor in 2007, compared to more than 20 per cent in other urban areas and almost 35 per cent in rural areas, where approximately 80 per cent of the population lives. While

Table 3 | Poverty and inequality trends.

	% Population	Poverty Headcount (%)			Gini Coefficient	
		1993/1994	2004	2007	2004	2007
		Phnom Penh	9.9	11.4	4.6	0.83
Other urban	10.2	-	24.7	21.8	0.44	0.47
Rural	79.8	-	39.2	34.7	0.34	0.36
Cambodia	100	47	34.7	30.1	0.40	0.43

Source: Knowles (2008) for the 2004 and 2007 data and World Bank Cambodia Poverty Assessment (2006) for 1993/1994 data. Owing to limited coverage of the 1993/1994 survey, poverty data for Cambodia in 1993/1994 have been extrapolated.

Table 4 | Poverty levels of selected population groups.

Group	% Population	% Poor	Poverty Gap
Elderly (65 years old or above)	4.3	25.9	5.5
Employed	53.3	28.3	6.6
Members of female-headed households	18.2	27.9	7.2
Members of male-headed households	81.8	31.2	7.5
Members of employed-headed households	91.1	31.0	7.5
People with disabilities	1.3	28.6	7.2
Ethnic minorities	2.2	36.1	10.0
Infants (below 1 year old)	4.0	38.9	10.0
Children (ages 0-14)	33.5	37.4	9.4
Cambodia	100	30.5	7.4

Source: Cambodia Socio-Economic Survey (CSES) 2007..

inequality in Phnom Penh has decreased, it has increased in other urban and rural areas, leading to an overall increase in inequality from a Gini coefficient of 0.39 to 0.43 in only three years (2004-2007) (table 3). A large proportion of the population also remains nearly poor and vulnerable to shocks that can push it into poverty.

An increasing number of rural households have also become landless since land redistribution in the 1980s. A 2004 Oxfam study estimated that 20 per cent of rural households were affected by landlessness, with the number of those affected rising by 2 per cent per year. Another 25 per cent of households have less than 0.5 hectares, an insufficient amount of land to sustain them. The poor also lack or have few basic assets –

including draft animals or adequate housing – that ensure a flow of income and can act as collateral to obtain credit. Lack of assets also means that the poor have few instruments to cope with consumption or income shocks.

The non-diversification of household economies exacerbates the vulnerability of rural Cambodians. Most rural households rely heavily on subsistence agriculture for their livelihood, with rice cultivation accounting for 90 per cent of total cultivated area and 80 per cent of agricultural labour input. Cambodia's unique hydrological regime and very low levels of coverage by water-control infrastructure mean that agricultural production (and thus household food security) is heavily dependent on the weather and can fluctuate significantly from year to

Table 5 | Summary of the coverage of main risks.

Age group	Main Vulnerabilities	Progress to Date	Gaps and Challenges
Early childhood (0-4 years)	<ul style="list-style-type: none"> Stunted child development. 	<ul style="list-style-type: none"> Some maternal and child nutrition programmes are in place; Breastfeeding practices are improving. 	<ul style="list-style-type: none"> Supply of services remains limited and of poor quality; Coverage is not universal.
Primary school age (5-14 years)	<ul style="list-style-type: none"> High dropout rate; Poor quality of education; Child labour. 	<ul style="list-style-type: none"> Some maternal and child nutrition programmes are in place; Breastfeeding practices are improving. 	<ul style="list-style-type: none"> Supply of services remains limited and of poor quality; Coverage is not universal.
Youth (15-24 years)	<ul style="list-style-type: none"> Low productivity; Low human capital/skills; Underemployment. 	<ul style="list-style-type: none"> Scholarships are improving attendance; Some programmes in place to improve quality of education and of vocational training. 	<ul style="list-style-type: none"> Quality of education remains poor; Low attendance; Coverage is not universal; Almost nonexistent second-chance programmes to improve productivity of unskilled workers.
Adults (25-64 years)	<ul style="list-style-type: none"> Low productivity; Low human capital/skills; Underemployment. 	<ul style="list-style-type: none"> Public works programmes are providing some assistance during lean season or crises. 	<ul style="list-style-type: none"> Limited coverage; Funding and assistance remain volatile, defying their safety-net role.
Elderly and disabled	<ul style="list-style-type: none"> Low income; Underemployment. 	<ul style="list-style-type: none"> Pensions for civil servants; Some donor assistance to the disabled. 	<ul style="list-style-type: none"> No pensions for the poor except for civil servants; Very limited assistance to the disabled.
All groups	<ul style="list-style-type: none"> Health shocks. Crisis and natural disasters. 	<ul style="list-style-type: none"> Health equity funds are financing health care for the poor. Public works have shown to be an effective and rapidly expandable safety-net instrument during crises and natural disasters. 	<ul style="list-style-type: none"> Quality of health care remains poor; Coverage and access are not universal. Limited coverage of existing public works programmes; Coverage is not universal and depends on funding

year. In the first half of this decade, unusual floods and droughts severely affected large parts of the countryside, resulting in three years with negative

rates of agricultural growth. Rice yields remain among the lowest in the region owing to limited and poor use of improved seed, fertilizer, tillage and

Table 6 | Major sources of vulnerability along the life cycle.

Group	Main Sources of Vulnerability
Pregnant mothers	High maternal mortality rates.
Infants and children	High malnutrition rates; Poor quality of education/High dropout rates; Child labour and sexual exploitation.
Youth	Poor quality of education/High dropout rates; Low productivity.
Working-age population	Low productivity; Disability.
Elderly	Inability to work.
Entire life cycle	Health shocks; Natural disasters; Food insecurity; Economic and (food) price crises.

water management. Because productive off-farm opportunities are limited, rural households lack alternatives that would enable them to maintain stable incomes or cope in times of poor harvest.

TRADITIONAL AND INFORMAL SOCIAL SAFETY NETS

The dramatic socio-economic and political changes of the past two decades have had a significant impact on the social fabric of Cambodia. The structure of Cambodian society has changed and its culture has been dislocated. None are more vulnerable to these upheavals than children and women. Families, which provide the first safety net for the survival, protection and healthy development of

children, have been fragmented and weakened by death and separation. Communities or villages, once composed of extended family networks established for generations, have been shattered and reformed by forced population movements, displacement and repatriation.

Cambodia’s traditional social safety net existed in the form of sharing, mutual assistance and, within the pagoda, extended families and neighbour networks through charity and community self-help activities. The monks and the pagoda played an important role in offering meals and temporary shelter to poor and vulnerable people in need within the community. The elderly or very poor are sometimes able to access services at the pagoda, in Muslim communities or in

Christian churches, but the availability of such services is limited to a few. Through extended family structures, most vulnerable and poorer members of relatives often received in-kind assistance. Traditional mutual help and support in the form of food and interest-free loans in times of need still exist within kinship systems, extended families and informal networks of occupational groups.

Moreover, other forms of safety nets in the modern history of Cambodia can be observed where wealthy families, high-ranking officials, business people and communities extended their own private means to assist and offer help to those who needed the most. Informal arrangements based on kinship and community practices and gifts from wealthy urban groups to poorer rural communities provide households with some protection against risk. Forms of humanitarian support in recent times include emergency assistance from the Cambodian Red Cross and political parties to households affected by disasters and gifts in cash or in kind from political parties. This assistance is needs-based, and poor and vulnerable workers who have met this assessment have received it. However, such assistance, available only as emergency support, is unreliable as a source of security and may come with political strings and/or is insufficient to ensure full recovery from crises. Moreover, such assistance is much rarer today (it was more common before the election of July 2008).

BACKGROUND OF SOCIAL PROTECTION IN CAMBODIA

EXISTING INSTITUTIONAL AND LEGAL FRAMEWORK FOR SOCIAL PROTECTION

After the war, Cambodia was moving from a phase of war towards peace, from a culture of continued conflict to a culture of compromise, dialogue and reconciliation. In response to the challenges, the strategy for the National Programme for Rehabilitation and Development of Cambodia (NPRDC) was developed, adopted and implemented. The broad aims of the Government of Cambodia were set out in the NPRDC in February 1994 and elaborated in Implementing NPRDC in February 1995: "Striving to Achieve a Sustainable Growth with Equity and Justice". The extensive experience of Cambodia in providing social protection intervention to the people from the most difficult time (1979) to rehabilitation (1991) and national development (post-1993) is one of the success stories of the country.

In the document, war was declared on poverty, and the development of the rural areas is seen as critical to raising the living standards for the majority (80 per cent) of the Cambodian population. Since 1993, rural development has played, and will continue to play, an important and active role in implementing and achieving the goals and targets set forth in the Government's various policy documents, such as the National Programme for Rehabilitation and

Development of Cambodia (NPRDC), the Socio-economic Development Plan (SEDP I-II) and the National Poverty Reduction Strategy (NPRS). Work in the rural-development sector has contributed towards the reduction of poverty in rural areas through decentralized and participatory approaches to the improvement of rural accessibility and to creating opportunities for rurally based people in their own development. The vision of "Returning to the Villages" was and continues to be the theme for rural-development activities that seek to alleviate poverty through the implementation of projects and programmes that will improve accessibility to socio-economic services in rural areas and that will strengthen and empower the local grassroots organizations at the village level. The goal is to achieve sustainable development and self-reliance.

In response to the needs in rural areas, external assistance was provided through loans and grants to rural-development projects and programmes. The Asian Development Bank, the Department for International Development (DFID), the European Union, the German Agency for Technical Cooperation (GTZ), the Japan International Cooperation Agency (JICA), Kreditanstalt für Wiederaufbau, the Swedish International Development Cooperation Agency (SIDA), the World Bank and United Nations entities (i.e., the International Labour Organization (ILO), the United Nations Development Programme (UNDP), the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP) and the World Health Organization (WHO)) and other development partners have provided financial and technical assistance to

Box 1. Legal framework of social protection stated in the Constitution.

Article 36: Every Khmer citizen shall have the right to obtain social security and other social benefits as determined by law.

Article 46: The State and society shall provide opportunities to women, especially to those living in rural areas without adequate social support, so they can get employment, medical care, and send their children to school, and to have decent living conditions.

Article 73: The State shall give full consideration to children and mothers. The State shall establish nurseries, and help support women and children who have inadequate support.

Article 74: The State shall assist the disabled and the families of combatants who sacrificed their lives for the nation.

Article 75: The State shall establish a social security system for workers and employees.

improve rural accessibility and increase opportunities for rural people. Rural development activities included but were not limited to the following: rehabilitation of the rural infrastructure such as roads, markets, water supply and

sanitation; expansion of rural credit services and income-generating activities; and strengthening of the institutional and human-resource capacity at the national, provincial and local levels.

Box 2. Organic laws codifying some aspects of social protection in Cambodia.

Organic laws that have codified some aspects of social protection in Cambodia are as follows:

- Labour Law (October 1998);
- Insurance Law (June 2000);
- Law on Social Security Schemes for Persons Defined by the Provisions of the Labour Law (September 2002);
- National Action Plan to Combat Violence against Women has been developed in accordance with the Law on the Prevention of Domestic Violence and the Protection of Victims (2005);
- Law on Suppression of Human Trafficking and Sexual Exploitation (2007), consistent with the United Nations Palermo Protocol; and
- Law on the Protection and the Promotion of the Rights of People with Disabilities (2009).

Table 7 | Cambodia’s Strategic Framework for Social Protection.

Institution	Dimension(s) of Social Protection and Social Safety Nets	Current Sectoral Policy/Strategy
<p>National government institutions mandated to deliver social services to the population and to protect specific vulnerable groups against risks</p>	<ul style="list-style-type: none"> • National Social Safety Fund for private-sector employees; • Vocational training; • Child labour elimination programme. 	

Table 7 | Cambodia’s Strategic Framework for Social Protection (cont’d.).

Institution	Dimension(s) of Social Protection and Social Safety Nets	Current Sectoral Policy/Strategy
Ministry of Social Affairs, Veterans and Youth Rehabilitation	<ul style="list-style-type: none"> • National Social Security Fund for civil servants; • Services for veterans; • Services for the homeless and destitute, victims of trafficking, children and youths, people living with disabilities; • Emergency relief to those affected by natural disasters. 	Work Platform 2009-2013.
Ministry of Women’s Affairs		
National government institutions that implement specific safety-net interventions		
Ministry of Health	<ul style="list-style-type: none"> • Health equity funds; • Community-based health insurance for the poor and vulnerable. 	Health Strategic Plan 2008-2015; Strategic Framework for Health Financing 2008-2015; Master Plan for Social Health Insurance 2003-2005.
Ministry of Education, Youth and Sport	<ul style="list-style-type: none"> • Scholarship for the poor programme. 	Education Sector Strategic Plan 2006-2010.
National government institutions with complementary activities		
Ministry of Agriculture, Forestry and Fisheries	<ul style="list-style-type: none"> • Food production, livelihoods. 	Strategy for Agriculture and Water 2006-2010.
Ministry of Public Works and Transport	<ul style="list-style-type: none"> • Implementation of national policy concerning all public works construction. 	
Ministry of Rural Development	<ul style="list-style-type: none"> • Rural infrastructure works. 	
Ministry of Water Resources and Meteorology	<ul style="list-style-type: none"> • Rural infrastructure works. 	
Ministry of Planning	<ul style="list-style-type: none"> • Identification of Poor Households Programme. 	Ministry of Planning Strategic Plan 2006-2010.

Safety-net interventions are scattered across several ministries (see tables 7 and 9). Individual ministries and even non-governmental organizations (NGOs) have their own mandate and policy framework regarding social protection. In developing a National Social Protection Strategy for the Poor and Vulnerable (NSPS), the challenges of separated policy frameworks existing in different stakeholders must be taken into consideration. The Ministry of Labour and Vocational Training, the Ministry of Social Affairs, Veterans and Youth Rehabilitation, and the Ministry of Women’s Affairs are all mandated to manage State social services for the wider population and help to protect specific vulnerable groups against risks. In collaboration with the World Food Programme (WFP), the Ministry of Rural Development and the Ministry of Water Resources and Meteorology are also implementing a

food-for-work programme that distributes 3,500 tons of rice per year to approximately 20,000 households.

The Ministry of Social Affairs, Veterans and Youth Rehabilitation and the Ministry of Labour and Vocational Training are the two main government providers of social protection schemes. The former provides assistance to retired civil servants, veterans and their dependents while the latter oversees social protection schemes for private-sector workers.

In 2005, the Government (through the Ministry of Social Affairs, Veterans and Youth Rehabilitation) made payments to civil servants, military, police, disabled people and deceased and/or patriot-dead military and their dependents that totalled US\$16.4 million and benefitted 120,000 persons (table 8). It is interesting to note that dependents such as the children and

Table 8 | Types of pension schemes and beneficiaries.

Type of Pensioner	Estimated Total Number of Beneficiaries	Amount of Benefits (in millions of US\$)
Retired civil servant*	19,489	4.024
Retired military**	5,151	1.140
Disabled military (retired)***	31,121	7.010
Disabled civil servant (retired)****	5,151	1.125
Dependent of dead patriot military*****	54,895	2.400
Dependent of dead civil servant	4,000	0.606
Total	119,807	16.305

* Also provides allowance to 13,364 spouses and 13,820 children.
 ** Also provides allowance to 4,417 spouses and 12,132 children.
 *** Also provides allowance to 28,607 spouses and 91,328 children.
 **** Also provides allowance to 102,007 parents and 103,788 children.
 ***** Also provides allowance to 4,000 children.

Table 9 | Social safety nets and social protection framework in various ministries.

Risks and Shocks	Programme Type	Programme	Lead Ministry
1. Situations of emergency and crisis	Food distribution	Emergency Food Assistance Project (free distribution of rice)	MEF
		Disaster response and preparedness; general food distribution (Ketsana)	NCDM
		Package of emergency relief to vulnerable and victims of emergency (including victims of land mines)	MoSVY
	Budget support	Smallholder Agriculture and Social Protection Development Policy Operation	MEF
	Commune transfers for emergency assistance	Emergency assistance – cash and in-kind assistance to communes to support achievement of Cambodian Millennium Development Goals	Mol
2. Human development constraints			
Poor maternal and child health and nutrition	Nutrition programmes	Child survival: components on improving maternal health and newborn care, promotion of key health and nutrition practices Maternal and Child Health and Nutrition Programme Other interventions	MoH
	Social security	Maternity benefits for all workers EXCEPT domestic workers, civil servants, armed forces and police; 90 days of maternity leave; pay at half salary covered by employer (Labour Law Article 183)	MoLVT
Poor access to quality education	Scholarships in cash	Fast Track Initiative (FTI) (grades 4-6); Cambodia Education Sector Support Project (CESSP) (grades 7-9); Japan Fund for Poverty Reduction (JFPR) (grades 7-9); Basic Education and Teacher Training (BETT) Project (grades 7-9); Enhancing Education Quality Project (EEQP) (grades 10-12); Dormitory Project (grades 10-11); various projects (grades 7-9)	MoEYS
		Emergency Food Assistance Project (grades 5-6 and 8-9)	MEF
Child labour, especially its worst forms	Direct intervention and livelihood improvement	Project of Support to the National Plan of Action on the Elimination of the Worst Forms of Child Labour (NPA-WFCL) 2008-2012	MoLVT
Poor access to quality training	Second-chance education programme	Technical and Vocational Education and Training (TVET) pilot skills bridging programme TVET post-harvest processing TVET voucher skills training programme (non-formal)	MoLVT
3. Seasonal unemployment and livelihood opportunities	Public works programmes (PWPs)	Food for work	MRD
		Food for work (Emergency Food Assistance Project)	MEF
		Cash for work (Emergency Food Assistance Project)	MEF
	School feeding	School feeding	MoEYS
		Emergency Food Assistance Project	MEF
Take-home rations	Take-home rations	MoEYS	

Table 9 | Social safety nets and social protection framework in various ministries (cont'd.).

Risks and Shocks	Programme Type	Programme	Lead Ministry
4. Health shocks	Insurance	National Social Security Fund (NSSF) health insurance (planned for 2011)	MoLVT
		NSSF employment injury coverage	
		Health insurance for retired civil servants (planned)	MoSVY
	Fee waiver	Exemptions at rural facilities for poor patients	MoH
	Health equity funds (HEFs)	HEFs in 50 operational districts (ODs)	
	Community-based health insurance (CBHI)	13 CBHI schemes	
5. Special vulnerable groups	Social welfare for elderly	Elderly persons' association support and services	MoSVY
	Pensions	Invalidity pensions for parents or guardians of deceased soldiers, spouses of people living with disabilities, retirees and people who have lost their ability to work	
	Social welfare for families living with disabilities	Physical rehabilitation centres/community-based rehabilitation services for people with disabilities	
	Social welfare and policy development for children and orphans	Orphans: allowance, alternative care, residential care; child victims of trafficking, sexual exploitation and abuse; children in conflict with the law and drug-addicted children	
		Child protection: helps to develop laws, policies and standards and raise awareness to protect children at particular risk	
	Social welfare for families living with HIV/AIDS	Social services and care to children and families of victims and people affected by HIV/AIDS; children in conflict with the law; drug-addicted children	
		HIV/AIDS workplace programme for garment factory workers	MoLVT
		Food Assistance to People Living with HIV and AIDS	MoH,
For tuberculosis patients	Food Assistance to Tuberculosis Patients	MoSVY	
6. Other	Pensions	Civil servants and veterans retirement pensions	MoSVY
		NSSF employer-based pension schemes (planned)	MoLVT
MEF	Ministry of Economics and Finance		
MoEYS	Ministry of Education, Youth and Sport		
MoH	Ministry of Health		
Mol	Ministry of Interior		
MoLVT	Ministry of Labour and Vocational Training		
MRD	Ministry of Rural Development		
MoSVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation		
NCDM	National Committee for Disaster Management		
NPA-WFCL	National Plan of Action on the Elimination of the Worst Forms of Child Labour		

the spouse and/or parents of deceased civil servants and deceased military receive pensions.

The National Social Security Fund for Civil Servants (NSSF-C), established in 2008, replaces direct payments of social security benefits to civil servants through a contribution-based system that provides a number of benefits: pensions, disability, maternity, work injury, funerals and survivors' pensions. It covers 180,000 civil servants and their families. The National Social Security Fund for Private-sector Employees (NSSF), established in 2008, is set to provide, by 2012, the following to all private-sector employees of firms with more than eight employees: (a) employment injury coverage (employment injury insurance was launched in November 2008 and, in December 2009, was already covering 350,000 workers from roughly 900 enterprises), (b) health insurance and (c) pension coverage.

NGOs play a significant role in assisting households in distress. In 2007, NGOs channelled roughly 26 per cent of total official development assistance (ODA) in Cambodia (Council for the Development of Cambodia (CDC) ODA database), with US\$65 million spent on social protection alone in 2007. Within the health sector, much assistance goes towards primary health care and access to hospitals and clinics. In education, it focuses on basic education for the poor and vocational training. NGOs are also very active in providing community and social welfare services through orphanages and general assistance to vulnerable children and youth.

GAPS AND CHALLENGES IN THE PROVISION OF SOCIAL PROTECTION

The Government has also identified the following institutional and implementation constraints with regard to the effective and efficient provision of social protection:

- Safety-net implementation often reflects immediate priorities (such as the need to respond to food and financial crises) rather than a shared longer-term vision for safety-net development.
- Programmes are often implemented in parallel with the national government structure, failing to build capacity of local government to gradually take over safety-net management, therefore generating a vicious cycle of low local capacity and sustained parallel implementation of programmes.
- Limited coordination among social protection interventions has resulted in uneven coverage, duplication of efforts, and lack of sustainability and overall impact.
- Geographic coverage of existing programmes, even the largest ones, is far from universal. Moreover, programmes do not necessarily prioritize poor areas.
- Targeting has not yet been mainstreamed into safety-net implementation, and many safety-net programmes still rely on ad hoc targeting procedures whose accuracy has not been investigated, adding to transaction costs and inefficiencies.

- Few programmes or institutions are actually collecting critical monitoring information beyond inputs, outputs and the mere list of beneficiaries, which makes it difficult to assess the effectiveness of ongoing programmes and improve them on an ongoing basis. Even fewer are using monitoring data to improve their procedures on a continuous basis. Moreover, there are few rigorous and thorough evaluations of existing safety-net interventions, making it difficult to assess how well they perform by international standards and where there are areas for improvement.
- Feedback and complaint resolution systems – a central pillar for guaranteeing good governance, transparency and effectiveness of safety-net interventions – tend to remain underdeveloped. Very few programmes have evaluated the effectiveness of their feedback systems.
- As an underlying challenge, the budget for safety-net implementation remains low, with the majority of funding provided by development partners and earmarked for interventions that are often implemented in parallel with the national government system.

Table 10 | Gaps and challenges in existing interventions.

Main Risks and Shocks		Most Vulnerable Groups	Progress to Date in Response	Gaps and Challenges in Response						
1. Situations of emergency and crisis	Economic crises	<ul style="list-style-type: none"> • All poor and near-poor. 	<ul style="list-style-type: none"> • Public works have shown to be an effective and rapidly expandable safety-net instrument during crises and natural disasters. 	<ul style="list-style-type: none"> • Limited coverage and coordination of existing public works programmes. 						
	Climate, environmental, natural disasters	<ul style="list-style-type: none"> • All poor and near-poor; • People living in flood- and drought-prone areas. 			2. Human development constraints	Poor maternal and child health and nutrition	<ul style="list-style-type: none"> • Girls and women of reproductive age; • Pregnant women; • Early childhood (0-5 years). 	<ul style="list-style-type: none"> • Some maternal and child nutrition programmes are in place; • Breastfeeding practices are improving. 	<ul style="list-style-type: none"> • Supply of maternal and child nutrition services remains limited and of poor quality; • Coverage of these services is not universal; • Other demand-side factors (eating, feeding and care practices) are not being adequately addressed. 	Poor access to quality education
2. Human development constraints	Poor maternal and child health and nutrition	<ul style="list-style-type: none"> • Girls and women of reproductive age; • Pregnant women; • Early childhood (0-5 years). 	<ul style="list-style-type: none"> • Some maternal and child nutrition programmes are in place; • Breastfeeding practices are improving. 	<ul style="list-style-type: none"> • Supply of maternal and child nutrition services remains limited and of poor quality; • Coverage of these services is not universal; • Other demand-side factors (eating, feeding and care practices) are not being adequately addressed. 						
	Poor access to quality education	<ul style="list-style-type: none"> • School age (6-14 years). 			<ul style="list-style-type: none"> • Scholarships and school feeding programmes are improving attendance. 	<ul style="list-style-type: none"> • Quality of education remains poor; • Coverage of education services is variable; • Coverage of scholarships and school feeding programmes does not reach all poor areas. 				

Table 10 | Gaps and challenges in existing interventions (cont'd.).

Main Risks and Shocks	Most Vulnerable Groups	Progress to Date in Response	Gaps and Challenges in Response
<p>Poor access to quality second-chance programmes</p>	<ul style="list-style-type: none"> • Youth (15-24 years). 	<ul style="list-style-type: none"> • Establishment of vocational training curricula; • Some programmes in place for second-chance education. 	<ul style="list-style-type: none"> • Quality of vocational training remains poor; • Supply of second-chance programme is minimal; • Poor link between training offered and employers' needs; • No certification/accreditation system in place for private sector.
<p>3. Seasonal unemployment and livelihoods opportunities</p> <p>Under- and poor nutrition</p>	<ul style="list-style-type: none"> • All poor and near-poor; • Pregnant women; • Early childhood (0-5 years); • Families with greater age dependency ratio; • Landless and land poor. 	<ul style="list-style-type: none"> • Some targeted food distribution; • School feeding; • Public works programmes are providing some assistance during lean season or crises. 	<ul style="list-style-type: none"> • Limited coverage and coordination of existing public works programmes; • Funding and assistance remain volatile.
<p>4. Health shocks</p> <p>Ill-health, injury, illness, death, pandemics</p>	<ul style="list-style-type: none"> • All poor and near-poor; • Pregnant women; • Early childhood (0-5 years); • Elderly; • People living with a disability. 	<ul style="list-style-type: none"> • Health equity funds (HEFs) are financing health care for the poor in some areas. 	<ul style="list-style-type: none"> • Quality of health care remains poor; • Coverage/access of HEFs is not universal.
<p>5. Special vulnerable groups</p> <p>Inability to work, marginalization</p>	<ul style="list-style-type: none"> • Elderly; • People living with a disability; • People living with chronic illness; • Ethnic minorities; • Orphans; • Child labourers; • Victims of violence, exploitation and abuse; • Veterans; • Families of migrants. 	<ul style="list-style-type: none"> • Pensions for civil servants, National Social Security Fund for private-sector employees; • Some donor assistance to the disabled; • Some assistance to ethnic minorities. 	<ul style="list-style-type: none"> • No pensions for the poor; • Very limited assistance to people with disabilities; • Limited assistance to other special vulnerable groups.

PROGRESS ON SOCIAL SAFETY-NET DEVELOPMENT

SCOPING AND MAPPING EXERCISE ON EXISTING SAFETY-NET PROGRAMMES

The Government of Cambodia agreed that the first step is to undertake a mapping exercise to determine the nature of the existing provision of safety nets and to identify policy, institutional and capacity gaps for developing a more systematic and integrated safety-net system. To start this process, responsibility for this mapping and scoping exercise is assigned to the Technical Working Group on Food Security and Nutrition (TWG-FSN) (box 3), chaired by the Council for Agricultural and Rural Development. To succeed, this analysis and subsequent safety-net devel-

opment will require the intensive engagement of social-sector ministries.

The starting point for a work programme for the Technical Working Group on Food Security and Nutrition is to prepare the concept note on the assessment of the country's overall situation of social protection. Development partners will support the development of the social safety-net strategy (SSNS) by contributing to the draft and providing technical assistance where possible. The Government, in collaboration with development partners – specifically, through the Interim Working Group on Social Safety Nets of the Technical Working Group on Food Security and Nutrition – will lead efforts towards a social safety-net strategy. WFP, co-facilitator of the Technical Working Group and the largest SSNS development part-

Box 3. The initial role of the Council for Agricultural and Rural Development (CARD) in the mapping and scoping exercise of existing social safety nets.

The Technical Working Group on Food Security and Nutrition, working with relevant government institutions and development partners, committed to carrying out the mandate given by the Government as follows:

- mapping and scoping by end of May 2009, with World Bank support, building very much on what is already in the draft concept note and pulling together all the available information in a core paper for the July National Forum;
- concurrent work on a draft of policy options to be presented at the July Social Safety Net National Forum, which will be supported by the World bank in collaboration with WFP and other development partners of the Interim Working Group on Social Safety Nets;
- policy option paper to be finalized by September 2009; CARD/Technical Working Group on Food Security and Nutrition to lead, with the support from development partners; and
- Social safety net strategy by December 2009; CARD to lead, development partners to support.

ner, will facilitate coordination with other development partners. On the Government side, the Council for Agricultural and Rural Development will coordinate among the many government agencies with social-policy programmes and an interest in the issue. The overall National Social Protection Strategy is the successful outcome of a long collaboration process between the Government and the development partners and other stakeholder involved, where the initiative comes from the willingness of the Government.

TECHNICAL CONSULTATION ON SOCIAL PROTECTION STRATEGY AND OPTIONS

In preparing the National Social Protection Strategy for the Poor and Vulnerable, the Council for Agricultural and Rural Development (CARD) in 2009 and 2010 convened meetings and held technical consultations with a broad set of national stakeholders, giving government representatives (national and subnational), development partners, civil society representatives and other development practitioners the opportunity to explore the options and priorities in depth (table 11).

Table 11 | Summary of the consultation process on the National Social Protection Strategy for the Poor and Vulnerable.

Timeline	Activity/event	Outcomes
3-4 Dec. 2008	Cambodia Development Cooperation Forum	National government commitment to develop and implement an integrated national strategy for social safety nets.
Jan.-Jun. 2009	Interim Working Group on Social Safety Nets (under the Technical Working Group on Food Security and Nutrition)	Shared knowledge and consensus-building on the key concepts and broad direction for policy development and inventory of ongoing social protection interventions.
6-7 Jul. 2009	National Forum on Food Security and Nutrition under the theme of Social Safety Nets in Cambodia	During the two-day forum, 400 participants (government, development partners and civil society) held discussions, with Prime Minister Hun Sen providing the closing address.
19-22 Oct. 2009	Technical Consultation on Cash Transfers, with a focus on addressing child and maternal malnutrition	Participants from government, development partners and civil society consulted during a workshop in Phnom Penh. A group of participants also visited health and educational services and held discussions with commune councils and the provincial office in Kampong Speu. The consultation culminated in a brainstorming session by key stakeholders to produce the "Note on Cash Transfers".

Table 11 | Summary of the consultation process on the National Social Protection Strategy for the Poor and Vulnerable (cont'd).

Timeline	Activity/event	Outcomes
12-14 Jan. 2010	Technical Consultation on Public Works	80+ participants (government, development partners, civil society) consulted during a workshop in Phnom Penh. The core group (about 30 participants) also visited sites of cash-for-work and food-for-work projects (Asian Development Bank- and WFP-supported interventions) in Kampong Chhnang, including a consultation with representatives of a commune council and beneficiaries of the projects. The consultation culminated in a Next Steps Meeting by CARD and a core group of development partners and the production of the “Note on Public Works”.
3-4 Feb. 2010	Technical Consultation on the Role of a National Social Protection Strategy in Augmenting Human Capital through Promoting Education, Reducing Child Labour and Eliminating Its Worst Forms	100+ participants (government, development partners, civil society) consulted during a two-day workshop in Phnom Penh. The consultation built consensus on integrating education and child labour issues into the National Social Protection Strategy (NSPS), particularly in instruments such as cash transfers, as well as the need to explore greater access to safety-net schemes to prevent child labour and withdraw vulnerable children from it, especially its worst forms. The “Note on Child Labour and Education” was prepared by a core group of development partners as a contribution to the NSPS.
Mar.-Apr. 2010	Consultations on draft National Social Protection Strategy (NSPS)	An executive drafting team was set up to prepare and consolidate inputs into the draft NSPS. Several consecutive drafts of the NSPS were shared and discussed in the extended format of the Interim Working Group on Social Safety Nets. Several rounds of consultations on the content of the NSPS and the proposed objectives took place to advance the shaping a coherent strategy.

This transparent and rigorous consultation process has ensured that the analytical and policy inputs have gone through several rounds of discussion and are the result of a combined effort by all stakeholders. Coordination and the role of CARD as a focal point of dialogue among stakeholders that have different policies and agendas for achieving the strategy constitute a big success story in Cambodia.

THE DEVELOPMENT OF SOCIAL PROTECTION FOR THE POOR AND VULNERABLE

Another success story in Cambodia is the achievement of developing a strategy for national social protection for the poor and vulnerable. The development of this strat-

egy is mainly based on the triangulation of three specific environments (fig. 1). The legal direction is the result of Cambodia’s high-level legal framework, where social protection is a priority of the national government, as expressed in the Constitution, in the Rectangular Strategy for Growth, Employment, Equity and Efficiency - Phase II, in the National Strategic Development Plan Update 2009-2013 and

in various national laws (see box 2). Also important are international conventions to which Cambodia is a signatory. Identification of the gaps in the existing social protection programmes, meanwhile, provided a strong learning experience on which to draw in developing the strategy. Numerous social protection programmes and interventions have been implemented successfully across a range of sectors.

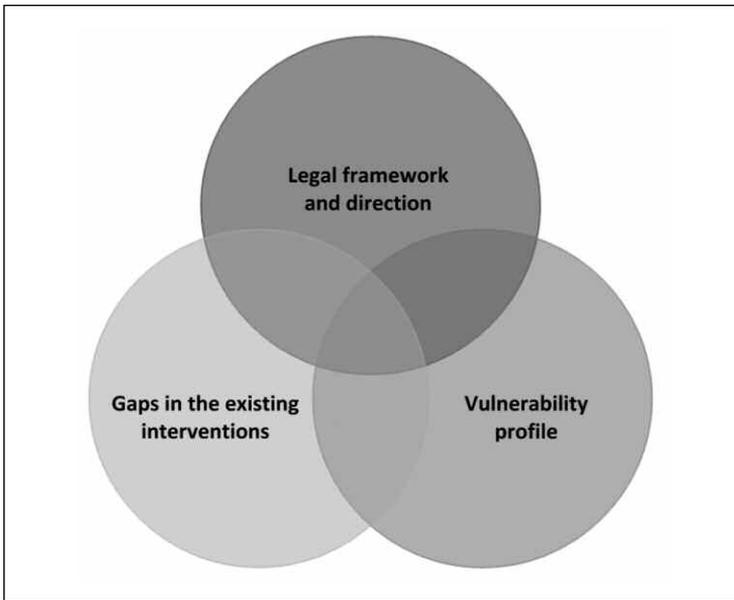


Figure 1 | Triangulation of environments to develop the National Social Protection Strategy for the Poor and Vulnerable.

The main rationale behind a National Social Protection Strategy for the Poor and Vulnerable (NSPS) is the need to accelerate progress towards meeting the Cambodian Millennium Development Goals. Achievement of these Goals has been further delayed by the recent food, fuel and financial crises, which have had a negative impact on the poor and widened social disparities. Social protection, a crosscutting policy area, can address the challenges involved in reduc-

ing poverty, inequality and disparities. The strategic intent of the NSPS is to achieve socio-economic security for the population – as outlined in the Rectangular Strategy - Phase II, the National Strategic Development Plan Update 2009-2013, and sectoral policies and plans – and to bring coherence across policy formulation and implementation. Another consideration is the fact that chronic poverty resulted from three decades of civil wars and the recent eco-

conomic crises, driving people into a situation of transience and being nearly poor.

SCOPE

The national government promotes investment in social protection as both a contribution to long-term poverty-reduction goals and a short-term emergency-/shock-response measure to address the consequences of crises. The poverty and vulnerability of many Cambodians have been exacerbated since 2007 by food-price inflation and the global financial and economic crisis. The latter has affected the fastest-growing sectors of the economy (especially garments, construction and tourism) and has resulted in deterioration in employment, incomes, remittances and access to essential population services. Social protection is an investment in poverty reduction, human development and inclusive growth that contributes to the achievement of the poverty target, which the economic crisis has further widened. The National Social Protection Strategy for the Poor and Vulnerable (NSPS) is thus expected to play a critical role in reducing poverty and inequality.

Following the policy directions outlined in the Rectangular Strategy for Growth, Employment, Equity and Efficiency - Phase II, the national government is advancing social protection for the formal sector while prioritizing expanding interventions aimed especially at reducing poverty, vulnerability, and risks for the poor and vulnerable.

In the medium term, the NSPS focuses on social protection for the poor and vulnerable, who are defined as:

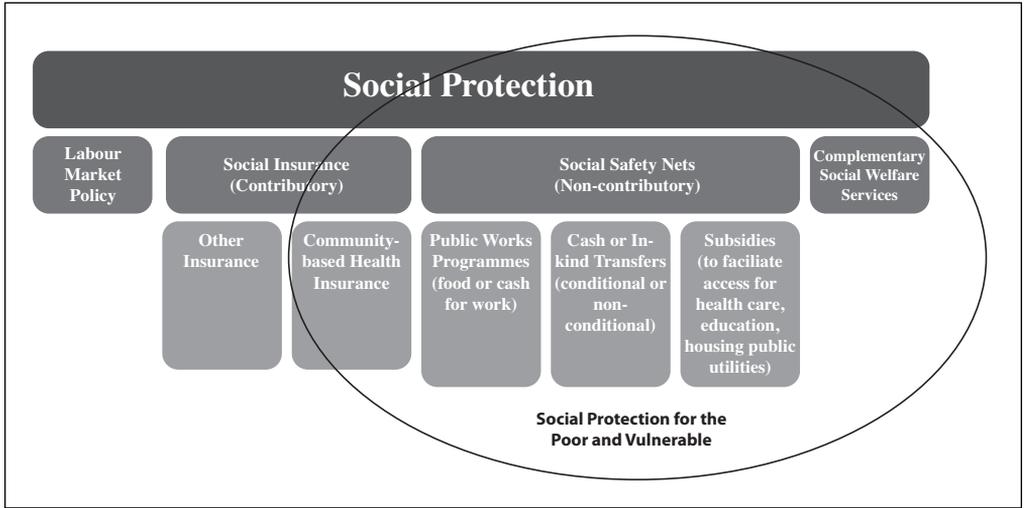
- people living below the national poverty line; and
- people who cannot cope with shocks and/or have a high level of exposure to shocks (of these, people living under or near the poverty line tend to be the most vulnerable) as well as infants and children, girls and women of reproductive age, food-insecure households, ethnic minorities, the elderly, people living with chronic illnesses, people living with HIV, and people living with a disability (vulnerable groups in the NSPS).

The NSPS prioritizes the development of effective and sustainable social safety nets targeted to the poor and vulnerable, with complementary social welfare services for special vulnerable groups, such as people living with HIV and orphans made vulnerable or affected by HIV.¹ The contributory intervention of community-based health insurance is also included since it is targeted at the nearly poor who are vulnerable to falling into poverty as a result of health shocks (see table 4). Figure 2 illustrates the scope of the NSPS.

At the same time, the NSPS sets the framework for sustainable and comprehensive social protection for all Cambodians over the long term. This

¹The HIV Law (Article 26) also enshrines the right of people living with HIV to primary health-care services, free of charge, in the public-health-sector network.

Figure 2 | Scope of the NSPS, focusing on the poor and vulnerable.



includes both contributory and non-contributory schemes. Figure 3 illustrates the relationship between coverage of basic non-contributory social protection for all and contributory social insurance for those with higher incomes, in particular formal-sector workers. The figure can be viewed as a stepwise social protection floor where basic social protection is largely based on the Social Safety Net

provision (as the focus of the National Strategic Development Plan), and the parallel contributory system (National Social Security Fund (NSSF), for instance) is expanded. Based on future economic and social development, more people will be covered over time under an insurance scheme that is based on a social protection mechanism.

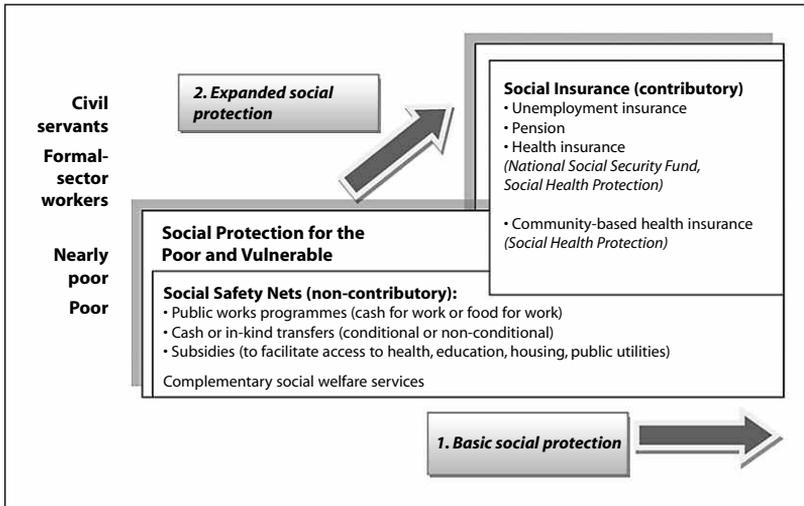


Figure 3 | Gradual progression towards comprehensive social protection as per the long-term provision of the National Social Protection Strategy for the Poor and Vulnerable (NSPS).

The development of comprehensive social protection implies ensuring that the relevant components (non-contributory and contributory) are developed in parallel with a sustainable system whereby those who can afford social protection will access it based on their formal contributions and those who cannot will rely on the State for support until they develop such capacity over time. In between, partially subsidized social protection schemes may be developed for informal-economy workers and their families, who have a limited capacity to contribute. There are linkages and complementarities between the two major components of a comprehensive system of social protection.²

VISION, GOAL AND OBJECTIVES

The National Social Protection Strategy for the Poor and Vulnerable (NSPS) envisions that all Cambodians, especially the poor and vulnerable, will benefit from improved social safety nets and social security as an integral part of a sustainable, affordable and effective national social protection system. The main goal of the NSPS is that poor and vulnerable Cambodians will be increasingly protected against chronic poverty and hunger, shocks, destitution and social exclusion and benefit from investments in their human capital.

From the perspective of achieving this goal, continuing social protection programming on a business-as-usual basis is inadequate. The current dominance of emergency relief and public works represents too limited a toolbox. In the drive to introduce such national social protection programmes, the broader objectives and the range of the instruments of social protection are focused as a response to vulnerability, not just to poverty. In figure 4, the vulnerable or targeted population groups are matched to a wide range of interventions/instruments in response to vulnerabilities.

Under this goal, the NSPS has the following objectives (see also table 12):

- The poor and vulnerable receive support to meet their basic needs, including food, sanitation, water and shelter, in times of emergency and crisis.
- Poor and vulnerable children and mothers benefit from social safety nets to reduce poverty and food insecurity and enhance the development of human capital by improving nutrition and maternal and child health, promoting education and eliminating child labour, especially its worst forms.
- The working-age poor and vulnerable benefit from work opportunities to secure income, food and liveli-

²Including complementary coverage of benefits and services for population groups of different ability, and complementary financing mechanisms towards fiscal sustainability, whereby the contributory system (to a large extent) funds the development of the non-contributory system through its cross-subsidizing function and direct contribution to public revenues as well as through stronger societal support to the system, including through taxation. The ultimate aim of the dual gradual system is to ensure universal coverage to protect the population against risks, shocks and chronic situations and vulnerabilities.

Figure 4 | Matching targeted groups to instruments/interventions to address vulnerabilities.

	Food & Nutrition	Water, Sanitation & Shelter	Access to Affordable, Quality Health Care	Education, Fight against Child Labour	Income Security (Public Works Programmes)	Social Care
Populations in situations of emergency	x	x	x			
Children, women, mothers	x		x	x	x	
Working-age poor and vulnerable			x		x	
All groups			x			
Special vulnerable groups*			x		x	x

* Including orphans, the elderly, single women with children, people living with disabilities, people living with HIV/AIDS and tuberculosis.

hoods while contributing to the creation of sustainable assets of physical and social infrastructure.

- The poor and vulnerable have effective access to affordable, quality health care and financial protection in case of sickness or illness.
- Special vulnerable groups, including orphans, the elderly, single women with children, people living with disabilities, people living with HIV and patients with tuberculosis and other chronic illnesses, receive income, in-kind and psycho-social support and adequate social care.

The achievement of these objectives requires a mix of programmes that cover

both chronic and transient poverty as well as hunger and help to promote human capital. Addressing major sources of vulnerability will take priority while simultaneously building the foundations of an effective safety-net system that can be developed further. Given these priorities, the following are the preferred instruments for short- and medium-term implementation:

- cash and in-kind transfers and fee exemptions (as already being applied in health and education, with new cash-transfer programmes to address high malnutrition and the worst forms of child labour);
- public works programmes (improved labour-intensive

Table 12 | Objectives of the National Social Protection Strategy for the Poor and Vulnerable (NSPS).

Priority Area and Related Cambodian Millennium Development Goal(s) (CMDG)	Objective	Medium-term Options for Programmatic Instruments
Addressing the basic needs of the poor and vulnerable in situations of emergency and crisis (CMDG 1, 9)	1. The poor and vulnerable receive support, including food, sanitation, water and shelter, to meet their basic needs in times of emergency and crisis.	<ul style="list-style-type: none"> • Targeted food distribution; • Distribution of farm inputs; • Other emergency support operations.
Reducing the poverty and vulnerability of children and mothers and enhancing their human development (CMDG 1, 2, 3, 4, 5)	2. Poor and vulnerable children and mothers benefit from social safety nets to reduce poverty and food insecurity and enhance the development of human capital by improving nutrition, maternal and child health, promoting education and eliminating child labour, especially its worst forms.	<ul style="list-style-type: none"> • Cash, vouchers, food or other in-kind transfers for children and women towards one integrated programme (e.g., cash transfers focusing on maternal and child nutrition; cash transfers promoting education and reducing child labour; transfer of fortified foods to pregnant women, lactating mothers and children); • School feeding, take-home rations; • Outreach services and second-chance programmes for out-of-school youth and supporting social welfare services.
Addressing seasonal un- and under-employment and providing livelihood opportunities for the poor and vulnerable (CMDG 1)	3. The working-age poor and vulnerable benefit from work opportunities to secure income, food and livelihoods while contributing to the creation of sustainable assets of physical and social infrastructure.	<ul style="list-style-type: none"> • National labour-intensive public works programmes; • Food-for-work and cash-for-work schemes.
Promoting affordable health care for the poor and vulnerable (CMDG 4, 5, 6)	4. The poor and vulnerable have effective access to affordable, quality health care and financial protection in case of sickness or illness.	<ul style="list-style-type: none"> • Expansion of health equity funds (for the poor) and community-based health insurance (for the nearly poor) as envisioned in the Master Plan on Social Health Protection (pending Council of Ministers approval).
Improving social protection for special vulnerable groups (CMDG 1, 6, 9)	5. Special vulnerable groups, including orphans, the elderly, single women with children, people living with HIV, patients with tuberculosis and other chronic illnesses, receive income, in-kind and psycho-social support and adequate social care.	<ul style="list-style-type: none"> • Social welfare services for special vulnerable groups; • Social transfer and social pensions for the elderly and people with chronic illnesses and/or disabilities.

approaches along with revamped existing cash and food-for-work initiatives, integrating issues of education and child labour); and

- social welfare services for special vulnerable groups.

The National Social Protection

Strategy for the Poor and Vulnerable outlines short- and medium-term response measures to address the consequences of shocks confronting Cambodian citizens and provides a long-term framework for a comprehensive social protection system to contribute to the sustainable reduction of poverty over time.

Table 13 | Options for the near future.

Main Risks and Shocks	Progress to Date in Response	Gaps and Challenges in Response	Options for the Near Future
Situations of emergency and crisis	<ul style="list-style-type: none"> • Public works have shown to be an effective and rapidly expandable safety-net instrument during crises and natural disasters. 	<ul style="list-style-type: none"> • Limited coverage and coordination of existing public works programmes. 	<ul style="list-style-type: none"> • Harmonize public-works approaches and guarantee stable financing; • Establish unit in national government to be in charge of public works for rural development and emergency situations.
Seasonal unemployment and livelihood opportunities	<ul style="list-style-type: none"> • Some targeted food distribution; • School feeding; • Public works programmes are providing some assistance during lean season or crises. 	<ul style="list-style-type: none"> • Limited coverage and coordination of existing public works programmes; • Funding and assistance remain volatile. 	<ul style="list-style-type: none"> • Harmonize public-works approaches and guarantee stable financing; • Establish unit in national government to be in charge of public works for rural development and emergency situations.
Health shocks	<ul style="list-style-type: none"> • Health equity funds are financing health care for the poor in some areas. 	<ul style="list-style-type: none"> • Quality of health care remains poor; • Coverage of/access to health equity funds is not universal. 	<ul style="list-style-type: none"> • Improve and expand social health protection for the poor and vulnerable (health equity funds and community-based health insurance).
Human development constraints	<ul style="list-style-type: none"> • Some maternal and child nutrition programmes are in place; • Breastfeeding practices are improving. 	<ul style="list-style-type: none"> • Supply of maternal and child nutrition services remains limited and of poor quality; • Coverage of these services is not universal. • Other demand-side factors (eating, feeding and care practices) are not being adequately addressed. 	<ul style="list-style-type: none"> • Improve and expand nutrition services; • Develop cash-transfer programme targeting poor families with children; • Design cash-transfer programmes in health and education so that they can eventually be harmonized/coordinated/merged.

Table 13 | Options for the near future (cont'd.).

Main Risks and Shocks	Progress to Date in Response	Gaps and Challenges in Response	Options for the Near Future
Human development constraints (cont'd.)	<ul style="list-style-type: none"> Scholarships and school feeding programmes are improving attendance. Establishment of vocational training curricula; Some programmes are in place for second-chance education. 	<ul style="list-style-type: none"> Quality of education remains poor; Coverage of education services is variable; Coverage of scholarships and school feeding programmes does not reach all poor areas. Quality of vocational training remains poor; Supply of second-chance programme is minimal; Poor link between training offered and employers' needs; No certification/ accreditation system in place for private sector. 	<ul style="list-style-type: none"> Improve quality and access to education; Expand programmes addressing demand side (in particular, scholarships) both in terms of coverage and covering all years of basic education; Improve coordination of education and child labour programmes. Boost second-chance programmes; Improve quality of vocational training programmes by linking training to employers' needs; Develop certification/accreditation system to regulate quality of training provided.
Special vulnerable groups	<ul style="list-style-type: none"> Pensions for civil servants, National Social Security Fund for private-sector employees; Some donor assistance to the disabled. 	<ul style="list-style-type: none"> No pensions for the poor ; Very limited assistance to the disabled; Limited assistance to other special vulnerable groups. 	<ul style="list-style-type: none"> Identify and pilot social protection programmes for the disabled and elderly poor and other special vulnerable groups; Extend targeted cash-transfer programme to the elderly and disabled.

For the long term, the National Social Protection Strategy for the Poor and Vulnerable (NSPS) sets the framework for sustainable and comprehensive social protection for all Cambodians. The aim is to achieve universal coverage for risks and vulnerabilities with a basic package of transfers and services commensurate with the economic development of the country in accordance with the Social Protection Floor Initiative. This compris-

es both contributory social security mechanisms for the formal sector and improved social safety nets for the informal sector.

IMPLEMENTATION

Implementation is the responsibility of line ministries and decentralized government institutions. The active involvement of decentralized structures of gov-

ernment (provincial, district and commune councils) is essential to successful implementation. Some of the key interventions outlined earlier are already ongoing. The National Social Protection Strategy for the Poor and Vulnerable thus complements the efforts of line ministries in achieving sector targets by using existing sector-embedded social protection measures. To increase impact, coverage of these measures needs to be expanded or their implementation streamlined and harmonized.

Other interventions, new to Cambodia, will be piloted, evaluated and expanded based on effectiveness and sustainability. These new programmes will address existing social protection gaps for the poor and vulnerable by relieving chronic poverty, promoting equity and investing in human capital.

COORDINATION

The National Social Protection Strategy for the Poor and Vulnerable (NSPS) adds value by providing a framework to support ministries and subnational institutions in delivering interventions that are sustainable, effective and efficient. Most programmes in the NSPS are by nature inter-sectoral and require coordination across ministries and government agencies to avoid thematic and geographical overlaps, to harmonize implementation procedures and to coordinate the effective and effi-

cient use of available funds from the national budget and development partners. Coordination also entails active dialogue with supportive development partners and civil society organizations.

According to the National Strategic Development Plan Update 2009-2013, the Council for Agricultural and Rural Development (CARD)³ is mandated to ensure that effective inter-ministerial coordination mechanisms are in place involving Government ministries and agencies responsible for delivering social safety-net programmes to the poor and vulnerable. At the third Cambodia Development Cooperation Forum, CARD is to establish the Provisional Social Protection Unit. The primary tasks are to evaluate the workload scope of coordinating the implementation of social protection interventions at the national and subnational levels and to develop the cost of the social protection programme. Coordination of the development, implementation and monitoring of an effective and affordable NSPS includes policy oversight, monitoring and evaluation, knowledge and information management, and capacity-building.

This will entail the following actions:

1. Establish an appropriate structure and mechanisms to coordinate the development and implementation of the National Social Protection Strategy for the Poor and

³CARD is a permanent structure of the Government for coordinating the activities of agricultural and rural development, with the specific task of developing of a social protection strategy. CARD comprises representatives of about 27 Ministers or Secretaries of State. The process is mainly mandate-based whereby CARD is establishing itself as coordinator but not as an implementer of any programme (which is different from the situation in some other countries where this kind of council tried to implement the social protection programme on its own).

Vulnerable (NSPS), ensuring policy oversight, partnership and dialogue, monitoring and evaluation, and information and knowledge management.

2. Establish a monitoring and evaluation framework for the NSPS in order to ensure effective, cost-efficient and transparent implementation and provide evidence-based feedback for the further development of programmes and interventions of the NSPS.
3. Develop an annual progress report on the NSPS through a technical consultation process.
4. Strengthen social protection information and knowledge management to ensure the up-to-date collection, generation and dissemination of information among stakeholders.
5. Develop capacity to ensure understanding and build skills for effective implementation of the NSPS at national and decentralized levels.

Close monitoring and evaluation of interventions and programmes and of the strategy as a whole, together with effective knowledge management, will be crucial for ongoing strategic development.

FINANCING A SOCIAL PROTECTION STRATEGY

The consolidated costing of the overall strategy is to be developed between June

and December of 2010. Two design scenarios are proposed: the costing of coordination, and the costing of piloting the short- and medium-term priorities. The costing exercise will be part of a broader social-budgeting exercise, including a social protection expenditure review and a modelling of future social expenditures and revenues that takes into account assumptions on the extension of coverage (number of persons to be covered, contingencies and levels of coverage, etc.) by existing and planned schemes. This exercise would be very useful to assess the viability and financial sustainability of the different schemes planned and should lead to a discussion on the fiscal space for social protection (and the necessary long-term commitment of the Government, development partners and other funding sources). In addition, it will help to refine the design of the planned schemes and provide evidence in the choice of the most appropriate/feasible scenario.

It is hard to determine the level of spending on social protection by the national government given the current budget structure. Government expenditure on these items totalled US\$181 million across all government agencies in 2008, showing a 55 per cent increase from 2007. Nevertheless, given the level of aggregation in the budget, it is impossible to determine how much of this goes to social protection activities and how much to other types of social intervention. Most of the explicit social protection spending currently targets public employees and workers in the formal sector.

Table 14 | Estimated cost of a cash-transfer programme.

Item	Value
Total population, 2007	13,395,682
Share of population living in rural areas, 2007 (%)	79.80
Population living in rural areas, 2007	10,689,754
Extreme poverty rate in rural areas, 2007 (%)	20.78
Number of extremely poor people, 2007	2,221,331
Composition of household: children under 5 yrs. of age in lowest quintile (%)	11.5
Total number of extremely poor children under 5 yrs. of age	255,453
Number of extremely poor pregnant mothers	43,302
Total number of beneficiaries	298,755
Size of benefit per child/mother (\$)	15
Yearly frequency	4
Total yearly transfer per child (\$)	60
Total cost of benefits only - per year (\$)	17,925,293
Administration costs (%)	10
Total cost of programme (\$)	19,717,823
Gross domestic product, 2008 (\$)	9,573,000,000
Total cost of programme as percentage of GDP	0.21

Source: Cash-transfer programme to support the poor while addressing maternal and child malnutrition: A discussion note, March 2010.

CHALLENGES

Social protection programmes in Cambodia may face several challenges relating to implementation, institutional and financing issues. From an implementation point of view, the challenge is the move from fragmented project-based interventions to the more integrated and systematic programme beyond 2013. While the current safety net interventions exclude some important vulnerable groups, the newly developed National

Social Protection Strategy for the Poor and Vulnerable (NSPS) is to include the broader objectives and range of instruments of social protection and is focused as a response to vulnerability.

Given the many sources of vulnerability faced by the country's poor, safety nets ought to be a key component of the development of social protection. Cambodia has implemented many major donor-supported projects and programmes to reintegrate, rehabilitate and improve food security; to effectively respond to

emergency situations; and to improve the livelihood of poor Cambodians. Still, the country has not yet made significant use of some types of safety net programmes that have proved successful in other countries – for instance, the conditional cash transfers (programmes that provide households with cash payments so long as they make use of public services). Institutionally, the experience of a social safety net is not new to Cambodia, but the term and understanding might be conceptually different. Over the last 18 months, participatory dialogue among line ministries and government institutions with development partners has been very crucial and this process must be sustained in the long term. Last but not least, owing to the budget constraint, financing of the social protection programme must be seen as an investment rather than as an expenditure.

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^{iv} World Bank, *World Development Indicators 2008 and Global Development Finance 2008*.

^v National statistics, 2009.

^{vi} World Bank, *World Development Indicators 2008 and Global Development Finance 2008*.

^{vii} Ibid.

^{viii} Ibid.

^{ix} National Statistics, 2008.

^x UNDP, *Human Development Report 2009*.



Chile

Population ⁱ	16,803,952
Age structure	
• 0-14 years	23.2
• 15-64 years	68.1
• 65 years and over	8.8
Infant mortality rate (per 1,000 live births) both sexes ⁱⁱ	7
Life expectancy at birth (years) female	81.7
Life expectancy at birth (years) male	75.6
Maternal mortality ratio (per 100,000 live births) ⁱⁱⁱ	16
GDP per capita	
• Current USD ^{iv}	10,084
• PPP (current international \$) ^v	14,436
• Constant local currency	3,848,916
Unemployment rate ^{vi}	8.6
Human development index (HDI) rank ^{vii}	44
HDI poverty indicators – Human poverty index rank	10

The *Red Protege*, the Social Protection System, 2006-2010

Clarisa Hardy

7
Chile

Summary

The social protection system, the *Red Protege*, integrated with intersectoral components (mainly education, health, housing and social security), is organized in three core parts or subsystems:

- the poverty and vulnerability social protection system (Chile Solidario);
- the comprehensive child social protection system (Chile Crece Contigo); and
- the labour social protection system.

The social protection system elaborated between 2006 and 2010:

- supports and guides people throughout their life cycle;
- considers the family, in all its diversity, as the recipient and not the supporter of social protection;
- combines direct monetary transfers (immediate distributive actions) with promotional or development initiatives to build and equalize opportunities; and
- secures rights based on a legal framework that institutionalizes social protection.

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INTRODUCTION

The most significant shift in the direction of social policies in Chile in the last 20 years – counting from 1990, when the democratic process resumed after being interrupted by the 1973 military dictatorship – is the transition from a logic based on satisfying basic needs to one of guaranteed rights.

Although a great effort was made to progress in social development in the first decade of the democratic governments of the Concert of Parties for Democracy (Concertación de Partidos por la Democracia), the majority of the public policies were directed to dealing with the magnitude of poverty inherited from the dictatorship period. It was only in the late 1990s – which saw marked progress in

eradicating poverty through two consecutive governments – that a new social-policy model based on guaranteed social rights began to be endorsed.

The first initiatives emerged under the government of President Ricardo Lagos (2000-2006). These initiatives included a new programme for overcoming poverty, called Chile Solidario, which covers the provision of minimum guaranteed benefits for the poorest families in the country. Guaranteed rights were also present in a health reform that, through the Universal Plan of Explicit Health Guarantees (el Plan de Acceso Universal con Garantías Explícitas, AUGE), establishes explicit assurances for a set of pathologies. Likewise, the unemployment insurance was guaranteed for all formal-sector workers.

These guidelines were adopted by the successive government of Michelle Bachelet (2006-2010),¹ which is moving towards not only guaranteeing social rights to the population (including all social policies throughout the life cycle of families) but also extending these rights to social groups further away from poverty and institutionalizing them in the form of a social protection system. For purposes of public dissemination, the system was named the *Red Protege*.

This case study, which sheds light on the social protection system, the *Red Protege*, first reviews the context in which this social protection system emerged: the political, economic and social back-

ground that preceded it between 1990 and 2006. This is followed by an analysis of the conceptual and empirical foundations that support the system. The third part of the study presents the characteristics of the social protection system and its components as well the instruments used for its implementation. The case study concludes with a discussion of the legal and financial mechanisms that make the *Red Protege* feasible as part of a political agreement that allows social protection to be understood not as a government programme but as a definite State policy – a policy not to be questioned at every change of government.

BACKGROUND (1990-2006)

The broad social achievements to which the democratic governments initially committed themselves were overcoming poverty, ensuring the transition from dictatorship to democracy, and building political trust in the ability of the ruling centre-left coalition to manage the economy responsibly. This combination of priorities to establish and stabilize democracy, to govern the country's economy responsibly and to integrate the poorest people into Chilean society was what enabled the centre-left alliance to rule without interruption for 20 years, through four successive governments, and to guarantee gradual institutional continuity to social policies, achieving successful results in terms of overcoming

¹During the Lagos government, a political reform shortened the presidential term from six to four years – a reform that came into effect with the next administration.

poverty and universalizing access to social benefits.

Between 1990 and the start of the Bachelet administration and the implementation of the social protection system in 2006, the rate of economic growth in Chile averaged 5 per cent (including the recession period caused by the Asian crisis), per capita income tripled (from US\$3,000 to approximately US\$10,000),² and poverty decreased from 38.7 per cent to 13.7 per cent of the population. Extreme poverty, meanwhile, declined from 13 per cent to 3.1 per cent. In relation to the rest of Latin America, Chile went from being the country with the fifth-highest poverty level in 1990 to the one with the least amount of poverty in 2006.^{viii}

At the same time, there have been advances in securing universal access to social benefits, including the achievement of universal coverage in primary education; the reduction of secondary-education dropout rates (now less than 15 per cent); a marked decrease in maternal and child mortality (from 65 maternal deaths per 1,000 to 16 per 1,000 between 1990 and 2006, and, for child mortality, from 18 per 1,000 live births to 8 per 1,000 for the same period); the disappearance of malnutrition (from 5 per cent to 0.5 per cent of children in 15 years); and an increase in life expectancy, with the national longevi-

ty now similar to that of more developed countries.^{ix} These indicators are among the most relevant and the most useful in explaining the prominent rank that Chile now holds in the human development index – a position that enables it to join the group of countries with the highest level of human development and that places it at the head of the group (along with Argentina and Uruguay) for the best social results in Latin America.^x

The backdrop to this poverty reduction and progress on basic social indicators has been a fiscal policy option, regulated since 2000 (with the government of Ricardo Lagos), that, on the basis of the structural balance rule, supported the escalation of social spending, thus counteracting and preventing adverse economic cycles from punishing social spending and investment. In this way, Chile has been able to overcome economic crises by uninterruptedly increasing social spending, which now accounts for two thirds of total public expenditure.

Notwithstanding these significant social-integration indicators, which have enabled large segments of the population to break the circle of poverty and marginalization, distributional inequalities remain virtually unchanged³ and discrimination continues to prevail with respect to unequal citizenship rights (owing to socio-economic reasons, gender, ethnicity,

²At the end of Michelle Bachelet's term (in March 2010), per capita income reached about \$15,000, thus integrating Chile into the region's middle-income group of countries. This is important to keep in mind for the purpose of understanding the scope of Chile's social protection system and the lessons to be learned from countries with similar socio-economic realities. *Source:* Treasury Department, Government of Chile.

³Between 1990 and 2006, the Gini coefficient slightly dropped from 0.57 to 0.54. Ministry of Planning and Cooperation (MIDEPLAN), "Serie 2: Distribución del Ingreso e Impacto Distributivo del Gasto", Survey of Socio-economic Characteristics (Encuesta de Caracterización Socioeconómica Nacional, CASEN) 2006.

age and territorial differences).^{xi} These realities highlight the problem of social risks and defencelessness that hits thousands of socially unprotected households even if they are not poor or not only because of their poverty.

This scenario of combined economic progress, countercyclical policy and fiscal responsibility, low levels of poverty and the progressive universalizing of access to social benefits, along with the prevalence of inequalities, led to a shift in social policy as of 2000. This shift was consolidated during the government of Michelle Bachelet through the implementation of an approach of guaranteed rights for a broad set of social policies.

CONCEPTUAL AND EMPIRICAL FOUNDATIONS

Two aspects influenced the change in social policies and the shift from the view of people as “subjects of necessity” to “subjects with rights”: the existence of a more informed citizenry, aware of its rights and demanding of their enforcement, and the rapid socio-economic change experienced by Chilean society in a short period.

Regarding the first factor, as the tran-

sition to democracy and the establishment of civil and political rights progress, the population is growing less and less dependent and subordinate, having become aware of its rights and therefore able to demand that they be enforced. Since the late 1990s, after a decade of democratic governments, an increase in social mobilization has been observed in neglected sectors and in workers’ sectors that had held back – owing to fears that an authoritarian regime would return – on asserting their demands at the beginning of the transition to democracy.

This new political reality comes at a time when Chilean society is experiencing rapid social and economic changes: all the empirical evidence shows not only an accelerated reduction in the magnitude of poverty but in its “quality”, with the transition from a traditional to a modern poverty (a more educated populous, with access to improved housing conditions and basic social services, etc.).⁴ At the same time, the number of non-poor who are working in low-paid and precarious jobs has increased,^{xii} which produces a rise in mass access to benefits, though of a very different quality.⁵ This situation creates, along with increased expectations of social mobility, frustrations and uncertainties associated with these new inequalities.

⁴This trend can be observed in the general modernization of the consumption pattern of the population, when comparing the last two Population Censuses (National Institute of Statistics, 1992 and 2002, Government of Chile), and the changes observed in terms of mass access to benefits and social services, housing and basic social infrastructure, and telephone and the Internet, to mention a few important areas (Ministry of Planning and Cooperation, CASEN from 1990 to 2006).

⁵As many opinion polls reveal – polls that reflect the perceptions of public opinion and are supported, for example, by large gaps in the academic performance of students in public and subsidized private education compared to those who attend private schools financed entirely by families. *Source:* Quality of Education Measurement System (Sistema de Medición de Calidad de la Educación, SIMCE), Ministry of Education.

Poverty rotation is another important indicator of these changes as well as a manifestation of inequality phenomena, as evidenced by longitudinal studies conducted with the same group of nuclear families during a period of 10 years.^{viii} In fact, these studies show that approximately one third of poor families that cease to be poor re-experience an episode of poverty at a certain point in their life cycle. On the other hand, families that are not poor do experience poverty conditions at some stages of their life. Successful poverty alleviation policies do not necessarily address the risks of falling into poverty – risks that are unequally distributed in society since vulnerabilities are unevenly spread out in a society with large socio-economic gaps. Indeed, 70 per cent of households have incomes below the national average income.^{xiv}

This shows that social protection policies that persist in targeting only the poorest run the risk of becoming regressive, considering the extent of vulnerable non-poor sectors that, without any support, face either low incomes or uncertainty and job instability, or both.⁶

Figures on the distributional impact of social spending are illuminating, showing the significant distributive efficacy of the

State in society's poorest segment. However, the distributional impact is considerably lower in segments that are non-poor but still low-income; these segments have significant levels of vulnerability. The poorest decile of the population nearly tripled its revenues thanks to cash transfers and State health and education subsidies. Meanwhile, the following decile almost doubled its total revenues because of State intervention. However, from the third decile on, transfers decline considerably and are especially low between the fourth and the seventh decile, seeing as these households have incomes (as noted earlier) that fall below the average national income, which itself is low.⁷

In short, two thirds of Chilean families have incomes that are well below the national average and, of these families, barely less than half benefit from significant transfers.

Thus, at the beginning of the Bachelet government, the dilemma facing the new administration was not, as was the case a decade ago, how to reduce poverty but how to prevent its emergence and reproduction and how to ensure social protection (the observance of social rights) to those in need either because of their poverty conditions or

⁶Data disaggregated by deciles of the CASEN 2006, regarding education, the national labour force participation rate and female participation rate, unemployment, housing, female-headed household and national income share, which all reveal very high vulnerability in the first two deciles but also the presence of different grades and types of vulnerability between the third and the seventh decile (Ministry of Planning and Cooperation, 2006, "Serie 2..." and "Resultados de Trabajo...").

⁷For purposes of illustration and for providing examples in Chilean pesos, the average income of the poorest decile amounts to Ch\$63,866. Adding the cash transfers and health and education subsidies, the total revenue in the first decile rises to Ch\$164,595. In the case of the second decile, the average income amounts to Ch\$144,442 and with social spending transfers ends up at Ch\$229,621. This trend continues but declines gradually until the seventh decile, whose households have an average income of Ch\$437,417, in which case the transfer of social spending will add only Ch\$30,000, scarcely useful to cover expenses for education – especially higher education – or catastrophic illnesses and chronic diseases, etc. (Ministry of Planning and Cooperation, 2006, "Serie 2...").

their vulnerability that exposes them to risk of impoverishment.

Based on the notion of citizenship rights in their most complete sense (civil and political as well as economic, social and cultural rights) and in consideration of the social reality of inequality that unevenly distributes opportunities and capabilities, the Bachelet government established the social protection system, the *Red Protege*.

The prevailing socio-economic reality and the choice of a social policy aimed at addressing social vulnerabilities led the Bachelet government to recognize the necessity of extending social protection coverage to a radius that goes beyond poverty. However, the coverage of social protection components was not uniform and was defined differently for each component according to budget frameworks determined by economic authorities. Hence, the degree of coverage of the whole social protection system did not rely on analysis of the types of risk and vulnerability traits to be protected.

In fact, although the social protection system, the *Red Protege*, was extended beyond poverty, its coverage was different for each benefit (from protecting 20 per cent of the lowest incomes in the case of certain benefits to universal coverage of others); the notion of a standard population to be protected, whose definition

would determine budgetary requirements, was ignored. This matter was still pending at the end of the Bachelet government, and the need to extend social protection to the middle class was part of the presidential campaign at the end of 2009 (and is now part of the present political debate).

THE SOCIAL PROTECTION SYSTEM, 2006-2010: FEATURES, COMPONENTS AND TOOLS

The central features and logic behind the social protection system elaborated between 2006 and 2010 can be summarized as follows:

- **to support people throughout their life cycle.** For the first time, the social protection system recognizes the need to address, in an indivisible way, the beneficiaries of social protection policies throughout their life cycle, from birth to old age, not only privileging certain periods of their life or only certain age groups;⁸
- **to consider the family, in all its diversity,⁹ as the recipient and not the supporter of social protection.** In families, it is likely to find members at different stages of

⁸A logic that has not been present in many known welfare models, which have generally favoured the final stage of the life cycle, focusing on pension schemes or retirement benefits at the expense of initial life stages or the protection of children, which is often partially or entirely marginalized. This has the effect of placing total or partial responsibility for childcare onto families (mothers), which not only leaves children unprotected but, given the nature of gender relations in the domestic and working realms of most countries, also imposes overly heavy demands on women's roles in society.

⁹The changes introduced, since 2006, in many programmes and cash transfers have enabled the extension of benefits to various forms of family and not only to married couples, which actually represent only half of Chile's families.

their life. This leads to a view of the nuclear family as the unit that needs to be protected – as opposed to isolating only some of its members for protection. This notion allows the synergy of different actions towards all members in the family group and the demand for the intersectoral actions that such an approach involves. Additionally, the absence of a predefined notion of the kind of family to be protected and the deployment of the system to the plurality of existing families – which freely and privately define their members – avoid the exclusion of non-traditional families. Most importantly, however, the distinguishing feature of this system is that it defines the family as a subject of protection as opposed to a unit that must bear the burden of the protection of its members. This is exemplified by the massive policies of child care and pre-school education introduced in 2006, which cover the period from nursery to kindergarten, thus giving mothers the time to study and work without compromising the cognitive and emotional development of children;

- **to combine direct monetary transfers (immediate distributive actions) with promotional or development initiatives to build and equalize opportunities (social investment with distributive impact in the medium term).** This is a central aspect of the new orientation of social policy, which

openly expresses an immediate redistributive option through cash transfers and housing subsidies, in combination with an option of equal opportunities, as a distributive medium-term strategy carried out through investments preferably but not exclusively in education and health. The articulation of these two components and their mutual determination allows cash transfers to be part of (but not to substitute for) opportunity policies; and

- **to secure rights based on a legal framework that institutionalizes social protection, specifying by law which rights are guaranteed and how they are to be extended.** Such areas as the coverage of diseases in the Universal Plan of Explicit Health Guarantees (Plan Acceso Universal con Garantías Explicítas en Salud, AUGE), the number of years of schooling guaranteed, the coverage of family allowances, basic solidarity pension, maternity protection and child care are expressly formulated in the relevant laws and regulations that operationalize the legal framework, gradually altering the previous arrangements in which budgets defined the type and extent of rights to be covered.

The social protection system has three core parts:

- **the poverty and vulnerability social protection system, Chile Solidario**, originally designed (in 2003 when its implementation

began) for families living in extreme poverty. As the system began making progress in the eradication of poverty, it started to incorporate other sectors of society, including non-indigent poor populations or groups with specific vulnerabilities, such as the homeless, the elderly and families with a disabled family member. For families of Chile Solidario, guarantees of rights are established in such important areas as: child, adolescent and adult education; health care for the whole family; and employability and income-generation programmes for heads of households. Perhaps the most innovative aspect of Chile Solidario is the personalized intervention in each family that makes this possible. Through professional psychosocial support, these interventions strive to reinforce family dynamics in order to restore or strengthen family ties and ways of living together as a condition for mobilizing personal will for integration and for exerting rights. The greatest achievement of Chile Solidario is managing to bring public services to the poorest and the most vulnerable – those who, despite being entitled to such rights, were not able to access them owing to misinformation, lack of initiative (the learned helplessness of systematic poverty) or inefficiencies in the public system. In addition, this system has generated sectoral coordination through its highly decentralized

operations and management;

- **the comprehensive child social protection system, Chile Crece Contigo**, designed to reach children in their early years and until they enter the school system. Chile Crece Contigo takes into account not only the rights of children ages 0 to 4 years but also maternity protection and the incentive for socially protected work of women. Among the rights guaranteed, there is a special subsidy for pregnant women (for the entire gestation period) and for children (from birth to 18 years of age) that reaches 40 per cent of the most vulnerable households. In addition, there are free nurseries and kindergartens – with time schedules personalized to the needs of mothers who work, study or seek employment – that are guaranteed to 40 per cent of the most vulnerable households in the first stage of implementation and are extendable to 60 per cent in the second stage as of 2010. Two other goals of Chile Crece Contigo are to humanize the process of pregnancy's labour throughout the public health system and – through primary health-care centres – to support the biopsychosocial development of children in the first year of life. Child development funds for children with disabilities – as well as preferential housing benefits, legal assistance, and job training for the mothers and fathers of these chil-

dren – will cover 40 per cent of the most vulnerable households. As in the case of Chile Solidario, the decentralized management of the comprehensive child protection system allows the synergy of all sectoral services located in the communities, the health system being the entry point when mothers have their first pregnancy check-up. It is important to keep in mind that 80 per cent of mothers are cared for by the public health system; and

- **the labour social protection system**, designed to promote decent work of male and female workers. This system led to legislation to regulate outsourcing, to impose a sanction on anti-union practices, and to establish labour courts and a labour council (although other legal initiatives are still pending, especially those relating to collective bargaining). It also includes unemployment insurance improvements. In order to protect the elderly at the end of their working life, the reform of the pension system provides for the strengthening of the non-contributory solidarity pillar. This measure protects all elderly men and women who have not planned for their old age by granting them a basic solidarity pension. This pension will cover 40 per cent of the lower-income households in the first stage and 60 per cent in the second stage (starting in 2010). This reform of the solidarity pillar also includes

State contributions for low pensions, social security contributions for youth and a bonus to all women for each child born alive. This way, women can increase their pensions if they are contributing workers or if they do not contribute but receive a basic solidarity pension.

These three axes are integrated with cross-sectoral components, particularly health, education and housing components. Since health has a central role throughout the life cycle, it is addressed through such areas as: bio-psychosocial support during pregnancy and the first year of life; strengthening of family health care, including during pregnancy and childbirth; reproductive health and teen pregnancy prevention; occupational health and safety; and special and free care for bedridden seniors.

To illustrate the deployment of the social protection system, the *Red Protege*, over the entire life cycle, the following table summarizes the main benefits provided during the stages of infancy; childhood and youth; adulthood; and, finally, old age.

In order to direct services to users, the social protection system, the *Red Protege*, requires instruments capable of identifying the factors of poverty and vulnerability. In this way, it can attend to personal and family situations and to the characteristics of the territories in which these families live – characteristics that may limit or exacerbate the families' living conditions.

Components of the social protection system, the *Red Protege*, throughout the life cycle

Stage of the Life Cycle	Benefit
Infancy (from pregnancy until school entry)	<p>Chile Crece Contigo</p> <ul style="list-style-type: none"> • Guide to pregnancy and the first year of life; • Bio-psychosocial support in the first year of life; • Extension of post-natal care to adopted children; • Free nurseries and kindergartens (0-3 years) for 60 per cent of lower-income households; • Automatic child benefit for 40 per cent of lower-income households.
Childhood and youth	<ul style="list-style-type: none"> • Guaranteed free pre-kindergarten and kindergarten (4 to 5 years of age); • Obligatory primary and middle school; • Extension of the scholarship system; • Diversification of student support (study materials, food, school transport); • Extension of scholarship in higher education (technical college and universities) and postgraduate education; • Housing subsidies for young people; • Subsidy for the hiring of young workers.
Adulthood	<ul style="list-style-type: none"> • Equal wage for men and women; • Non-discriminatory curriculum and code of good working practices in the public sector; • Benefit to mothers for each child born alive; • Job training; • Unemployment insurance; • Housing subsidies for 40 per cent of lower-income households.
Old age	<ul style="list-style-type: none"> • Basic solidarity pension for 60 per cent of lower-income households and disabled people; • Solidarity pension contribution for lower-income households; • Subsidy for caregivers of bed-ridden people.

The Government has developed instruments capable of identifying these social and territorial vulnerable conditions and identifying and assigning the type(s) of services needed:

- **social protection form:** A cus-

tomized instrument for access to the social protection system that identifies the families and individuals of the various programmes and benefits on the basis of their application, by request, at the community level. More than

10 million Chileans (over half the population) have their data recorded on a social protection form in all municipalities;

- **regional vulnerability maps:**

Contain the mapping of those territorial units that show no presence or a weak presence of services, and deteriorating environmental and living conditions. These units serve as a basis for a comprehensive and decentralized model of social protection intervention. Therefore, these maps are a tool that enables the prioritizing of social investment in basic services, especially connectivity, energy, water and sanitation or sewage treatment;

- **the Survey of Socio-economic Characteristics (CASEN):** An essential tool for the identification, characterization and measurement of orders of magnitude of the poor and vulnerable population (with different vulnerabilities to be covered by the social protection system). Mainly, however, the CASEN is an instrument for evaluating social policies and the distributive impact of social spending. Currently, the Survey is done every three years, but there are discussions on carrying it out more periodically to track yearly the impact of social policies. Besides this instrument, there exists an ex-

post permanent evaluation process for social impact programmes and investments, which evaluates a number of these programmes each year as background to the discussion of the Budget Law. The results of this evaluation process are decisive for establishing the continuity, interruption or redesigning of the programmes in question, whose budget is determined in terms of compliance with the evaluation's recommendations;¹⁰ and

- **the Integrated Social Information System (SIIS):** Its function is to provide timely, relevant and detailed social information concerning the entire social services network, which reaches families through the social protection system, the *Red Protege*, and thus allows for the network's monitoring and tracking. This implies having a public sector capable of immediately responding to the specific social protection needs of families. This system, which has not yet been fully implemented, requires that all social information from all government departments be scanned and that all administrative records be operationally centralized. It is also a legal requirement associated with the cross-sectoral social protection system.

¹⁰This procedure was agreed to by the Ministry of Finance and the National Congress in 1998 and has, to date, been used to evaluate more than 300 programmes, some of them more than once.

CONDITIONS OF FINANCIAL AND POLITICAL FEASIBILITY

As the Chilean case shows, the feasibility of a social protection system is based on its institutionalization, which relies on bodies and legislation to ensure its funding and management arrangements.

POLITICAL CONDITIONS: DEMOCRATIC DELIBERATION AND PARTICIPATION

The *Red Protege* is not a government programme but a legally regulated social protection system providing multiple services whose funding is secured by law. Thus, the first condition for the feasibility of the social protection network has been the strength of the country's political system, which has made it possible for the initiatives included in this network to achieve standards based on important democratic deliberations in the National Congress. Ultimately, these deliberations resulted in the obtaining of an equal commitment from both the opposition and the current governing forces, thus ensuring the institutionalization and continuity of the system even in the scenario of a change in power.

Yet one of the most interesting variations in the democratic process to achieve social reforms and their institu-

tionalization in the social protection system has been the participatory initiatives pushed by the last government of the Concertación, led by Michelle Bachelet. Although the initiatives were criticized at the time by the opposition, they are being replicated as a formula for the new government, which is composed of the same political forces that criticized them earlier. These participatory bodies, the so-called Presidential Advisory Committees,¹¹ created conditions for achieving greater transversal political agreements between the divergent political forces in the parliament. The Committees were convened to address reforms in issues pertaining to social protection, placing special emphasis on child-protection policies (which would lead to the legal establishment of Chile Crece Contigo) and on pension reform (the precursor to the current pension reform in force). The participatory processes discussed previously also resulted in the less effective Committees on Education and on Labour and Equity. These Committees culminated in major disagreements over the previous Committees but also led to some legislative initiatives. These initiatives included the creation of a set of institutions responsible for the quality of education in the case of the Committee on Education and the subsidy for the hiring of young

¹⁰The Presidential Advisory Committees, which originated during the first several months of the mandate of President Bachelet, were created to address some of the issues of the presidential campaign that involved substantive reforms requiring extensive parliamentary agreements. To clear the way before the parliamentary debate and to reflect the initiatives' pluralistic views on the respective subjects, these Committees included multidisciplinary experts with different values and political views and social actors involved in possible reforms. In addition, almost all of these Committees organized regional consultations and hearings with civil society organizations, hence broadening participation in the formulation of proposals. In a maximum six-month time frame, the reports emanating from these Committees were taken by the Government as a guide for the drafting of bills, almost all of which were later submitted to parliament. Among the most emblematic Committees associated with social protection were those relating to child protection, pension reform, educational quality, and the quality of work and equity.

workers in the case of the Committee on Labour and Equity.

Thanks to this participatory mechanism, which enabled many agreements and disagreements between key actors to be processed prior to the release of the respective government bills to parliament, the length of time for congressional approval of laws has been considerably reduced. In fact, the deliberation of members of the Presidential Advisory Committees and public hearings led to reports containing agreed proposals and divergent positions (in lesser numbers). With these reports, which largely cleared the political-technical debate, the Government drafted the respective bills, which, once submitted to Congress, facilitated the discussion and agreement of parliamentarians.

In summary, thanks to this procedure, the Chile Crece Contigo Act on child protection and the Pension Reform each took only about a year to be approved and become effective in the same presidential term. This contrasts, for example, with health reform and the establishment of the AUGE Plan, which, managed by the previous administration and implemented through the traditional procedure, required more than three years of parliamentary debates.

FINANCIAL CONDITIONS: FINANCIAL AND MANAGEMENT SUSTAINABILITY

In the Chilean presidential system, only the executive branch of the government

can take legal initiatives that require financing. Consequently, all initiatives and reforms proposed by the executive branch to the parliament have required the presentation of detailed information about the requisite financing and guarantees about what funding sources will permit these initiatives and reforms. In effect, this ensures their sustainability and therefore their continuity as State policies, eliminating the risk of having these initiatives and reforms left to the discretion of successive governments.

The legal framework that supports all the initiatives of the *Red Protege* establishes the financial commitment required for their implementation, from the initial deployment until the time that they come into full force.

The introduction of these legal changes, which led to the approval of initiatives based on guaranteed social rights, generated a new phenomenon. For the first time since the introduction of cash subsidies related to the *Red Protege* and since the regulation of coverage, the Treasury has been forced to provide resources for all citizens who request them (and qualify for benefits). In the past, there were waiting lists of people who qualified for benefits but could not obtain the subsidies since the provision of resources was set annually in the Budget Law at the discretion of economic authorities.

With the establishment of a protection system of rights guaranteed by law, obligations were increasingly imposed on

the public budget, whose expenditure on social spending cannot be reduced or redirected to alternative uses.

The structural-balance policy, a fiscal policy instrument consistent with this system, operates as a guarantee of the fulfilment of financial obligations in terms of social spending. As suggested earlier, it has also enabled the escalation of social spending over time regardless of adverse economic cycles. Although Chile is not among the countries with the highest social spending per capita in Latin America, its social spending has been growing steadily over time, maintaining a high proportion in relation to total public expenditure. Indeed, in 1990, social spending per capita amounted to US\$370 and social spending accounted for 61.2 per cent of total public expenditure, while by 2008, social spending per capita had increased to US\$830 and total social spending represented just over 68 per cent of total public expenditure.^{xv} Therefore, the fiscal space is there to assure the required implementation of the social protection system.

It is important to note, however, that citizen demand for expanded rights and their extension to more sectors of society will impose increasing fiscal pressures. Beyond the efforts targeting the poor, there are growing pressures from the middle class, which finds itself unprotected and whose vulnerabilities were made even more visible by the February 2010 earthquake and tsunami than they had been during the economic crisis.

In this context, there is an evident

and unavoidable need for a debate on tax reform in order to review both the current weight of taxes – which is no higher than 18 per cent of the GDP (an average amount in South America, a continent that has significantly lower tax burdens than those in Europe) – and their present composition.^{xvi}

It is important to note that the *Red Protege* previously allocated resources to central levels of the respective sector ministries (given that Chile is a unitary State). Recently, however, it has initiated a process of decentralized management, providing some of these resources to municipalities through a process that is progressing but still emerging.

In sum, the gradual nature of processes as well as the fiscal space and its progression and institutionalization ensures that social protection is not threatened by changes in government. This also ensures, from the standpoint of both programmatic as well as financial commitments, that social protection can be sustained over time, at least at the level of the rights and coverage achieved by March 2010.

IN CONCLUSION

Taking stock of the outcome of Chile's experience in establishing a social protection system is well worth doing at a time when the country is confronted with a change of government that effectively represents political change. This transformation took place in March 2010 when,

after two decades of centre-left coalition governments, the centre-right won the presidency.

Given this political shift in power, one wonders whether the existence of the *Red Protege* is at risk, especially in light of the previous Chilean historical evidence (1973-1990), which minimized the social role of the State, or the experiences in some other Latin American countries, where changes in government may have jeopardized the continuity of its policies.

In light of the background information provided in this case study report, it can be said that the current social protection system – which certainly can and should be expanded, deepened and refined – is not at risk of being reversed although there is the possibility that it could stagnate at the levels already achieved in line with the argument that management and outcomes need to be improved before the system can be further expanded. Still, this outcome seems unlikely given that social protection has been strengthened by its positive public evaluation and that it has been part of the campaign proposals of all presidential candidates in the last election.

It is important to note, then, that there is a consensus, at both the civil society and political actor's levels, on the benefits of social protection not as emergency and transitory policies but as permanent policies, enshrining hard-won social rights. This is a great strength that sustains social protection as a democratic achievement. To date, this reality is expressed by the annual approval of the

Budget Law, which increasingly allocates resources to social protection programmes based on norms that institutionalize the social protection system currently in force. This legal framework and the fiscal space guarantee the operation of the system and its gradual development at least at the levels already ensured by present laws. (As noted earlier, the health rights guaranteed under the AUGE Plan, the child protection in Chile *Crece Contigo*, the Basic Solidarity Pension guaranteed and the pension reform – to name important components of the *Red Protege* – have secured, through law, gradual increases in coverage.)

Another significant strength is the management experience accumulated, which ensures the performance of social programmes and actions. Although it is possible to demand even greater efficiency and effectiveness from social policies, they already have a strong foundation built on excellence and professionalism, which ensures their good performance, especially because they have already begun to internalize a culture of more comprehensive and intersectoral public management, breaking with the excessive sectoralism of traditional social policies.

At the time that this case study was written, the Government of Chile released the results of the 2009 Survey of Socio-Economic Characteristics (CASEN), whose field study of a sample of 73,000 families was conducted in the midst of the economic crisis (for the first time since 1990, the CASEN was carried out during a recession). Results of the survey showed a slight increase in poverty

(around 1.1 percentage points) compared to the figure from the 2006 survey, which was conducted at a time when the economy was booming. According to the country's most prestigious analysts, this rise is directly attributable to the global phenomenon of the disproportionate increase in food prices – specifically those food items that are part of the basic food basket used to establish the poverty line. These prices have declined from the time that the study was conducted and thus translate, only months after the measurement, into an automatic drop of the poverty line. Paradoxically, the same 2009 survey found that, despite the increase in the poverty rate, educational coverage grew – at all levels of education, from pre-school and early education to higher education – while membership in health systems was universalized and basic services were expanded. More remarkable, cash transfers easily offset the reduction in incomes suffered by poor households due to job loss caused by the crisis. In fact, the total income of these poor households – adding the cash transfers to their own incomes – was higher than that recorded in the previous survey, in 2006, when the country was growing economically.

These recent results demonstrate the positive impacts of the *Red Protege* precisely during the economic crisis and confirm the need to implement guaranteed social protection floors. Thus, the results of the 2009 CASEN reveal that there are objective grounds for the high value that citizens ascribe to social protection policies.

However, the same CASEN results show that it is the poor who are hit hardest by the effects of the crisis since they are the first to lose their jobs and since, even if they manage to keep their jobs, they are faced with very low incomes because of the increase in precarious employment. The results also demonstrate that the *Red Protege*, simultaneously being a mitigation policy (through cash transfers) and a policy on providing opportunities for capacity-building (especially through education and health), has not successfully coordinated with labour policies and quality jobs. This question appears to be one of the pending issues to resolve not only in Chile but also in existing social protection systems and one that certainly merits more substantive reflection on the redesign of social protection floors.

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^{xiii} Survey Panel, CASEN 1996, 2000 and 2006, carried out over a decade with the same sample of 5,000 families.

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^{ix} Sources: National Institute of Statistics, Ministry of Health, Ministry of Education and Ministry of



China

Area	9,640,821 km ²
Population ⁱ	1,335,000,000
<ul style="list-style-type: none"> • Urban population (%) • Rural population (%) 	<ul style="list-style-type: none"> 46.6 53.4
Age structure	
<ul style="list-style-type: none"> • 0-14 years (%) • 15-64 years (%) • 65 years and over (%) 	<ul style="list-style-type: none"> 20.5 71.5 7.9
Infant mortality rate (per 1,000 live births) both sexes ⁱⁱ	18
Life expectancy at birth (years) female	74.9
Life expectancy at birth (years) male	71.4
Maternal mortality ratio (per 100,000 live births) ⁱⁱⁱ	45
GDP per capita	
<ul style="list-style-type: none"> • Current USD^{iv} • PPP (current international \$)^v • Constant local currency 	<ul style="list-style-type: none"> 3,267 5,971 22,698 yuan
Total social security expenditure as % of GDP	4.19
Public social security expenditure as % of GDP	3.87
Public social security expenditure as % of total government expenditure	18.61
Unemployment rate (%) ^{vi}	4.3
Human development index (HDI) rank ^{vii}	92
HDI poverty indicators – Human poverty index rank	36

Note: In this case study, US\$1.00 = 6.77 RMB/yuan at the official exchange rate and US\$1.00 = 3.8 RMB/yuan PPP.

Developing a Basic Rural Medical Security System

8

China

*Zhengzhong Mao**Wei Fu**Xuefei Gu**Yuanping Wang*

Summary

The rural New Cooperative Medical Scheme (NCMS) and the Medical Assistance Scheme (MAS) have been established separately since 2002. They are the main medical security schemes targeting rural residents and the poor in China.

Rural New Cooperative Medical Scheme (NCMS):

- Target population: all rural residents;
- Enrolment: on a voluntary basis;
- Provides reimbursements for enrollees' health spending on inpatient care, outpatient service, some selected catastrophic diseases, pregnancy's institutional delivery, and physical examinations. The approximate reimbursement rate of inpatient care was 39.82 per cent in 2009;
- 833 million enrollees by the end of 2009; the enrolment rate was 94 per cent of the target population and about 62 per cent of the whole population in China;
- Has a multi-channel financing mechanism. Both central and local governments subsidize the enrollees. The households of the enrolled farmers also contribute. Donations from the social sector constitute another funding source.

Medical Assistance Scheme (MAS):

- Target population: the rural poor;
- Provides financial assistance as well as exemptions for catastrophic health expenditures and some frequently occurring diseases for the poor and low-income groups;
- Funds come mainly from government revenue (central and local governments, including public welfare lottery) and from social-sector donations.

Both Schemes have made great improvements in helping rural households, especially rural poor households, to cope with the financial burden from combating disease. The proportion of out-of-pocket expenditure has come down from nearly 80 per cent to about 60 per cent. Farmers' out-of-pocket spending as a share of per capita net income decreased from 74 per cent to 44 per cent with the introduction of the Schemes.

However, out-of-pocket share of inpatient cost is still as high (approximately 60 per cent, 70 per cent several years ago), which is beyond the affordability of the poor. Thus, the New Cooperative Medical Scheme (NCMS) alone cannot solve the issue of accessibility and equity for the poor. In fact, among its members, the poor use many fewer services than

Summary (cont'd.)

the non-poor. This situation will not change unless the Medical Assistance Scheme (MAS) becomes integrated with the NCMS and pays all or part of the co-payment for the poor so that their out-of-pocket share can drop to 20 per cent or below.

In 2009, total NCMS expenditure was about 92.29 billion yuan and MAS expenditure was about 5.99 billion yuan. Compared to the overall GDP (33,535.3 billion yuan), however, NCMS and MAS expenditures are inappreciable. All of these expenditure amounts represent net benefit expenditures for the beneficiaries (administrative expenditure, which is financed by the fiscal payment and which has not been published, is not included).

	2004	2005	2006	2007	2008	2009
NCMS expenses (100 million yuan)	26.4	61.8	155.8	346.6	662.0	922.9
MAS expenses (100 million yuan)	4.4	7.8	--	28.1	38.3	59.9
Gross domestic product (100 million yuan) at current year	159,878	183,217	211,924	257,306	300,670	335,353

Source: 2010 Chinese Health Statistical Digest, Ministry of Health (available at: <http://www.moh.gov.cn/publicfiles//business/htmlfiles/zwgkzt/ptjty/digest2010/index.html>).

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INTRODUCTION

The first decade of the new century has witnessed great progress in China’s medical security system in rural areas. Moreover, China faces new opportunities, given that its medical security system has been acknowledged as one of the priorities in the ongoing health-care reform. This case study presents an overview of the rural medical security system in China, offering

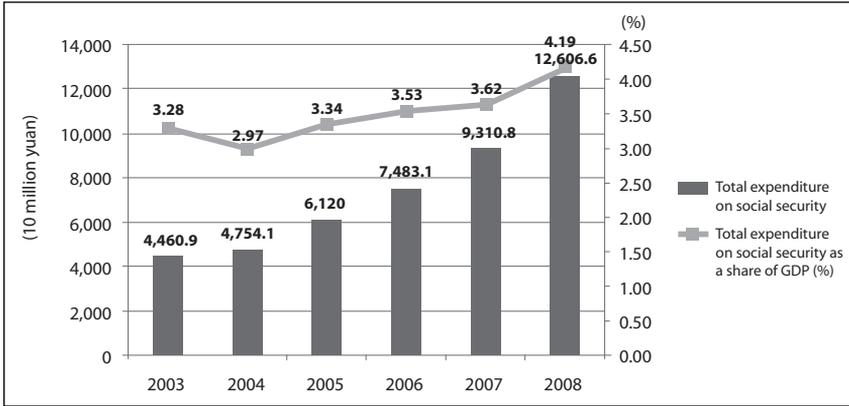
a broad context to facilitate understanding of its development and current state.

CONTEXT

In the 30 years since reform, China has made remarkable strides on almost all fronts of human development, including poverty alleviation, education, health and social security. At the same time, total expenditure on social security and its share

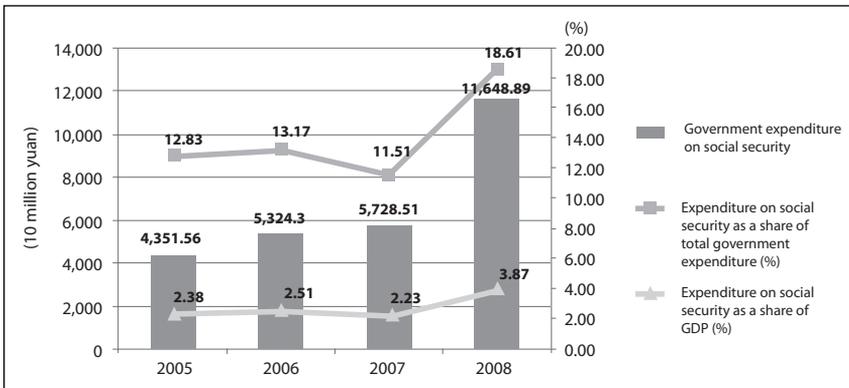
of GDP have been growing rapidly (fig. 1). From 2003 to 2008, total expenditure on social security rose from 44.6 billion yuan to 126.1 billion yuan (by a factor of 2.83) while its share of GDP rose from 3.28 per

cent to 4.19 per cent. Government social security spending as a share of GDP and of total government expenditure also increased dramatically from 2005 to 2008, as shown in graphs 1 and 2.



Graph 1 | Changes in total social security expenditure and its share of GDP.

Sources: Expenditures on social security include 2003-2008 expenditures on a new rural cooperative medical scheme published in the 2010 China Health Statistics Summary on the official website of the Ministry of Health; and expenditures on pension insurance, medical insurance, unemployment insurance, labour injury insurance and maternity insurance published in the 2003-2009 Statistical Statement on Labour and Social Security Undertakings on the official website of the Ministry of Human Resources and Social Security. Expenditures on social welfare and social assistance are those released in the 2003-2009 Statistical Report on Civil Affairs Development on the official website of the Ministry of Civil Affairs. Data on GDP is from the 2009 China Statistical Yearbook of the National Statistics Bureau.



Graph 2 | Total social security expenditure as a share of total government expenditure and of GDP.

Source: The data on fiscal social security expenditure is taken from the Social Security and Employment spreadsheet in the 2005-2008 National Financial Settlement Report of the Ministry of Finance.¹ The government health expenditures relating to social security were announced in the 2009 Study Report on China's National Health Account.² Fiscal expenditure data are from the 2005-2008 National Financial Settlement Report of the Ministry of Finance while GDP data are from the 2009 China Yearbook on Statistics of the National Statistics Bureau.

¹It includes items such as social security and employment services, civil affairs management, allowance to social security fund, supplement to national social security fund, retirement pension, allowances on enterprise reform, employment subsidy, death annuity, reintegration of decommissioned soldiers, social welfare, service for the disabled, urban subsistence allowances, other urban and township social relief, rural social relief, subsistence relief in time of natural disasters and Red Cross services.

²These expenditures include basic medical insurance for urban employees, basic medical insurance for urban residents, new rural cooperative medical scheme, urban and rural medical assistance scheme, health operating expenses of public service units, and medical expenditure allowances targeting enterprise employees.

In the meantime, China's sustainable and rapid economic growth helps to offer more jobs, increase income and alleviate poverty. Using the latest official rural poverty line of 1,196 yuan, which was announced by China in 2009, it can be said that the country had a rural poor population of 35.97 million by the end of that year. According to the World Bank report,^{viii} 254 million Chinese people still consumed less than US\$1.25 a day in 2005 (purchase power parity), giving China the second-largest number of poor people after India.

Progress in social economic reform has led to a better livelihood, higher educational attainment and a longer life for the Chinese people, as demonstrated by the dramatic rise of China's human development index (HDI). In 2009, the HDI was 0.793: 0.773 for life expectancy, 0.923 for education and 0.683 for GDP. These figures stand in contrast to those of 2000, when the HDI was 0.726: 0.80 for life expectancy, 0.76 for education and 0.61 for GDP.

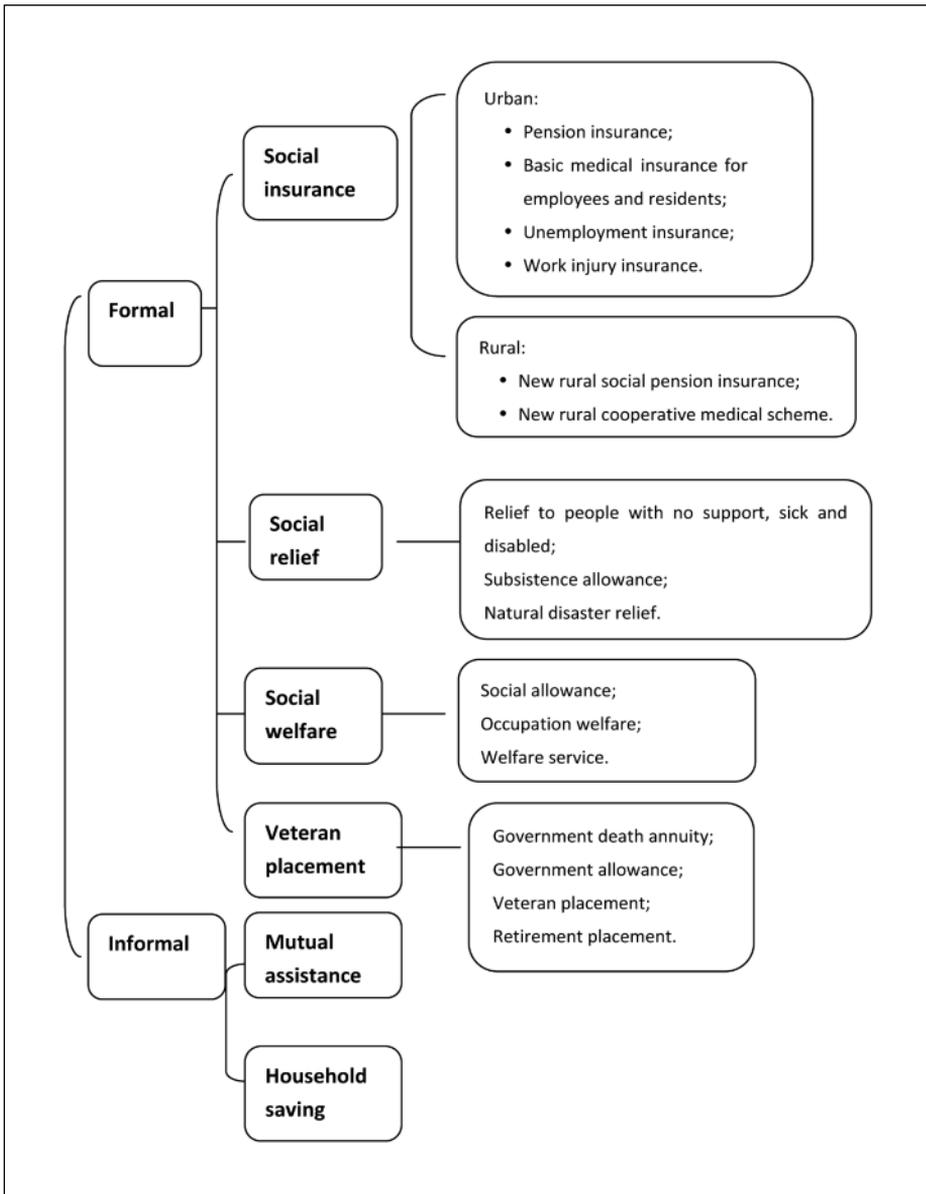
THE SOCIAL SECURITY SYSTEM IN CHINA

During the first decades of the economic reform, the political focus was on economic development through market forces. Consequently, social development, including the health sector, was left behind.

The guiding concept of the central

government has changed, however. With the official Scientific Outlook on Development as a guiding philosophy for national development, a harmonious society became the goal for social advancement, and a focus on people became the core concept for government administration in the twenty-first century. Universal access to social security has become a solemn political commitment for the government, making a social security system covering cities and the countryside an integral component of the bid to improve livelihoods, promote social economic advancement and maintain social stability. Social security undertakings have made strong headways in China. At present, social security covers social insurance, social welfare, veteran placement, social relief and a housing service, among which social insurance constitutes the core (fig. 1). In cities, China has established a five-pillar social insurance system covering pension insurance, basic medical insurance targeting urban employees and urban residents, unemployment insurance, work injury insurance and maternity insurance (table 1). It has also rolled out social assistance programmes such as subsistence allowances and medical assistance programmes. In the countryside, China has in place the rural New Cooperative Medical Scheme and is currently advancing a subsistence allowance system. In addition, the Government is exploring a rural pension insurance system.

Figure 1 | The social security system in China.



Source: Li Zhen, *Theory of Social Security*, China Labor and Social Security Publishing House, 2000; White paper titled China's Social Security and Its Policy, Information Office of the State Council of the People's Republic of China, September 2004.

Table 1 | Population groups covered by different social security mechanisms.

	Mechanism	Name	Population Covered		
Social insurance	Pension insurance	Basic Pension Insurance for Urban Employees	Employees reaching mandatory retirement age (60 years for male and 55 for female officials, and 50 years for female workers), with a 15-year or longer record of individual contribution.		
		Company annuity	Where conditions permit, companies may offer company annuity to employees on top of mandatory basic pension insurance.		
		New rural pension insurance	Rural residents 16 years of age and older (students not included) who are not enrolled in basic pension insurance.		
	Medical insurance	Basic medical insurance for urban employees	Basic medical insurance for urban employees	Employees and retirees of all types, including government agencies, public service units, enterprises, civil society organizations and private non-business units. Employees in the informal sector may choose to enrol.	
			Basic medical insurance for urban residents	Urban students (college students included), children and other non-employed urban residents.	
			Supplementary medical insurance	Where conditions permit, enterprises may offer supplementary medical insurance on top of mandatory basic medical insurance.	
		Medical allowance system for civil servants	Civil servants and employees of public service units enjoy government medical insurance.		
		New rural medical cooperative insurance	Rural residents.		
		Unemployment insurance	Unemployment insurance system	Unemployment insurance system	Enterprises, public service units and their employees; individuals paying unemployment insurance contributions for over one year; those whose employment has been suspended involuntarily; those who have already registered for unemployment and intend to find a new job.

Table 1 | Population groups covered by different social security mechanisms (cont'd.).

	Mechanism	Name	Population Covered
Social insurance (cont'd.)	Work injury insurance	Work injury insurance system	Enterprises and private dealers with employees.
	Maternity insurance	Maternity insurance system	Urban enterprises and their employees. In some regions, female employees of government agencies, public service units, civil societies and enterprises are covered.
Social relief		Subsistence support to groups	The elderly, the disabled and minors with no statutory supporters or with statutory supporters incapable of offering support; with no labour ability; with no sources of revenue.
		Subsistence allowance system	Urban and rural residents with per capita household income lower than the local minimum living standard; residents with no sources of livelihood and no statutory supporters.
		Medical assistance	Urban and rural poor people afflicted by illness.
		Disaster relief	Disaster-stricken people.
		Relief to homeless and beggars	Urban homeless and beggars.
Social welfare		Social welfare services	The elderly, orphans, the disabled and other population groups.
Veteran placement		Veteran placement system	Targets of placement, mainly soldiers and their dependants.

Source: Edited according to *Social Security Status and Policies in China* (the White Paper on Social Security in China), Information Office of the State Council of the People's Republic of China, September 2004.

DEVELOPMENT OF THE MEDICAL SECURITY SYSTEM

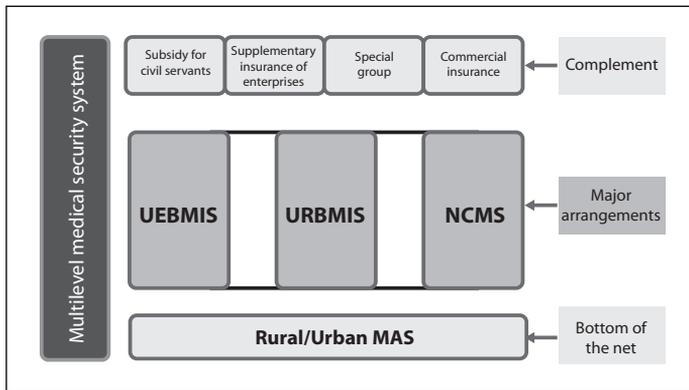
China has set up a multilevel medical security system. The major players are

the Urban Employees' Basic Medical Insurance Scheme (UEBMI), the Urban Resident Basic Medical Insurance Scheme (URBMIS) and the New Cooperative Medical Scheme (NCMS). The Medical Assistance Scheme (MAS)

covers both rural and urban poor populations at the bottom of the safety net, and various other health insurance organizations provide supplementary protection (fig. 2). One of the major goals of the

ongoing health-care reform is to accelerate the development and improvement of various medical insurance schemes and ultimately to achieve universal access to essential health care.

Figure 2 | Framework for China’s Medical Security System.



The *Decision of the State Council on Establishing the Urban Employees’ Basic Medical Insurance Scheme (UEBMIS)*, promulgated by the State Council in 1998, proposed to set up the Urban Employees’ Basic Medical Insurance Scheme (UEBMIS) and a multilevel medical security system and listed the tasks and principles of supportive reform in the health-care system. Afterwards, UEBMIS expanded to urban informal workers, workers in mixed-ownership enterprises and the private sector as well as rural migrant workers. The Scheme is financed by both employers and employees (about 6 per cent of total salary from the employer and 2 per cent from the employee). The contribution is allocated into individual saving accounts and a municipality-level or county-level social pooling fund. The benefit includes both inpatient and outpatient care.

The Urban Resident Basic Medical Insurance Scheme (URBMIS) was piloted in 79 cities nationwide after the State Council released *Guiding Opinions of the State Council about the Pilot Urban Resident Basic Medical Insurance Scheme* in 2007. The voluntary enrolment Scheme targets urban students (including university students), children and other non-working urban residents. Its contributions are collected based on household size, pooled at the city level and subsidized by the Government. In 2009, URBMIS, which protects its members from catastrophic expenditure in outpatient and inpatient care, achieved universal coverage ahead of schedule.

Since the implementation of UEBMIS and URBMIS, the enrollees in the two Schemes have increased rapidly. At the end of 2009, people with the urban basic medical insurance totalled 401.47 million:

219.37 million of them were UEBMIS members and 182.1 million were URBMIS members. The yearly revenue of urban basic medical insurance funds amounted to 367.2 billion yuan (US\$54.239 billion, or US\$96.632 billion PPP), and total disbursement reached 279.7 billion yuan (US\$41.315 billion, or US\$73.605 billion PPP). The accumulat-

ed surplus in the pooling fund added up to 288.2 billion yuan (US\$42.570 billion, or US\$75.842 billion PPP). With stronger capacity, the urban basic medical insurance system has increased its coverage and reimbursement level.

The financing of different medical security schemes has been on the rise, as shown in table 2.

Table 2 | Financing of China's medical security system (in billions).

	2005			2006			2007			2008		
	RMB	US\$ Official Rate	US\$ PPP	RMB	US\$ Official Rate	US\$ PPP	RMB	US\$ Official Rate	US\$ PPP	RMB	US\$ Official Rate	US\$ PPP
Yearly revenue of UEBMIS	140.554	20.761	36.988	174.710	25.806	45.976	221.424	32.707	58.269	288.550	42.622	75.934
Yearly revenue of URBMIS										15.493	2.288	4.077
Contribution by government										7.449	1.100	1.960
Contribution by individuals										6.775	1.001	1.783
Yearly revenue of NCMS	7.534	1.113	1.983	21.359	3.155	5.621	42.796	6.321	11.262	78.458	11.589	20.647
Contribution by government	4.235	0.626	1.114	15.048	2.223	3.960	32.591	4.814	8.577	65.571	9.686	17.256
Contribution by individuals	2.873	0.424	0.756	5.801	0.857	1.527	9.576	1.414	2.520	12.068	1.783	3.176
Interest and others	0.427	0.063	0.112	0.510	0.075	0.134	0.629	0.093	0.166	0.819	0.121	0.216
MAS	0.890	0.131	0.234	1.954	0.289	0.514	4.249	0.628	1.118	6.800	1.004	1.789
Total	148.978	22.006	39.205	198.023	29.250	52.111	271.020	40.032	71.321	389.302	57.504	102.448

Source: Health Expenditure Report 2009, China Health Economics Institute, Ministry of Health.

ESTABLISHMENT AND DEVELOPMENT OF THE RURAL MEDICAL SECURITY SYSTEM: THE NEW COOPERATIVE MEDICAL SCHEME AND THE MEDICAL ASSISTANCE SCHEME

One of the major achievements in

China's medical security system is the establishment and constant improvement of the rural New Cooperative Medical Scheme (NCMS) and the Medical Assistance Scheme (MAS).

ESTABLISHMENT AND DEVELOPMENT OF THE NEW COOPERATIVE MEDICAL SCHEME (NCMS)

In the 1960s, the traditional (or so-called “old”) Cooperative Medical Scheme was developed rapidly throughout the country and it covered almost all rural residents by the 1970s. Its risk-pooling was at the village level, with funding coming from a village’s collective savings, and villagers managed the Scheme themselves. The Scheme played an important role in providing farmers with primary health care. However, it broke down in most rural areas because its financing base (the collective economy) was weakening. In the 1990s, the Government of China managed to resume the Scheme but it did not succeed and the Government grappled with the issue of rural medical security.

The Decision on Further Strengthening Rural Health Care, issued by the Central Committee of the Communist Party of China (CPC) and the State Council in 2002, proposed to establish the NCMS and the MAS in rural areas. In 2003, the Ministries of Health and Foreign Affairs issued a joint *Opinion on Establishing the New Cooperative Medical Scheme*, specifying the organization and implementation of the Scheme. It identified the NCMS as a voluntary medical mutual-help scheme for farmers that was organized, guided and supported by the Government and financed by individual, collective and government monies, and it covered mainly catastrophic health expense using pooled funds. Compared with the old Cooperative Medical Scheme (CMS), the NCMS is characterized by the following:

- **an ad hoc organization and management system with a clear division of labour and responsibilities**

(fig. 3). The NCMS administrative departments were set up within the health administrations from the central to the local level. The NCMS Management Office was established at the county level and given responsibility for management of NCMS funds, monitoring the performance of contracted health-care providers, and reviewing and reimbursing applications and other daily tasks. The NCMS Management Office was staffed with full-time workers and supported financially by local funds;

- **a multi-channel financing mechanism.** Both central and local governments should subsidize the enrollees, and the households of the enrolled farmers should also contribute. In addition, social-sector donations are a funding source. Subsidies from the central government have increased from 10 yuan (US\$1.477, or US\$2.632 PPP) per capita in 2003 to 60 yuan (US\$8.863, or US\$15.789 PPP) per capita in the central and western regions in 2010. The average per capita contribution collected from all channels has increased from 30 yuan (US\$4.431, or US\$7.895 PPP) in 2003 to 150 yuan (US\$22.156, or US\$49.474 PPP) currently;
- **a benefit package focusing on inpatient services (inpatient expenditure).** Localities can nonetheless make their own decisions as to whether to include outpatient services in their benefit packages. Since 2008, the Ministry

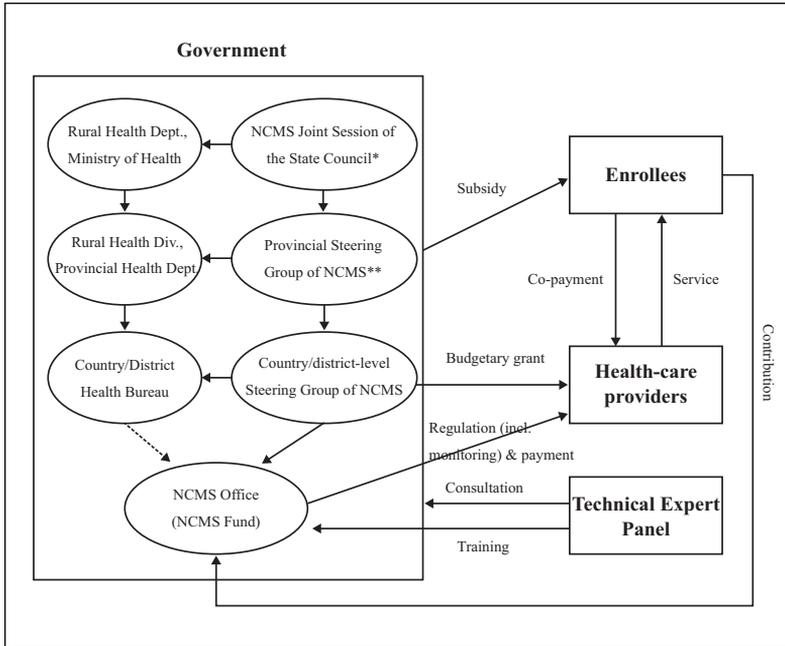


Figure 3 |
Framework of
the NCMS.

*Comprised of leaders from 12 ministries, including the Ministry of Health, the Ministry of Finance, the Ministry of Human Resources and Social Security, the Ministry of Civil Affairs and the National Development and Reform Committee.

**Comprised of leaders from 12 provincial departments, including Health, Finance, Human Resources and Social Security, Civil Affairs and the Development and Reform Committee.

of Health has encouraged localities to combine inpatient and outpatient pooling in order to discover an effective way to cover outpatient reimbursement, extend the scale of benefit packages and enhance the reimbursement level;

- **the principle of voluntary enrolment.** The NCMS enrolment is family-based and voluntary. Meanwhile, public monitoring and transparency are also stressed; and
- **establishment of a pooling fund at the county level** (the average population of a county is about 300,000). Since 2008, the Ministry of Health has advocated that places where conditions allow elevate their management and pooling fund to the municipal level.

ESTABLISHMENT AND DEVELOPMENT OF THE MEDICAL ASSISTANCE SCHEME

The Medical Assistance Scheme (MAS), funded by the Government and voluntary donations from social sectors, offers special financial assistance to the poor and other households that suffer or cannot afford large medical expenses. This medical security scheme helps target groups to gain access to necessary health care and improve their health status. It is a formal institutional arrangement led by the Government. The Ministry of Civil Affairs is responsible for its implementation.

In November, 2003, the Ministry of Civil Affairs, together with the Ministries of Health, Finance and Agriculture, issued the *Opinion on Implementing the Rural*

Medical Assistance Scheme, identifying its objectives, principles, coverage, forms of assistance, application and approval procedures, financing and management of the fund, and organization and implementation. The document outlined a standard, well-established medical assistance scheme to be implemented in the rural areas of all counties by 2005. The details of the Scheme are as follows:

- **target group:** those from Wu Bao (the “five guarantees” households), Di Bao (households eligible for China’s minimum-living-standard security system) and other poor farmers complying with the threshold requirements set by local governments;
- **diversified financing:** MAS funding comes mainly from government revenue (central and local governments, including public welfare lottery) and donations from social sectors;
- **multilevel assistance:** In the NCMS pilot areas, the MAS first pays individual contributions for its beneficiaries so as to get them enrolled and able to receive the NCMS benefits; second, it provides beneficiaries with additional financial assistance (second reimbursement) if the financial burden from combating disease is still so high that their basic subsistence is threatened. Moreover, in some places, the MAS gives Wu Bao, poverty-stricken households and other special groups additional subsidies for outpatient service

besides the household saving accounts for outpatient care in the NCMS. In places without the NCMS, the MAS offers an appropriate amount of subsidies directly to those who suffer from health expenses so great that the basic livelihood of their household is badly impacted.

IMPLEMENTATION OF THE RURAL MEDICAL SECURITY SYSTEM

The New Cooperative Medical Scheme (NCMS) and the Medical Assistance Scheme (MAS) were rolled out rapidly, soon covering all the rural areas of the country.

IMPLEMENTATION OF THE NEW COOPERATIVE MEDICAL SCHEME

In its annual report for 2008, the World Health Organization (WHO) evaluated a medical security scheme in terms of three dimensions: width (population that it covers), depth (service that it covers and its generosity) and its disbursement as a share of health spending. It collected the NCMS data from 563 counties. Given that all of them began implementing the NCMS between 2003 and 2005 (excluding counties/districts of Beijing, Shanghai and Tianjin), WHO reviewed the implementation of the NCMS based on those data as well as announced national data.

Financing and Coverage

By the end of 2009, with 833 million

members, the NCMS had reached an enrolment rate of 94 per cent and had almost achieved universal coverage in rural areas. It had covered 55.2 million poverty-stricken people, a 94 per cent coverage rate. Total contributions had amounted to 94.435 billion yuan (US\$13.949 billion, or US\$24.851 billion PPP), 113 yuan (US\$16.691, or US\$29.737 PPP) per capita, of which 74.822 billion yuan (US\$11.052 billion, or US\$19.690 billion PPP), or 79.2 per cent, had been from government.

According to the NCMS data in the 563 counties, coverage has been expanding steadily, reaching 94.55 per cent in 2009 (table 3). In particular, the coverage among poor people has exceeded 95 per cent (table 4). Per capita contributions also rose to 126.51 yuan (US\$18.69, or US\$33.29 PPP) in 2009 (table 5).

The NCMS is non-compulsory, or voluntary, so adverse selection has always been a concern. However, it is not a

problem in practice since almost all the farmers have enrolled. The expansive coverage is attributed to three factors: a government subsidy accounting for about

Table 3 | Coverage of the NCMS in the 563 counties (as a percentage).

Year	Overall	Eastern Region	Central Region	Western Region
2005	74.92	79.03	71.84	68.47
2006	83.49	86.80	81.18	78.30
2007	89.33	90.87	88.38	86.82
2008	93.25	94.01	92.83	92.24
2009	94.55	94.96	94.55	93.71

Table 4 | NCMS coverage among the poverty-stricken population in the 563 counties (as a percentage).

Year	Overall	Eastern	Central	Western
2005	70.41	69.54	69.61	71.43
2006	87.61	89.70	86.07	86.67
2007	89.14	93.69	86.27	86.94
2008	89.71	94.96	88.26	86.47
2009	96.25	97.83	94.78	95.83

Table 5 | NCMS contribution in the 563 counties (yuan per capita).

Year	Overall			Eastern			Central			Western		
	RMB	US\$	US\$ PPP									
2005	37.78	5.58	9.94	43.85	6.48	11.54	30.20	4.46	7.95	28.70	4.24	7.55
2006	53.03	7.83	13.96	58.92	8.70	15.51	46.42	6.86	12.22	43.79	6.47	11.52
2007	65.61	9.69	17.27	75.16	11.10	19.78	53.65	7.92	14.12	53.71	7.93	14.13
2008	104.45	15.43	27.49	118.22	17.46	31.11	89.41	13.21	23.53	87.84	12.97	23.12
2009	126.51	18.69	33.29	145.35	21.47	38.25	102.63	15.16	27.01	105.93	15.65	27.88

80 per cent of the total fund; government publicity and advocacy; and the incentive of tangible benefits to members.

Benefits Offered

The NCMS reimburses members’ spending on inpatient care, outpatient service, some selected catastrophic diseases, medical child delivery, and physical examinations (table 6). Inpatient care is the major focus of the Scheme. For instance, in 2009, reimbursement for inpatient care took up 82.6 per cent of the total fund. In contrast, reimbursement for outpatient care, selected catastrophic diseases and medical childbirth took up 13.2 per cent, 1.29 per cent and 1.32 per cent of the fund, respectively.

Reimbursement to Beneficiaries

Using the example of inpatient care, tables 7, 8 and 9 provide data relating to reimbursements paid to beneficiaries of the NCMS.

With more financing, farmers’ use of inpatient service has increased and so has the actual reimbursement rate. The proportion of out-of-pocket expenditure has decreased from nearly 80 per cent to about 60 per cent. It is still a low reimbursement rate, however.

A comparison of out-of-pocket spending as a share of farmers’ per capita net income before and after reimbursement shows that the share was 74 per cent beforehand and 44 per cent afterwards. In

Table 6 | Services covered by the NCMS, 2008-2009 (number of reimbursements in thousands).

Year	Inpatient Care	Outpatient (Pooling*) Service	Selected Catastrophic Disease	Pregnancy’s Institutional Delivery
2008	51,086.3	486,161.4	3,366.5	3,231.6
2009	61,721.4	489,935.8	5,037.3	3,702.5
Increase (%)	20.82	0.78	49.63	14.57

*The number is concerned only with counties that pool outpatient risk at the county level. The other counties use a savings account model for outpatient services.

Table 7 | Hospitalization rate in the 563 counties (as a percentage).

Year	Overall	Eastern	Central	Western
2005	3.05	2.82	3.18	3.60
2006	4.04	3.79	4.02	4.83
2007	4.85	4.58	4.69	5.80
2008	5.76	5.27	5.81	6.96
2009	6.64	6.03	6.75	8.12

Table 8 | Actual reimbursement rate of inpatient care in the 563 counties (as a percentage).

Year	Overall	Eastern	Central	Western
2005	22.79	21.97	24.25	25.75
2006	26.06	24.20	29.50	31.40
2007	29.46	28.00	31.26	34.49
2008	36.11	33.72	40.03	40.73
2009	39.82	38.04	41.67	44.78

Table 9 | Inpatient expenditure and income: distribution of out-of-pocket spending as a share of per capita income before and after reimbursement (as a percentage).

Year	<0.5*		0.50-1.0		1.0-1.5		1.5-		Mean	
	Before	After	Before	After	Before	After	Before	After	Before	After
2005	9.15	23.76	54.48	59.05	25.23	12.80	11.15	4.39	0.97	0.75
2006	13.14	36.32	60.22	53.84	20.80	8.76	5.83	1.08	0.86	0.62
2007	14.88	47.85	63.08	46.06	18.83	5.37	3.24	0.72	0.80	0.56
2008	16.73	60.61	64.21	35.62	14.22	3.42	4.86	0.36	0.79	0.50
2009	21.46	70.35	62.13	27.61	13.42	1.87	2.99	0.19	0.74	0.44

*Means that out-of-pocket expenditure is less than 0.5 per cent of income.

more than 70 per cent of counties, the rate was under 50 per cent after reimbursement. However, in 19 per cent of counties, the rate was still more than 150 per cent. Generally speaking, the NCMS benefits alleviate farmers' financial burden from combating disease.

IMPLEMENTATION OF THE RURAL MEDICAL ASSISTANCE SCHEME (MAS)

The rural Medical Assistance Scheme (MAS) covered all counties as early as 2005. The revenue and disbursement of rural MAS monies have increased continuously (table 10) as has the number of its

Table 10 | Revenue and disbursement of rural medical assistance, 2005-2009 (in millions of yuan, US\$, US\$ PPP).

Year	Revenue			Disbursement			Subsidy for NCMS Contribution			Financial Assistance for Major Disease Expenditure		
	Millions of yuan	Millions of US\$	Millions of US\$ PPP	Millions of yuan	Millions of US\$	Millions of US\$ PPP	Millions of yuan	Millions of US\$	Millions of US\$ PPP	Millions of yuan	Millions of US\$	Millions of US\$ PPP
2005	1,090	161.00	286.84	780	115.21	205.26	95	14.03	25.00	480	70.90	126.32
2006	2,300	339.73	605.26	1,310	193.50	344.74	260	38.40	68.42	880	129.99	231.58
2007	4,100	605.61	1,078.95	2,810	415.07	739.47	480	70.90	126.32	2,050	302.81	539.47
2008	5,070	748.89	1,334.21	3,830	565.73	1,007.89	710	104.87	186.84	2,740	404.73	721.05
2009	8,040	1,187.59	2,115.79	6,460	954.21	1,700.00	1,050	155.10	276.32	4,940	729.69	1,300.00

Source: Statistical Report on Civil Affairs, 2005-2009, Ministry of Civil Affairs.

beneficiaries receiving medical assistance for inpatient spending and subsidies for NCMS contributions (table 11). This shows that the Government attaches great importance to the health care of the poor. The Scheme has constantly improved by adopting a lower threshold, using streamlining procedures, achieving better fund efficiency, offering more health service utilization, and decreasing the disease burden among the target group. The *Opinion on Improving the Urban and Rural Medical Assistance Scheme* adopted by the Ministry of Civil Affairs, the Ministry of Health, the Ministry of Finance and the Ministry of Human Resources and Social Security in 2009 proposed a "one-stop-shop" service and real-time settlement of medical spending, reimbursement and assistance in order to (a) increase the number of low-income groups beyond Wu Bao and Di Bao households, and (b) transfer its major focus from assistance only for "catastrophic health expenditure" to common and frequently occurring diseases. From the national data (table 12), medical assistance still remains at a low level and its role in the medical security system has yet to be improved.

Table 11 | Beneficiaries of rural medical assistance, 2005-2009 (in millions).

Year	Total Number of Beneficiaries	Those Receiving NCMS Contribution Subsidy	Those Receiving Major Disease Expenditure Assistance
2005	8,545	6,549	1,996
2006	15,590	13,171	2,419
2007	28,944	25,173	3,771
2008	41,919	34,324	7,595
2009	47,357	40,591	6,766

Source: Statistical Report on Civil Affairs, 2005-2009, Ministry of Civil Affairs.

Table 12 | Rural medical assistance benefit per case, 2005-2009 (in yuan, US\$, US\$ PPP)

Year	Per Capita Subsidy for NCMS Contribution			Financial Assistance for Major Disease Expenditure per Case*		
	In yuan	US\$	US\$ PPP	In yuan	US\$	US\$ PPP
2005	11.1	1.64	2.92	240.5	35.52	63.29
2006	19.7	2.91	5.18	366	54.06	96.32
2007	19.1	2.82	5.03	543	80.21	142.89
2008	20.7	3.06	5.45	360.3	53.22	94.82
2009	25.9	3.83	6.82	676.6	99.94	178.05

Source: Statistical Report on Civil Affairs, 2005-2009, Ministry of Civil Affairs.

*According to the statistics of the Ministry of Civil Affairs, major disease prevention is the main (but not only) target of financial assistance for inpatient spending.

INTEGRATION OF THE NEW COOPERATIVE MEDICAL SCHEME AND THE MEDICAL ASSISTANCE SCHEME

Given the low reimbursement rate of the New Cooperative Medical Scheme (NCMS) and the big share of out-of-pocket spending, affordability still keeps the poor from using health services. To ensure that they obtain adequate benefits

from the NCMS and the Medical Assistance Scheme (MAS) and to improve equity, it is necessary to integrate the two Schemes in designing a benefit package, management and service.

In terms of designing a benefit package, reimbursement and assistance scheme, the two can be integrated at the following four levels (inpatient services are taken as an example):

- **Level 1:** Getting the MAS target group enrolled in the NCMS. This is the basic condition for integrating the two systems and for making sure that the MAS target group can benefit from the NCMS;
- **Level 2:** Reducing or eliminating the NCMS deductible for MAS beneficiaries. This can improve their accessibility to inpatient services and deepen their coverage;
- **Level 3:** Medical assistance after NCMS reimbursement, that is, reducing co-payment by assistance. The MAS target group can benefit more if there is synergy between the two Schemes; and
- **Level 4:** Provisional assistance for spending that is higher than the ceiling of NCMS compensation. For those who are not in the target group of MAS but who have great financial difficulties even after they receive cap reimbursement from the NCMS, MAS reimburses their health spending beyond the ceiling for another two times through provisional

assistance or other sources of charity. This is done to prevent the group (a potentially impoverished population) from slipping below the poverty line. Assistance before the population falls below the poverty line is more cost-effective than regular assistance afterwards.

As for management and service, in the best-case scenario, MAS beneficiaries should pay out of pocket only when they are discharged from the contracted health-care facilities. They should not need to pay the entire cost in advance and wait for reimbursement later. In addition, the MAS and the NCMS should be integrated seamlessly in areas such as fund management, supervision of providers and information management. The measures mentioned above will reduce management costs, enhance efficiency, make the benefits more user-friendly and clear the institutional barriers to service use for MAS beneficiaries. A case study of this type of integration in Changshu City, Jiangsu Province, is described below.

The city introduced the NCMS in 2003 and maintained its coverage at more than 98 per cent in recent years. After seven years of practice and innovation, it has expanded the NCMS to urban areas and established an urban-rural integrated scheme (BMI-NCMS Scheme) that covers all citizens with local Hukou (residence permits) but excluded by the Urban Employees' Basic Medical Insurance Scheme (UEBMI).

In 2010, the total annual contribution to the scheme was 400 yuan (US\$59.08, or US\$105.26 PPP) per capita. Of this amount, 150 yuan (US\$39.47 PPP) come from city-level finances, 150 yuan (US\$39.47 PPP) from township-level finances (including 10 from village collectives), and 100 yuan (US\$26.32 PPP) from the members themselves.

Changshu City adopted the model of inpatient pooling plus outpatient pooling. The benefit includes reimbursement for common outpatient costs, chronic outpatient expenses for special diseases, inpatient expenditures and physical examination spending.

The Medical Assistance Scheme (MAS) is integrated with the New Cooperative Medical Scheme (NCMS) effectively:

- **MAS target group:** the Wu Bao households, Di Bao and potential Di Bao targets, the severely disabled, the target group for special care, children whose parents are employees and extremely poor, university students from poor families, and those who suffer extreme hardship due to annual health costs above 50,000 yuan (US\$13,157.89 PPP);
- **subsidies for the individual contributions to the BMI-NCMS:** the potential Di Bao targets and the severely disabled excluded by the Di Bao system must pay their own contribution. The individual contributions of the remaining MAS

target population are covered by the township-level Finance Office where the beneficiaries live;

- **assistance for common outpatient spending:** for MAS beneficiaries, there is no deductible in the BMI-NCMS when they apply for reimbursement of their common outpatient cost covered by the BMI-NCMS benefit package. Their outpatient spending beyond 1,500 yuan (US\$394.74 PPP) (the annual reimbursement cap per capita in the BMI-NCMS) can be reimbursed again by the MAS fund. The rate is 90 per cent for Wu Bao, Di Bao and university students from poor families and 60 per cent for potential Di Bao targets, the severely disabled excluded by the Di Bao system, special-care targets and children whose parents are extremely poor employees;
- **assistance for inpatient costs and chronic outpatient expenses for special diseases:** for MAS beneficiaries, there is no deductible in the BMI-NCMS. MAS offered financial assistance for beneficiaries' actual out-of-pocket costs. The reimbursement rate of MAS is 90 per cent for Wu Bao, Di Bao targets and university students from poor families and 60 per cent for potential Di Bao targets, the severely disabled who are excluded by the Di Bao system, special-care targets and children whose parents are extremely poor employees;

- **assistance procedures:** the Wu Bao households, Di Bao and potential Di Bao targets, the severely disabled, the special-care target group, children whose parents are extremely poor employees, and university students from poor families bring their medical smart card and related papers with them when seeking care in designated service providers. They need to pay only their actual out-of-pocket cost. This means that they can obtain reimbursements and assistance in real time. The city-level BMI-NCMS management centre settles the cost, which is covered by the MAS fund, with designated providers in accordance with relevant regulations;
- **provisional assistance:** the MAS provides appropriate assistance to BMI-NCMS members who have regular difficulties assuring their livelihood due to an annual health cost over 50,000 yuan (US\$13,157.89 PPP). The assistance amount ranges from 2,000 yuan (US\$526.32 PPP) to 100,000 yuan (US\$26,315.79 PPP);
- **results of assistance:** the hospitalization rate among MAS targets was 32.3 per cent, higher than that of the non-target group. According to table 13, when the beneficiaries sought medical care in local township-level, city-level and non-local providers, the ultimate reimbursement rates were 73.09 per cent, 65.42 per cent and 47.52 per cent, respectively. Their financial burden was greatly reduced. As for the chronic outpatient cost for special diseases, the ultimate reimbursement rate was 83.95 per cent (table 14), which solved the problem of large outpatient expenditure for the target group quite well.

Table 13 | Reimbursement for the inpatient cost of the Medical Assistance Scheme beneficiaries in Changshu City, 2009.

Type of Provider	Number of Hospitalizations	Cost per Episode (in yuan) (US\$ PPP)	Reimbursement from BMI-NCMS per Episode (in yuan) (US\$ PPP)	Assistance from MAS per Episode (in yuan) (US\$ PPP)	Total Reimbursement per Episode (in yuan) (US\$ PPP)	Ultimate Reimbursement Rate (%)
Township-level	1,861	2,981.22 (784.53)	1,600.76 (421.25)	578.14 (152.14)	2,178.91 (573.40)	73.09
City-level	1,421	9,941.89 (2,616.29)	4,430.96 (1,166.04)	2,073.38 (545.63)	6,504.34 (1,711.67)	65.42
Non-local	81	18,205.80 (4,791.00)	5,607.72 (1,475.72)	3,042.80 (800.74)	8,650.51 (2,276.45)	47.52
Total/Total average	3,363	6,289.07 (1,655.02)	2,893.15 (761.36)	1,269.30 (334.03)	4,162.45 (1,095.38)	66.19

Table 14 | Reimbursement for chronic outpatient expenses of the Medical Assistance Scheme beneficiaries in Changshu City, 2009.

Type of Provider	Number of Outpatient Assistance Visits	Cost per Visit (yuan)	Reimbursement from BMI-NCMS per Visit (yuan) (US\$ PPP)	Assistance from MAS per Visit (yuan) (US\$ PPP)	Total Reimbursement per Visit (yuan) (US\$ PPP)	Ultimate Reimbursement Rate (%)
Township-level	151	71.08 (18.71)	19.60 (5.16)	29.44 (7.75)	59.04 (15.54)	83.07
City-level	11,071	443.28 (116.65)	204.76 (53.88)	168.02 (44.22)	372.78 (98.10)	83.99
Non-local	19	4,937.55 (1,299.36)	2,578.50 (678.55)	1,475.00 (388.16)	4,053.51 (1,066.71)	82.1
Total/Total average	11,241	446.43 (117.48)	206.28 (54.28)	168.50 (44.34)	374.78 (98.63)	83.95

MAJOR LESSONS LEARNED FROM CHINA'S EXPERIENCE

Since 2003, when China introduced the NCMS and the MAS, the country has established a medical security system covering more than 800 million farmers in 2,716 counties (districts). The establishment, implementation and improvement of the system have been advanced in a well-organized way without any significant accidents or setbacks. The achievement is widely acclaimed by people from all walks of life in China. The MAS has become an umbrella programme, protecting each poor individual with a similar pace and momentum. Reviewing the past experience, these lessons have emerged:

1. Guided by its official Scientific Outlook on Development, the Government shows great political will to promote the rural health

sector and the medical security system. This is the fundamental driving force behind the rapid establishment and development of the NCMS and the MAS in vast rural areas.

Chinese farmers usually work on their family-based land, live dispersedly and – despite their large numbers – lack a channel through which to express and represent their interests. This is why, despite the problem's long existence, Chinese society has not paid adequate attention to the absence of farmers' medical security.

Thanks to the Scientific Outlook on Development, rural social development (including the medical security system) has been improved. Guided by the philosophy of the report, the Government of China has spent a great deal of money on establishing the medical security fund and has mobilized a

huge number of human resources and materials to develop a management organization system for the NCMS. All of the efforts reflect the basic principle of the NCMS: "government-led". In fact, in 2003 when the NCMS was established, it was the first time that the Government had subsidized the demand side (20 yuan per capita) with its fiscal revenue, put a medical security fund in place and purchased health care for farmers. In 2009, government subsidies for the NCMS amounted to 74.822 billion yuan. At present, a county-level management team of 38,671 staff members is in charge of the daily management and implementation of the Scheme. The central government also subsidized each central and western province with 6 million yuan for an information management system. What is more, there are steering groups of the NCMS from the State Council present at all levels of implementation, from the provincial level down to the county/district level. They are responsible for the formulation of policies and for overall guidelines so as to make sure that the Scheme is always on track.

2. Coordination among different departments provides an institutional guarantee of the smooth progress of the NCMS and the MAS.

The development of the rural medical security system is not a mission of the Ministry of Health alone but one involving many departments, including the

Ministry of Finance, the Ministry of Civil Affairs, the Ministry of Human Resources and Social Security, and the National Development and Reform Committee. Balancing obligations and interests among them is always on the agenda. The NCMS Joint Session of the State Council selected the Ministry of Health to organize the implementation of the Scheme and asked other ministries to support it. The Department of Rural Health was set up within the Ministry of Health to guide the NCMS nationwide. The Ministry of Finance is responsible for financing, monitoring and managing the NCMS fund. The Ministry of Civil Affairs is in charge of the issues relating to the poor in rural areas. The Ministry of Human Resources and Social Security, together with the Ministry of Health, is responsible for studying how to recruit staff, as well as establishing and operating the organization and management system of the Scheme. The National Development and Reform Committee plays a major role in developing the NCSM information system and the service delivery system. The NCMS social security department and health department should often have consultations in order to coordinate the urban and rural security systems.

Those departments are well coordinated for three reasons. First, in accordance with the Scientific

Outlook on Development, rural medical security is the common responsibility of many departments and it is an important part of balance and sustainable development. Second, an appropriate leadership mechanism, the NCMS Joint Session of the State Council, is also an effective coordination instrument. By means of the Joint Session, departments can exchange their ideas frankly, which ensures the consistency of the guidelines. Third, the related departments share common interests in the development of the NCMS and do not have any fundamental conflicts. Therefore, coordination is not that difficult.

A case in point is the integration of the NCMS and the MAS. The civil affairs and health departments have worked hand in hand to pilot their integration in some places so that the rural poor can enjoy as much access to health care as do the non-poor. The MAS fund pays not only an NCMS premium for its beneficiaries but also part of their co-payment. As a result, service use among the poor is as high as or even higher than among the non-poor. The two departments have rolled out the pilot programme throughout the country.

3. **Voluntary enrolment with respect for farmers' decisions and the multi-channel financing mode must be respected by the NCMS.**

While the Government is responsible for "organizing and guiding"

farmers to participate in the NCMS, farmers can make the ultimate decision, which will be fully respected by the NCMS. In practice, almost all the farmers choose to participate, which is largely attributable to the big share of government subsidies in the programme. In 2003, when the NCMS had just been introduced, the government subsidy for each enrollee was 20 yuan, accounting for 66.7 per cent of the total contribution. In 2009, the contribution totalled 94.435 billion yuan (US\$24.851 billion, PPP), and 74.822 billion (US\$19.690 billion, PPP), or 79.23 per cent, was the government subsidy. Meanwhile, farmers' enrolment is family-based but their contribution is on a capitation basis. In 2009, the per capita premium was 23.5 yuan (US\$6.18 PPP). The Department of Civil Affairs also paid 917 million yuan (US\$241.32 million PPP) for the premiums of poor members. Moreover, NCMS has other financing options, such as donation.

The voluntary nature of the programme and its multi-channel financing mode are not sustainable unless the farmers begin to reap more generous benefits and always decide to participate.

4. **Rational and democratic decision-making provides technical support to the orderly and setback-free development of NCMS.**

The NCMS and the MAS are significant security schemes affecting

hundreds of millions of farmers. Even slight carelessness may lead to setbacks, to government's loss of credibility and to the weakening of the recognition of farmers.

When establishing and rolling out the NCMS, China adopted a strategy of "gradual roll-out after piloting to glean lessons and experiences". During the process, synergy between government officials and researchers has been given full priority. A technical guidance panel was set up at the very beginning. The panel has undertaken significant investigation, research and on-site supervision, and it has reported problems to programme administrators, enabling orderly adjustment. It has conducted continuous studies and monitoring in areas such as financing, design of benefit packages, fund management and safety, regulation of providers and cost containment. Moreover, it has studied the eastern, central and western regions and informed the decision-makers of its findings. The Joint Session selected some experienced experts to collect information in five chosen provinces and transmit it to the Joint Session. These measures ensure that the relevant policies are stable, coherent and feasible.

Most NCMS employees had insufficient knowledge and experience. To catch up to the fast pace of the two Schemes, the Ministry of Health invited experts and experienced officials, and organized repeated large-scale training ses-

sions. The training courses cover areas such as the NCMS institutional design, its organization and management, financing, management of medical risk, design of benefit packages, provider regulation, cost containment, fund safety and management, and management information systems.

5. The improvement of the service delivery system goes hand-in-hand with the progress of the medical security system and brings the latter into play to protect the health rights and interests of the people.

To ultimately guarantee access to health care for all, financial mechanisms such as the NCMS are indispensable but not enough. An equally important area is the supply of health services. Delivering services should go hand in hand with medical security.

In the past, the allocation of Chinese medical resources was imbalanced: most were concentrated in big cities and big hospitals. To reverse the situation, the Government has developed a rural medical security system and invested a great deal in a rural service delivery system.

(a) Improving Rural Medical Infrastructure

China has been implementing the *Development Planning of Rural Health Service Delivery System* since 2006. From 2004 to 2009, the Government spent 21.684 billion yuan (US\$5.706 billion

PPP) to renovate or newly build 36,000 rural health facilities. Among them, 24,000 are township health centres. As a result, rural providers have better conditions and stronger service capacity.

In 2009, the central government earmarked funds amounting to 20 billion yuan (US\$5.263 billion PPP) for the construction of 986 county hospitals, 3,549 central township health centres and 1,154 community health service centres.

Rapid progress in the post-earthquake reconstruction of the health service system in Sichuan, Gansu and Shaanxi has accelerated the upgrading of rural medical systems in the three provinces. By the end of November 2009, 1,531 projects had started, 760 had been completed and paid-up investment had reached 12.36 billion yuan (US\$3.253 billion PPP).

(b) Strengthening the Team of Rural Medical Workers

From 2005 to 2009, the central government invested 2.145 billion yuan (US\$0.564 billion PPP) in the training of health professionals, specifically training for township health centre directors, apprentices and village doctors in the central and western regions.

(c) Encouraging Urban Providers to Support Rural Ones

From 2005 to 2009, the central government set aside 1.04 billion yuan to carry out a partner assistance programme benefiting the county hospitals and township health centres in 592 national-level poverty-stricken counties and some provincial-level ones. As of 2009, 900 tertiary hospitals had been partnered with 2,200 county hospitals.

With a medical security system, farmers have more demand for health care. Only through a competent service delivery system can the demand be satisfied and the farmers' health rights actually be protected. In general, since the introduction of the NCMS, county hospitals and township health centres have provided service to about 82 per cent of hospitalized patients, which suggests success in the development of rural medical institutions.

Which department should manage the NCMS? This question was once controversial. The State Council decided that the Ministry of Health should be responsible for the NCMS, which is undoubtedly justified. Moreover, experience has proven that the existing management pattern is helpful for balancing the medical security

fund and service delivery, for strictly controlling costs and for guaranteeing the fund's safety. Based on the data from the Centre for Health Statistics and Information (CHSI) and the NCMS Research Institute, a comparison was made of the national average inpatient cost and the average for NCMS members. In 2005, the annual average inpatient cost of NCMS members was 3,260 yuan (US\$857.9 PPP) while the national average was 4,662 yuan (US\$1,226.84 PPP). In 2009, the two figures were 3,590 (US\$944.74 PPP) and 5,464 (US\$1,437.89 PPP) (both in nominal price), up by 9.2 per cent and 17.2 per cent, respectively. In 2005, the average hospitalization cost at county hospitals was 3,556 yuan (US\$935.79 PPP) for NCMS members and 3,381 yuan (US\$889.74 PPP) for the country as a whole. In 2008, the two figures were 3,791 yuan (US\$997.63 PPP) and 4,115 yuan (US\$1,082.89 PPP), up by 6.6 per cent and 21.7 per cent, respectively.

CHALLENGES

In spite of great progress, Chinese rural medical security is still faced with many challenges:

1. The coverage is still shallow and

a sustainable financing mechanism has yet to take shape.

In 2009, the total per capita contribution was only 113 yuan. The actual reimbursement rate was just 41 per cent even though 87 per cent of the total funds were used in reimbursement for hospitalization. The outpatient compensation per visit was only 18 yuan (US\$4.74 PPP). There are two ways to enhance the benefit. One is to increase the contribution; the other is to control the rising cost of health care.

At present, the contribution amount (from government and farmers' households) and its increase are dependent on administrative decisions, which are nonetheless influenced by many uncertainties. The NCMS fund cannot rise along with economic and farmers' income growth unless there is a mechanism for increasing financing that is based on laws and regulations. As such, it is urgent to formulate laws and regulations on the rural security system that tie increases in the NCMS subsidy to economic growth. In 2009, the fiscal revenue of the central government amounted to 6.8477 trillion yuan (US\$1.8018 trillion PPP) while the NCMS subsidy was 29.662 billion yuan (US\$7.8058 billion PPP), only 0.39 per cent of the former. A proportion of 0.8 per cent of the fiscal revenue will be needed if the NCMS reimbursement rate for hospitalization rises to 70 to 80 per cent and to 60 per

cent for outpatient service. There should be regulations for planning the steps to be taken. This is the essential condition for the sustainable and healthy development of the NCMS.

A farmer's annual individual contribution is about 30 yuan (US\$7.89 PPP), accounting for only 0.6 per cent of his/her net income, assuming a farmer's per capita net income was over 5,000 yuan (US\$1,315.79 PPP) in 2009. There should also be some rules stipulating that the individual contribution will increase with a rise in income at a given rate. Most experts agree that the appropriate ratio of contribution to income is 1 to 2 per cent.

2. Curbing the unreasonable rise of medical costs and fostering more effective service purchase are long-term projects.

With more investment in the rural health sector, enhanced service and technical capacity, medical costs tend to rise. As the fee-for-service payment system is currently prevalent, providers have an incentive to offer too many services. Cases of malpractice (over-prescription and over-examination) happen now and then. The average cost rises too rapidly (by over 10 per cent) in some places. Therefore, cost containment is a major challenge for the NCMS. On the one hand, some places have begun pilot reforms on the payment system by replacing fee-for-service with a

case-based or per-diem payment for inpatient service and with a capitation-based payment for outpatient service. On the other hand, many localities accelerate computerized management and strengthen supervision of providers using modern information technology instruments. However, all pilot reforms are still at an exploratory phase. A great deal more needs to be done to find out how to make better use of NCMS funds, how to render health-service purchasing more effective and how to benefit members more. Meanwhile, the quality of service has often been neglected. Attention should also be paid to the balance between cost and quality.

3. Further progress is needed to achieve equity and accessibility for the poor and the migrant worker.

For members, the out-of-pocket share of inpatient cost is still as high as approximately 60 per cent (even 70 per cent several years ago), which is beyond the affordability of the poor. Thus, the NCMS alone cannot solve the issue of accessibility and equity for the poor. In fact, among members, the poor use many fewer services than the non-poor. This situation will not change unless the MAS and the NCMS become integrated and the MAS pays all or part of the co-payment for the poor so that their out-of-pocket share can drop to 20 per cent or less.

However, given the current size of the MAS fund, this is impossible.

A rough estimate of the funding need of the MAS was carried out. According to the statistics of the Ministry of Civil Affairs, there were 62.677 million MAS beneficiaries in 2009. The financial assistance disbursed added up to 8.04 billion yuan (US\$2.116 billion PPP), that is, 128.3 yuan (US\$33.76 PPP) per capita.

The NCMS data from the 563 counties show that, for members, the average inpatient cost per episode was 3,780 yuan (US\$994.74 PPP) and the actual reimbursement rate was 41 per cent in 2009. If this were also the case with MAS beneficiaries, their out-of-pocket cost per episode would be 2,230 yuan (US\$58.68 PPP) after compensation by the NCMS. The two Schemes together cannot cover 80 per cent of their total cost unless the reimbursement rate of the MAS is 39 per cent, or 1,474 yuan per episode. Supposing the hospitalization rate were 9.9 per cent, there would be 6,205,023 MAS beneficiaries hospitalized, claiming 9.15 billion yuan (US\$2.408 billion PPP). Currently, within disbursed MAS funds, the ratio of outpatient compensation to inpatient reimbursement is about 3:7 (excluding the cost of non-communicable chronic diseases and catastrophic health expenditures). Based on this, the MAS fund for compensation would be 13.07 bil-

lion yuan. In 2009, the Ministry of Civil Affairs helped 43.66 million farmers with their NCMS contributions. Supposing the per capita contribution were 30 yuan (US\$7.89 PPP), the total disbursement would be 1.3 billion yuan (US\$0.342 billion PPP). In this case, the MAS fund would have needed 14.37 billion yuan (US\$3.782 billion PPP) in 2009, while its actual revenue was 8.04 billion (US\$2.116 billion PPP). This suggests a shortfall of 6.33 billion yuan (US\$1.667 billion PPP).

Even if the MAS has more financing, without effective integration with the NCMS, it cannot maximize its benefit to the poor. At present, only a few counties integrate the two effectively. Administrative instruments are needed to promote their integration throughout the country.

Rural migrant workers number about 120 million. Being away from home, they usually have a greater demand for medical service. Yet, owing to a lack of management capacity, the NCMS often refuses to reimburse, or reimburses at a very low rate, the medical expenses (for example, outpatient costs) that occur where migrants work. This negatively impacts migrant workers' service use and benefits. It is hoped that, with a national information network, members will receive compensation even in a place other than where they enrol. However,

under the current circumstances, it is hard to achieve such a system.

4. The NCMS should improve its own management capacity to meet the needs of the growing rural security system.

At present, every NCMS employee serves about 38,000 members. Many workers are in need of technical training. Moreover, the average operating cost per county is only 600,000 yuan (US\$157,894.7 PPP) and there is an average of 310,000 members per county. Given these circumstances, it is not surprising that providing high-quality medical security services is difficult.

Rural medical security is a long-term project. The prerequisites for its stable development include adequately qualified workers, the provision of various training opportunities for them and sufficient funds to cover operating costs. Unfortunately, these elements currently are not in place.

The NCMS benefit package, too, has yet to be improved. Questions outstanding include how to allocate funds among inpatient compensation, outpatient compensation and reimbursement for catastrophic health expenditure, and how to maximize the depth of coverage without running a deficit. In recent years, some counties consistently ran a deficit while others ran an overly high surplus simultaneously. Clearly, there is significant room for the adjustment of the benefit package.

The development of management information systems for rural medical security is imbalanced between localities. Some places have not made ample progress in the past several years. Provincial-level management information systems, in particular, lag behind, posing a barrier to offering convenient compensation services to members. Therefore, the need to accelerate the development of management information systems is quite pressing.

5. Integration of the urban and rural medical security systems

Balanced development calls for urban-rural integration, yet there is a gap in contribution amounts between the rural and urban medical security systems. In addition, residents in the two areas have different typical reasons for seeking medical care. Urban citizens prefer high-level urban hospitals while farmers usually go to grass-roots providers. To integrate the urban and rural systems, extra attention should be paid to protecting farmers' interests and preventing urban residents from taking advantage of farmers. Urban-rural integration suggests support from urban areas to rural areas and from industry to agriculture. Nevertheless, in some places, this principle is violated. As a result, the service use and benefits of farmers lag far behind those of urban residents. How should the urban and rural medical security systems be integrated? What impact

will integration have on the institutional management of the system? All of these uncertainties remain to be addressed.

China is currently undergoing health-care reform. The essential goal is to guarantee access to health care to all equally and to promote health for all. One of the major components of the initiative is boosting the development of the medical security system. This brings new vitality and new opportunities to the improvement of the rural system. China is capable of tackling challenges and overcoming difficulties so as to make the rural medical security system a success.

ⁱ National statistics, 2009.

ⁱⁱ WHO, Global Health Observatory, 2008.

ⁱⁱⁱ WHO, UNICEF, UNFPA and World Bank, Global Health Observatory, 2005.

^{iv} World Bank, *World Development Indicators 2008* and *Global Development Finance 2008*.

^v Ibid.

^{vi} Registered unemployment rate in cities and townships, 2009.

^{vii} UNDP, *Human Development Report 2009*.

^{viii} World Bank, 2009, World Bank 2005 survey-based estimates.



Colombia

Area	1,141,748 km ²
Population ⁱ	45,012,096
Age structure	
0-14 years	29.6
15-64 years	65.1
65 years and over	5.4
Infant mortality rate (per 1,000 live births) both sexes ⁱⁱ	16
Life expectancy at birth (years) female	76.8
Life expectancy at birth (years) male	69.4
Maternal mortality ratio (per 100,000 live births) ⁱⁱⁱ	130
GDP per capita	
Current USD ^{iv}	5,416
PPP (current international \$)	8,797
Constant local currency	6,234,943
Total health expenditures (as % of GDP)	7.44 ^v
Unemployment rate ^{vi}	12.2
Size of informal economy (%)	57 ^{vii}
Poverty (% of population)	45.5 ^{viii}
Extreme poverty (% of population)	16.4 ^{ix}
Human development index (HDI) rank ^x	77
HDI poverty indicators – Human poverty index rank	34
Minimum monthly wage (in US\$) 2010	221

The Subsidized Health-care Scheme in the Social Protection System

9

Elisa Carolina Torrenegra Cabrera

Colombia

Summary

- 1993 – Health-sector reform: converting a national health system into a system based on subsidizing demand (allocating money through subsidy to individuals, with administration by private insurance companies known as health-promoting entities (entidades promotoras de salud, EPSs) by assigning resources to the institutions in charge of health care, such as hospitals and clinics, from the nation's general budget;
- The General System of Social Security in Health (Sistema General de Seguridad Social en Salud, SGSSS) was created with two regimes: the contributive for those who can afford to pay and the subsidized for the poor;
- Objective: Universal health coverage - access to a variety of health services;
- Insures 41 million out of 46 million citizens;
- Beneficiaries of both the contributive and the subsidized regimes have access to a benefit package, but beneficiaries of the contributive regime enjoy additional services;
- Beneficiaries enrol with public or private insurers (health funds), have legal rights to an explicit package of health benefits, and receive care from a mix of public and private providers;
- Separation of the financing, stewardship and delivery functions within the health system;
- Introduction of a national equalization fund (Solidarity and Guarantee Fund (El Fondo de Solidaridad y Garantía, FOSYGA) to provide cross-subsidies between wealthy and poor, sick and healthy, old and young, and financing to shield health financing during economic crises;
- Establishment of the constitutional court and mechanisms to grant protection to individual rights, to enhance the public's access to the courts, and to help enforce the right to health;
- Financing: a mix of employer-employee contributions and general taxes;
- Results: increased public and private health expenditure and increased health insurance coverage.

Subsidized Health Insurance Scheme:

- Target group: Poor or informal workers;
- Selection of eligible poor and informal workers by the municipal authorities through a proxy means test;
- Financing: general taxes collected by the national government and transferred to the municipalities, reinforced by departmental and municipal contributions plus the transfer of 1.5 per cent of total collections from the contributive system.

Summary (cont'd.)

Contributive Health System:

- Target group: those who can afford to pay. Anyone with a labour contract or an income above two minimum salaries (if working independently) must be affiliated;
- Financing: wage contributions – 12 per cent of the declared income contribution, two thirds paid by the employer and one third by the employee.

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ECONOMIC AND SOCIAL CONTEXT OF THE SUBSIDIZED REGIME

Colombia's subsidized regime has its origins in the 1990s, a decade when international trends were based on the promotion of solidarity concepts, community participation, access to rural health services, self-management of health, health promotion and development through community participation, prevention in health care, and a focus on poor and vulnerable populations.

In Colombia, these global trends were consolidated through the establishment of the health plans serving the subsidized population (the Health Solidarity Organizations Programme (Programa de Empresas Solidarias de Salud, ESS). Established by the national government with support from the Inter-American Development Bank, these plans incorporated the public health policy concepts

that were already accepted internationally and promulgated in the discussion, analysis and decision-making processes of health systems around the world. This programme improved the organizing of rural communities and communities with a lower socio-economic status, empowering and teaching them how to manage their health themselves and promoting the adoption of healthy lifestyles. These concepts initiated the establishment of a Colombian health system that would facilitate the improvement of the population's living conditions.

In the 1990s, the country had a total health expenditure of approximately 6.2 per cent of the integrated gross domestic product (GDP) (table 1), comprising mainly out-of-pocket expenditure, which accounted for more than 3 percentage points and had a significant impact on poverty levels (see also table 2 for per capita expenditure on health).

Table 1 | Total health expenditure as a share of GDP.

	1993	1997	2000	2003
% of total expenditure on health/GDP	6.2	9.6	7.7	7.8
% of total public expenditure on health/GDP	1.4	3.4	3.2	3.1
% of social security expenditure on health/GDP	1.6	2.8	3.0	3.5
% of private expenditure on health/GDP	3.3	3.4	1.5	1.2
% of out-of-pocket expenditure /GDP	2.7	2.9	0.9	0.6

Source: Barón, G. (2007). *Cuentas de salud de Colombia 1993-2003: El gasto nacional en salud y su financiamiento*, Social Protection Ministry and National Planning Department.

Table 2 | Per capita expenditure on health.

	1993	1997	2000	2003
In current pesos	87,979	290,805	316,894	392,571
In constant pesos (2000 = 100)	255,717	403,147	316,894	320,074
In current dollars	112	255	152	136
In constant dollars (2000 = 100)	102	317	152	111

Source: Ibid.

The Gini concentration index for the second half of the 1990s was 0.56 (table 3).

After 2002, with the establishment of this programme and a combination of

Table 3 | Poverty statistics.

Year	GDP Growth (%)	Unemployment Rate	Gini Concentration Index	Income-Poverty Line (PL) (%)	Poverty Unsatisfied Basic Needs UBN (%)	Internally Displaced Persons (IDPs) per Year
1995	5.4	8.7	0.569	55.0	n.a.	89,000
1996	2.0	11.9	0.544	53.8	n.a.	181,000
1997	3.2	12.1	0.555	54.2	26.9	257,000
1998	0.57	15.7	0.563	55.7	26.3	308,000
1999	-4.20	22.0	0.556	60.1	26.1	225,000
2000	1.56		0.566			

Source: Sarmiento Anzola, Libardo, *Exclusión y Desarrollo Societal*. Nov. Ed. Desde Abajo. *Datos de Desplazamiento Forzado (Data on Forced Displacement)*: Codees Informa No. 26, p. 3.

other social assistance measures aimed at improving levels of poverty and equity in resource distribution, 2008 recorded a Gini index of 0.59. The poverty that had affected 55 per cent of the total population in the late 1990s fell 7 points, leaving 53.7 per cent of the total population in conditions of poverty in 2002 and dropping to 46 per cent in 2008. The level of indigence also declined from 19.7 per cent in 2002 to 16.4 per cent in 2008 at the municipal level. Indigence remained virtually unchanged in all other territories in the country.

A comparison of these figures with the health expenditures in 1993 calculated with the same methodology shows

that the most evident change is the substitution of private expenditure (especially out-of-pocket expenditure) for insurance-financed expenditure (social security contributions): private expenditure on health (as a share of GDP) decreased from 3.3 per cent in 1993 to 1.2 per cent in 2003 (3.4 per cent in 1997) and out-of-pocket expenditure dropped from 2.7 per cent of GDP in 1993 to 0.6 per cent in 2003 and 0.38 in 2009. From 2002 to 2010, the Government defined and institutionalized social protection strategies to protect initially the economically active population and, for some risks, the poor and vulnerable populations (table 4).

Table 4 | Financial consolidation carried out by the guilds involved in the health sector regarding the money available for this sector, 2009.

Type	Source	US\$
Contributory scheme	Contributions to Solidarity and Guarantee Fund (FOSYGA)	4,654,694,725
	FOSYGA Promotion and Prevention (PyP) – Health-promoting entities (EPSs)	141,671,029
	FOSYGA surplus	391,656,363
	Co-payments and moderation fees	122,835,717
	Total	5,310,857,834
Subsidized scheme	FOSYGA	1,218,053,089
	General Participation System (SGP)	1,351,633,716
	Others – Resources of territorial entities	312,022,433
	Surplus	278,249,561
	Total	3,159,958,799
The uninsured (Vinculados)	General Participation System (SGP)	517,779,685
	Transfers to departments	173,444,576
	Resources of territorial entities	520,862,032
	Catastrophic Risks and Traffic Accidents (ECAT), Mandatory Insurance for Road Accidents (Seguro Obligatorio de Accidentes de Tránsito, SOAT), Support to State Social Enterprise (ESE)	52,219,751
	Total	1,264,306,044

Table 4 | Financial consolidation carried out by the guilds involved in the health sector regarding the money available for this sector, 2009 (cont'd.).

Type	Source	US\$
Special scheme Total		1,029,758,424
Occupational risks	Assistance coverage (25 per cent of the total accrued premium)	143,730,979
SOAT (Mandatory Insurance for Road Accidents)	Assistance coverage (95% of net premium contributions)	290,724,014
	Road Accident Insurance Fund (As a result of the reform, the health subsidy received by the poorest segment of the population increased from 6.2 per cent in 1992 to 49.2 per cent in 2003 for quintile 1 of the population (table 8) (Fondo de Seguro Obligatorio de Accidentes de Tránsito, FONSAT)	79,487,131
	SOAT additional premium	143,991,233
	Total	514,202,378
Public health	General Participation System (SGP)	210,023,085
	FOSYGA	117,240,898
	National budget	70,109,747
	Territorial resources	246,363,858
	Fund for road safety	11,923,200
	Total	655,660,788
Other private resources	Pre-paid medicines, prepaid ambulance services (SAP) and complementary care plans (PAC)	747,345,662
	Personal health and accident insurance	411,736,652
	Expenditure in medicines trade channels	1,380,625,443
	Out-of-pocket expenditure	836,699,940
	Total	3,376,407,697
Total		15,454,882,943

THE SOCIAL PROTECTION SYSTEM

Colombia's social protection system was established in order to achieve two main goals:

- to protect the population from economic risks whether they be individual or not; and

- to assist the poor in overcoming this condition.

The General System of Comprehensive Social Security and all existing assistance to employees achieve the first goal. The second is reached by the establishment of the Social Assistance System, formed partly by the subsidized health scheme, the Red Juntos, Familias en acción, the National Vocational Training Service (Servicio

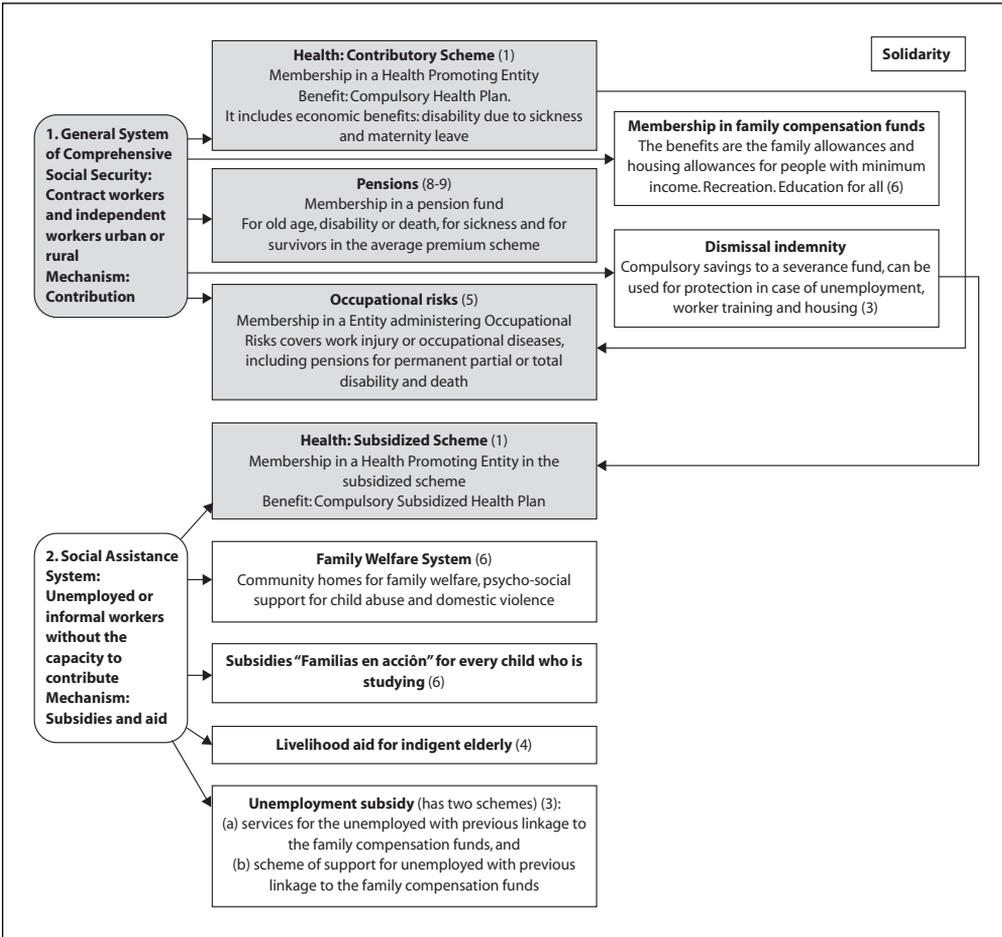
Nacional de Aprendizaje, SENA), and the programme of assistance to the elderly and the Colombian Family Welfare Institute (Instituto Colombiano de Bienestar Familiar, ICBF).

These various programmes or social assistance strategies cover the following risks: disease, nutrition, school dropout, capability to work, extreme poverty and old age. This list appears to cover all the life stages and all the conditions necessary for a person or family to be compe-

tent enough to enter the labour market, generate income and improve their quality of life in order to reach an optimal level of welfare. In reality, however, there is a lack of coordination of these efforts, a lack of comprehensiveness in the strategies defined to cover these risks, and a lack of intersectoral coordination, which reduces the efficiency of the social assistance system.

The social protection system has two components: the General System of

Figure 1 | Social Protection System of Colombia.



Comprehensive Social Security and the Social Assistance System. As a whole, the contents of each component respond to the call for new benefits contained in International Labour Organization (ILO) Social Security (Minimum Standard) Convention, 1952, as figure 1 shows, but they do not yet cover the entire population:

- (1) medical care;
- (2) monetary sickness benefit;
- (3) unemployment benefits;
- (4) old-age benefits;
- (5) occupational risk and injury benefits;
- (6) family benefits;
- (7) maternity benefits;
- (8) disability benefits; and
- (9) survivor benefits.

A. THE GENERAL SYSTEM OF COMPREHENSIVE SOCIAL SECURITY

Established in 1993, the General System of Comprehensive Social Security aims to guarantee the inalienable rights of the individual and the community to a quality of life commensurate with human dignity by providing protection against various contingencies that arise throughout the life cycle (Article 1, Law 100 of 1993). It is based on the principles of (a) efficiency (the best use of resources), (b) universality (protection for all without discrimination), (c) integrality (coverage of all contingencies that affect health, economic capacity and general life conditions of the

population), (d) solidarity (practice of mutual help between people, generations, economic sectors, regions and communities), (e) unity (articulation of policies, institutions, procedures and benefits in order to achieve the goals of social security), and (f) participation (the contribution of the community). The System includes four basic components: pensions, health, occupational risks and social assistance.

THE GENERAL PENSION SYSTEM

General Features

The General Pension System seeks to ensure protection against the contingencies arising from old age, invalidity and death through the recognition of pensions and benefits determined by law, and progressively extends coverage to the segments of the population not yet covered (Article 10, Act 100 of 1993).

The System has both compulsory and voluntary membership. Mandatory members are all persons linked by an employment contract; civil servants; persons providing services directly under service provision contracts; and independent workers and public servants who entered Ecopetrol (a Colombian petroleum company) as of 29 January 2003. The volunteer members are the following: all natural persons residing in the country; Colombians living abroad who are not compulsory members and are not specifically excluded by law; and foreigners who, under an employment contract, can remain in the country and are not covered by any pension scheme in their country of origin and decide to contribute to a pension fund.

THE OCCUPATIONAL RISKS SYSTEM

The Occupational Risks System covers occupational accidents and diseases (Atención en accidentes de trabajo y enfermedad profesional, ATEP), including pensions for total permanent or partial permanent disability and death.

Membership in the System is compulsory for:

- dependent domestic or foreign workers, linked by contract or as public servants; and
- retirees or pensioners, except those receiving disability benefits, who rejoin the workforce as dependent workers, linked by contract or as public servants.

Employers are obliged to register their workers from the start of the employment relationship between them, employers being the only financiers in this system. This process produces an affiliation agreement for all employees with an entity administering occupational risks (administradora de riesgos profesionales, ARP). The ARP receives contributions from employers and covers the promotion, prevention and response to risks related to injury and occupational diseases (ATEP) as well as pension coverage for disability or death caused by or during work.

ADDITIONAL PROTECTION

Additional protection is provided through the following:

- **child benefit:** a social benefit payable in cash, in kind and in services to workers with medium and lower incomes in proportion to the number of dependents whom they support. Its main objective is to alleviate the financial burden of sustaining a family, which is considered a basic unit of society. Employers collaborate with the family compensation funds to collect the 4 per cent from the monthly salaries of their employees, which is part of the 9 per cent of revenues that companies must deliver as para-fiscal contributions. Employees with a monthly income that does not exceed four times the monthly minimum wage are entitled to the benefit, which is calculated by taking into account the income of the spouse or permanent partner and any other labour income;
- **dismissal indemnity:** savings to cover dismissal. This is a social benefit of a special nature, which generally corresponds to one month's salary for each year of service and proportionately for fractions of a year. The benefit is paid annually and is required by law to be entered into a severance fund. Each member is entitled to an individual account and the severance fund has a guaranteed minimum return. Under current legislation, partial withdrawals can be made for:
 - (a) acquisition, improvement or to eliminate a mortgage on housing;
 - (b) higher education in State-

recognized institutions for the member and his/her spouse or children; or (c) the purchase of State shares. Total withdrawals can be made only in cases of cancellation of the work contract.

THE GENERAL SYSTEM OF SOCIAL SECURITY IN HEALTH

Specific Goals

The specific goals of the General System of Social Security in Health (Sistema General de Seguridad Social en Salud, SGSSS) are as follows

- universal coverage for all Colombians;
 - access to basic health services of a uniform quality for a fair contribution;
 - efficiency: improve the health situation by reallocating resources towards preventive and primary care and into rural and poor areas; minimize losses in the provision of services;
 - quality: ensure that the care provided to all meets the basic standards of quality and that the care given is of the highest possible quality given the available resources.
- provide information to consumers about their rights, obligations and the quality of services in order for them to choose which health-promoting organization they want;
 - establish reliable mechanisms for the monitoring and allocation of resources and ensure the financial stability of the system;
 - specify the standard package of benefits to which each family is entitled – Mandatory Health Plan;
 - establish the risk premium adjustment to pay these benefits – Risk Adjusted per capita Payment;
 - define the appropriate payment systems to create incentives for efficiency and quality;
 - develop institutions, processes and information to improve the quality of services;
 - establish the legal basis for the system; and
 - establish a dual policy for areas without sufficient market competition so as to improve efficiency and quality.

Central Policy Instruments

The General System of Social Security in Health aims to:

- enrol the population in health promotion entities and collect from those who must contribute;

General Concepts and Principles

The General System of Social Security in Health is a solidarity system that aims to regulate the essential public health services and create conditions of access to all levels of care for all people.

In addition to the general principles enshrined in the Constitution, the concepts and principles guiding the System and the provision of public health services

are as follows: (a) equity, (b) obligation, (c) full protection, (d) free choice, (e) autonomy of institutions, (f) administrative decentralization, (g) social participation, (h) consultation, and (i) quality.

The System is managed by the Ministry of Social Protection, with the National Health Regulation Commission performing a regulatory role and the National Health Authority (SuperSalud) assuming a monitoring, inspection and control function.

The General System of Social Security in Health must ensure basic health benefits to the entire population present on the national territory in a gradual and permanent manner as well as economic benefits for people with employment contracts or independent workers who contribute to the System.

The System is based on insurance with the participation of public and private insurance entities, with State intervention, and is organized into two types of schemes: the contributory scheme and the subsidized scheme.

Administrative Agencies

The health-promoting entities (entidades promotoras de salud, EPS)¹ are responsible for recruiting and ensuring health care for the population, subject to the rules defined by the National Regulatory Commission and the Ministry of Social Protection.

The health-care providers (instituciones prestadoras de servicios de salud) are private and mixed public institutions attached to the Ministry of Social Protection, such as the National Institutes of Health and the National Cancer Institute.

The Solidarity and Guarantee Fund (FOSYGA) is a national fund with a legal personality established to raise solidarity funds for the General System of Social Security in Health. It consists of four sub-accounts:

- the account for the distribution and compensation of resources of the contributory scheme;
- the solidarity account to co-finance the subsidized scheme;
- the account to cover catastrophic risks and traffic accidents; and
- the account for promotion and prevention for members of the contributory scheme.

Organization and Financing

1. The Contributory Health Scheme

The Contributory Health Scheme is comprised of people with the capacity to contribute to social security. Members of this system are entitled to a basic health-care plan (which conforms to the baseline for the entire population of Colombia) as well as economic benefits for incapacity and maternity leave. The

¹To end the monopoly of the Social Security Institute on the administration of the obligatory health-care insurance, private enterprises (profit or non profit), cooperative enterprises and other public or mixed enterprises were allowed to compete. All these enterprises were called "health-promoting entities".

basic plan of this Scheme covers the interventions described in the mandatory health-care plan (more information is available at www.pos.gov.co). These benefits are guaranteed by the health-promoting entity, whose main functions are to manage the membership of people who freely choose to join the Scheme which is mandatory for employees, to collect the relevant contributions, to organize the delivery network to ensure the smooth operation of the basic health-care plan, to be an advocate for users and to provide mechanisms for user participation in the General System of Social Security in Health. This Scheme has national coverage, which means that enjoyment of the benefit is not tied to permanent residence in a particular municipality or geographic region.

Membership in the Scheme is by family, which means that the contribution of the member also benefits his/her spouse or long-term partner, children under 18 years of age, children over 18 years and up to 25 years who are financially dependent on their parents for their studies, and totally and permanently disabled persons.

Funding

The Scheme is financed by contributions from members, with the contribution base established at 12.5 per cent of the salary or monthly declared income, of which 8.5 per cent is provided by the employer and 4 per cent by the employee. Independent workers must pay 100 per cent of the contribution from the income reported at the time that they

become members. In no event will the contribution base be less than the monthly minimum wage legally in force. The monthly contribution to the subsidized health scheme for pensioners and self-employed workers is set at 12 per cent of the income of the respective monthly pension; when accrued over 25 monthly legal minimum wages, the contribution base is limited to these percentages.

The contributions are paid to health-promoting entities, which are then responsible for transferring the funds to the Solidarity and Guarantee Fund (FOSYGA). In turn, FOSYGA remits a capitation payment unit (unidad de pago por capitación, UPC) back to the health-promoting entities to cover the premium of the insured. The capitation payment unit initially adjusted risk based on three variables: age, gender and geographic location.

The resources collected by the health-promoting entities are included in the Solidarity and Guarantee Fund (FOSYGA) compensation subaccount by means of the compensation mechanism, with the purpose of recognizing the capitation payment unit for members and their beneficiaries according to their age and gender. This subaccount covers 1.5 per cent of the financing for the Subsidized Health Scheme.

2. The Subsidized Health Scheme

(a) Origins of the Programme

Before the 1993 reform in the 1980s, the coverage of the General System of Social Security in Health did not exceed 20 per

cent of the Colombian population and was only given to government employees affiliated with the Institute of Social Security (Instituto de Seguros Sociales, ISS), the local department provident funds, teachers and the military. The major problem with the System lay in ensuring access to health services for the poor and vulnerable segments of the population, given significant regional differences and the fact that there was no

mutual help among members and much less of it among the poor.

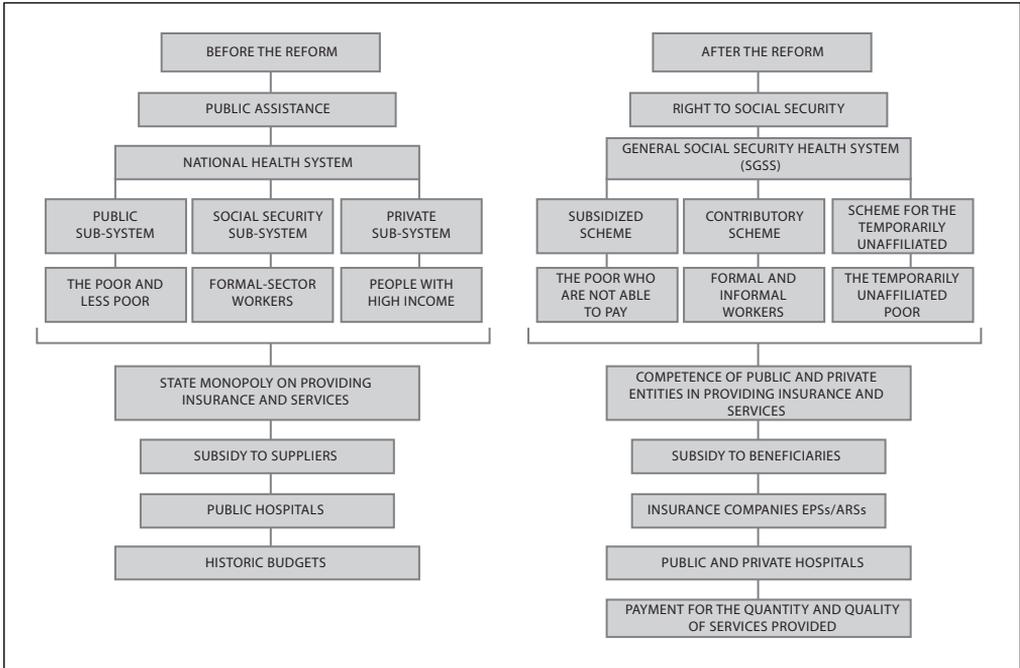
As stated in a March 1996 Harvard report,^{xi} there was an inefficient institutional organization, which produced highly inadequate results considering the sector spending and which led to growing user dissatisfaction.

Before the reform, those not incorporated into the General System of Social

Legal Bases of the Subsidized Health Scheme

1. Constitution of Colombia, Articles 1 and 2, Title II and Chapter II.
2. Act 100 of 1993, which established the comprehensive social security system and enacted other provisions.
3. Act 715 of 2001, which sets out organic regulations regarding resources and duties in accordance with Articles 151, 288, 356 and 357 (Legislative Act 01 of 2001) of the Political Constitution and which enacts other provisions for organizing the provision of education and health services, among others.
4. Act 1122 of 2007, which makes some changes to the General System of Social Security in Health and enacts other provisions.
5. Decree 1011 of 2006, which establishes the Compulsory System of Quality Assurance for Health Care of the General System of Social Security in Health.
6. Decree 050, whereby measures are taken to optimize the cash flow of resources from the subsidized scheme of the General System of Social Security in Health and which enacts other provisions.
7. Resolution 415 of 2009 through which the shape and operating conditions of the subsidized scheme of the General System of Social Security in Health are defined and other provisions are enacted.
8. Decree 1965 of 2010 – New Resource Flow.
9. Order 2086 of 2010 – Accelerated Procedure for a Drugs Registry.
10. Resolution 2114 of 2010 – Transfer Procedures.
11. Resolution 1805 of 2010 – Amends master accounts.
12. Ministry of Finance External Circular 017 of 2010 – Contract Settlement.
13. Digital Signature Circular of 2010.
14. Decree 1964 of 2010 on Recruitment.

Figure 2 | Key differences between the national health system and the Social Security Reform of 1993.



Note: EPSs = Health-promoting entities; ARSs = Subsidized Scheme Administrators.

Security in Health could access health services through health centres and public hospitals under a “charitable” scheme, which effectively meant that better health care was available only to those who could afford to pay for it out of their own pockets. The limit to the amount of care provided was set by the public provider and varied between regions and between institutions. There was neither an integrated, coordinated audit system nor a reference system to adequately respond to existing health problems.

The leading causes of death or disease were those typical of developing countries and associated with deficiencies in basic sanitation and public services infrastructure. However, in addition to

these, chronic and degenerative diseases began to appear – primarily those related to lifestyle and increased life expectancy such as diabetes, hypertension, cancer and chronic kidney disease. This reality required a shift in health-care approach, and specifically a greater involvement of society and a more preventive than curative approach. To achieve this goal, the Government of Colombia drew on the international trends of the 1990s, which thus affected the design and implementation of policy in Colombia.

(b) Description

Despite being part of the Social Assistance System, the Subsidized Health Scheme is considered a component of the General

System of Social Security in Health because of its financing system. The Scheme was designed for the poor and the indigent. This target population must apply to their municipality and undergo a means test. If they are under a certain level of income, they qualify and are authorized to become affiliated. The number of poor affiliates authorized in each municipality depends on the resources available.

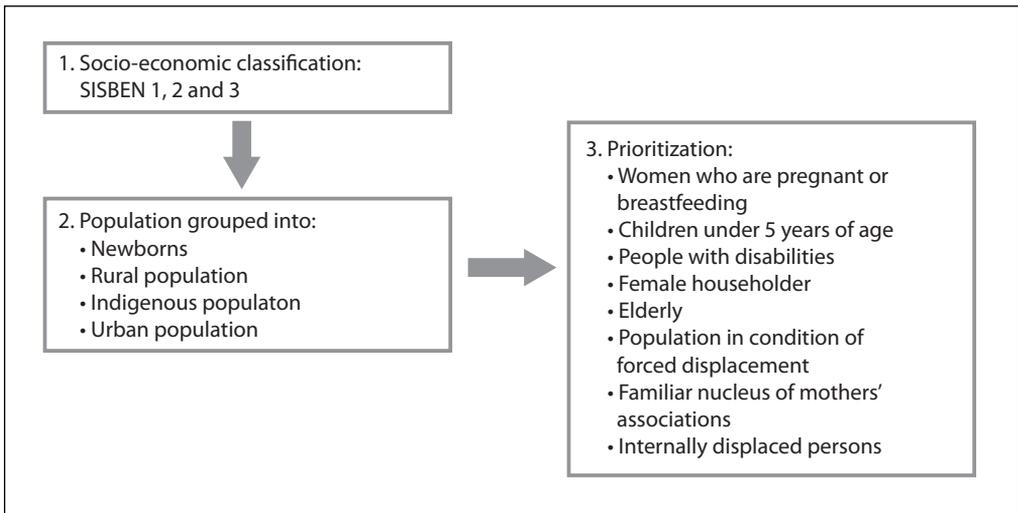
The proxy means test designed to identify the most vulnerable members of a municipality is organized through a questionnaire that is called the National System for Identifying and Selecting Beneficiaries for Social Programmes (Sistema nacional de identificación de beneficiarios de programas sociales, SISBEN). The SISBEN index is calculated at the household level and has six score levels, 1 being the poorest. People scoring at levels 1, 2 and 3 qualify for the Subsidized Health Scheme.

Potential beneficiaries are selected

from the list of prioritized individuals. The number of beneficiaries respects the established coverage goals and varies depending on the resources available for this purpose in each municipality. Ideally, family membership of prioritized populations is given precedence. However, this is not a necessary condition for membership. Thus individual membership may be granted if there are resource constraints and in particular if the case involves children under five years of age.

There also exist some special protection population groups, which are identified not through the SISBEN survey but through the census list prepared by the competent authority in each case. These groups are: (a) abandoned children; (b) indigent population; (c) population in conditions of forced displacement; (d) indigenous communities; (e) internally displaced persons; (f) abandoned and low-income elderly people; and (g) rural migrant populations.

Figure 3 | Beneficiary selection.



(c) Funding

Multiple funding sources and multiple organizations or agencies have been involved in order to achieve coverage of the entire population and ensure the provision of services originally chosen from the Basic Plan, which is offered to persons affiliated with the contributory Scheme. The three funding mechanisms for the Subsidized Health Scheme are national transfers from general taxation, solidarity contributions from the Contributory Scheme, and district and municipal efforts:

- the State through contributions from the national budget;
- 1.5 per cent of the contributions collected by the Contributory Scheme transferred by the Solidarity and Guarantee Fund (FOSYGA);
- the family compensation funds with 5 per cent or 10 per cent of child benefit receipts;
- territorial entities (departments, municipalities and districts) with resources that the nation transfers by means of the General Participation System (SGP) and resources from its own territorial efforts, which are the taxes taken from gambling and transfers for the Territorial Enterprise for Health (Empresa Territorial para la Salud, ETESA);

Table 5 | Coverage of the General System of Social Security in Health (SGSSS), 2009-2010.

	Value	% of Population
Country population*	45,508,205	100%
Contributory scheme members**	18,062,855	39.7
Employees, under contract, members of the subsidized scheme***	23,597,291	51.9
Members of Unique Affiliates Database (BDUA) subsidized scheme	20,772,333	45.6
Special schemes****	2,222,126	4.9
Total membership	41,057,314	90.2
Total funded	43,882,272	96.4
Unemployed population in the subsidized scheme	2,824,958	6.2%
Country population without funding	1,625,933	3.6%

*Source: National Administrative Department of Statistics (DANE), *Population Projection* 2010.

**Source: General Directorate of Policy Planning and Analysis (Dirección General de Planeación y Análisis de Política), until December 2009.

***Until 28 May 2010.

****Source: General Directorate of Policy Planning and Analysis, until June 2010.

- departments and the capital district, with the transfer of resources to the departments;
- 15 per cent of the additional resources received by municipalities, districts and departments by way of income tax on the production of oil companies in the Cupiagua and Cusiana area; and
- financial performance of the resources described above.

Today, this combination of funding sources, the use of solidarity between those who have the ability to pay and those who do not, the contribution of general, departmental and municipal taxes and out-of-pocket expenditure has led to the collecting of US\$3,159,958,799 in funds to meet the needs of the poorest and the most vulnerable populations. This has allowed the consolidation of an almost universal coverage, with more than 23 million poor and vulnerable people now having guaranteed access to health services.

(d) Membership

The membership process always requires: (a) the identification and prioritization of the population and the existence of resources to ensure the sustainability of membership; (b) the authorization of the National Health Authority (SuperSalud) for the health-promoting entities to operate the Subsidized Insurance Scheme in the region to which the municipality belongs, meeting the eligibility and/or permanence requirements; and (c) the

registration and authorization for the health-promoting entities to operate the Subsidized Scheme, given by the municipal health administration.

Once the preconditions are met, districts and municipalities must organize a transparent call for tenders, where, previously, potential beneficiaries of the Subsidized Scheme were called, in the order specified and in numbers equal to the numbers of the funded quotas. At this public event, the health-promoting entities are called on to participate on equal terms in order to be chosen by the exercise of free choice to which individuals are entitled. The membership process lasts for six to seven months from the time that the lists of potential recipients are published (90-120 days before) and starts the public event. Individuals select their preferred health-promoting entity before a municipal public official, and this will be expressed on a single membership form, which the member takes to a point of care provided by the entity selected in order to be enrolled and given a membership card.

The list of members of each health-promoting entity is consolidated with a defined structure entitled the Unique Affiliates Database (BDUA). This list is the central tool for the management and verification of rights and payments of the capitation payment unit for each participant entitled to insurance, as well as for system monitoring and statistics. This enables a monthly settlement, which in turn facilitates the liquidation of contracts at the end of each of their terms.

Membership in the Subsidized Scheme is municipal and is effective until a beneficiary changes municipalities. A member cannot retain membership beyond the contractual term; therefore, when people change their place of residence, they must report this change, exit the Scheme after completion of their contract, and then reapply as a potential beneficiary in the municipality that receives them.

There is also the possibility that Subsidized Scheme members change their income status or work activity at some time during the contract period, allowing them to contribute to the contributory regime. Therefore, the databases of the two Schemes need to be cross-checked every month in order to exclude temporarily or permanently all persons who meet this requirement.

These situations do not allow either adequate national portability, mobility within the territory with guaranteed access to health services, or adequate and timely mobility between Schemes – situations that are part of the great challenges faced by a system already accepted by the new Government. As a result of a recently established reform, the Unique Affiliates Database (BDUA) is managed by the Solidarity and Guarantee Fund (FOSYGA) and populated by the health-promoting entities through the presentation of monthly bulletins that report on membership retraction because of municipality change and on the transfer of health-promoting entities, among others.

Insurance Contract

Once the process takes effect, an insurance contract between the local entities and the health-promoting entity selected by the members is drawn up. This contract specifies the number of members that it covers, the value of the capitation payment unit (defined by the Regulatory Health Commission (Comisión de Regulación en Salud, CRES) for the corresponding period), the resources that finance the contract for each of the sources of funding, the database of members with the defined characteristics and the conditions set for this operation.

This recently modified contract has three features: it is electronic, standard within each municipality and multilateral. The real challenge, however, is standardizing the procedure with the Contributory Scheme in which there is no contract but rather a membership form between the health-promoting entity and the user and where the health-promoting entities support their members through the membership database and forms.

The local entity is responsible for monitoring and following up on the completion of the contract by the health-promoting entity operating within its territory. In order to achieve this goal, the local entity must have official supervision periodically and, as a condition for the periodic transfer of resources, must monitor compliance with agreed contractual obligations.

Another set of monitoring mecha-

nisms is the set of attention and user information mechanisms through which users can express dissatisfaction or make suggestions to ensure that the access to health services meets their needs.

(e) Health Insurance Management

Once the insurance contract is signed, the health-promoting entities guarantee access to the health services provided in the Mandatory Subsidized Health Plan (Plan Obligatorio de Salud Subsidiado, POSS), with the quality conditions agreed with the local authorities and accepted by the Quality Assurance System (Sistema Obligatorio de Garantía de la Calidad, SOGC).

The Quality Assurance System selects and hires the network of health-care providers who meet the enabling conditions defined by standards and negotiates the purchase prices of services and mechanisms of monitoring and follow-up, auditing, recognition and payment of services, and settlement. A contract sets out the agreed conditions between the health-promoting entities and the health-care providers (instituciones prestadoras de servicios de salud, IPSs) and provides, in the annex, the databases of members covered by said contract.

The health-promoting entity can use only 8 per cent of revenues from the capitation payment unit for administrative expenses; the 92 per cent left is to ensure access to health services and to

guarantee the health of members. Of this 92 per cent, 60 per cent must be contracted and executed with public institutions from the region.

Additionally, the health-promoting entities guarantee the reference and counter-reference system that enables users to access service at all levels of care. They also ensure participation in health care through partnerships and user associations to guarantee that users' voices are heard and appropriate adjustments are made to improve health care overall.

The health-promoting entities undertake a diagnosis of both the demography and the health risks of the populations that they cover to offer a wide range of covered risks. They then develop a health-care plan under the Mandatory Subsidized Health Plan and define the model of care that ensures access to initiatives of health promotion, prevention and early detection, health recovery and rehabilitation.

The health-promoting entities are also responsible for the regular monitoring of health-care indicators and health outcomes, as required by the Quality Assurance System and those contractually agreed, and for reporting to the authorities any deficiencies and improvement plans agreed on with the health-care providers in the monitoring of contractual obligations. Table 6 shows the results of the measurement of quality indicators from 2007 to 2009.

Table 6 | Quality indicators of the health-promoting entities, 2007-2009.

Indicator	2007- 1	2007- 2	2008- 1	2008- 2	2009- 1	2009- 2
Timely referral to a general practitioner (for general check-ups) (in days)	2.8	3.1	2.6	2.3	2.8	2.6
Timely referral to a medical specialist (in days)	6.6	7.3	7.5	7.4	7.3	8.8
Number of <i>tutelas</i> (court order/protection writ for the satisfaction of fundamental rights) for not receiving a service from POS* or POSS*	8,960	66,645	307,690	7,358	4,034	4,262
Timely delivery of medications, POS (%)	85.5	86.8	87.6	93.5	90.4	90.2
Timely action in carrying out planned surgery (in days)	12.8	13.9	15.4	15.6	14.2	11.8
Timely referral to general dentistry (in days)	3.7	4	3.9	3.4	3.8	4
Timely referral for medical imaging (in days)	4.1	4.2	4.1	4	3.6	3.1
Timely referral to an EPS, ARS, CCF, EA, MP (in hours)	3.7	2.2	2.3	2.6	4.5	5
Proportion of appropriate vaccination schemes in children under one year of age (%)	54	45.5	66.5	51.8	50	64
Timely detection of cervical cancer (%)	48.1	44.1	58.8	59.4	69.5	59.8
Mortality rate from pneumonia in elderly over 65 years of age (rate x 1,000)	13	10.5	14.6	7.2	8.7	12.2
Mortality rate from pneumonia in children under 5 years of age (rate x 1,000)	4.4	2.1	3.5	2.8	2.6	3
Maternal mortality rate (x 1,000)	51.9	40.6	47.1	41.3	53.2	44.6
Overall satisfaction rate (%)	71.2	78.7	81.5	81.8	87.1	91.1
Proportion of complaints resolved within 15 days (%)	83	84.3	74.2	73.5	83	80.4
Rate of transfers from EPS*, ARS*, CCF*, EA*, MP* (%)	0.8	0.4	0.6	1	1.2	0.8

*ARS: Subsidized Scheme Administrator (Administradora del regimen subsidiado)

*CCF: Family Compensation Fund (Caja de Compensación Familiar)

*EA: Administering entity (Empresa administradora)

*EPS: Health-promoting entity (Entidade promotora de salud)

*MP: Prepaid medicine (Medicina pre-pagada)

* POS: Mandatory Health Plan, for the employed (Plan Obligatorio de Salud)

* POSS: Mandatory Subsidized Health Plan (Plan Obligatorio de Salud Subsidiado)

(f) Benefit Plan

The Mandatory Subsidized Health Plan (POSS) corresponds to a selection of activities of the Mandatory Health Plan

(Plan Obligatorio de Salud, POS, which is for the employed) defined for the Contributory Scheme. However, it lacks a comprehensive range of services and

benefits and therefore needs to be updated and approved.²

The contents of the Mandatory Subsidized Health Plan are as follows:

- (a) comprehensive care for women during pregnancy, birth and the postpartum period for less than one year;
- (b) issues of a low level of complexity: health promotion and disease prevention as well as health recovery measures that are covered by general practitioners, other non-specialized health professionals and support staff and/or paramedics, and radiology services and low-complexity clinical laboratory work;
- (c) concerns of medium complexity: ophthalmology and optometry consultations for people below the age of 20 and over 60, strabismus care for children under five years of age, cataract treatment, orthopedics and trauma treatment, including magnetic resonance imaging (MRIs) and surgeries (appendectomy, hysterectomy, cholecystectomy, inguinal hernia, crural herniorrhaphy and umbilical herniorrhaphy, male and female surgical sterilization);
- (d) highly complex cases: heart diseases, thoracic and abdominal aorta, vena cava, pulmonary and renal vessels, surgical care for cen-

tral nervous system disorders, acute or chronic renal failure, care for burn victims, HIV and AIDS patient care, cancer patient care, partial or total hip or knee joint replacement, and intensive care.

The greatest challenge facing the country in terms of health content is to ensure updated and equal benefit plans for all people regardless of their employment situation. In light of this, the Regulatory Health Commission (Comisión de Regulación en Salud, CRES) is developing updated technical guidelines for the different diseases to be covered, and the new government has defined strategies to reach the financing goals that will allow the standardization of the benefit plans for all Colombians by 2014 at the latest.

(g) Capitation Payment

The capitation payment unit (unidad de pago por capitación, UPC) is the annual value of the health subsidy, which is set by the Regulatory Health Commission. It is the same amount for all members of the Subsidized Scheme and it is transferred periodically from the various funding sources to a master account to which municipalities, districts and departments must conform. These funding sources are combined into a common fund, with the resources from the funding coming from municipalities, districts and departments – available in the master account – and

²Law 100 mandates two standard health packages: the Mandatory Health Plan (Plan Obligatorio de Salud, POS) for the contributing population and the Mandatory Subsidized Health Plan (Plan Obligatorio de Salud Subsidiado, POSS) for the subsidized population. The POSS entails a less comprehensive package than the POS (initially); however, both include health promotion and basic preventive care while the contributory scheme includes curative and emergency services.

they must be turned over to the health-promoting entities two months in advance. This flow of resources has led to delays and to the loss of resources. Hence, another challenge for the new government is to shift resources directly to the health-promoting entities, enabling these resources to "follow" members in case they move or in case their socio-economic status changes.

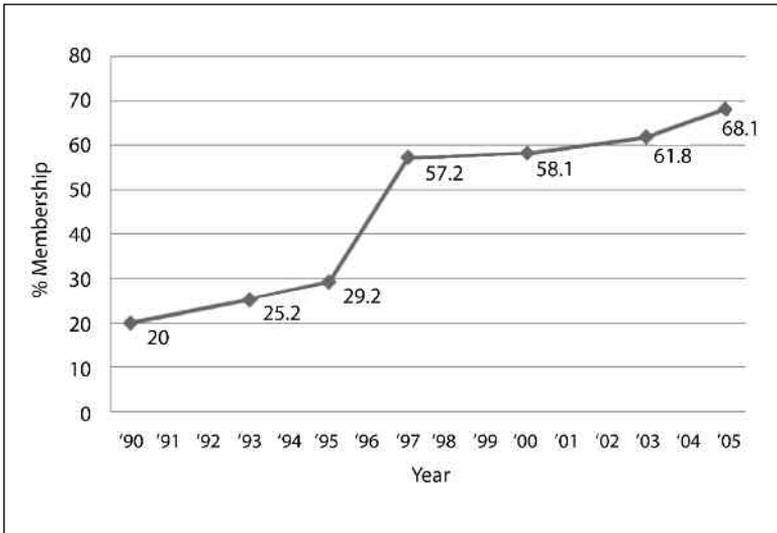
In geographically remote areas and in big cities and nearby urban centres, in which the population requires a greater and more complex range of health-care

services and has a higher concentration of diseases that are expensive to treat, the capitation payment unit is adjusted to take these risks into account.

(b) Impact of the Subsidized Scheme

Access

The study of the progress and challenges of achieving health equity in Colombia demonstrated that, as a result of 1993 reform, access to the General System of Social Security in Health increased from 20 per cent in 1990 to 68.1 per cent in 2005 (graph 1).



Graph 1 | Membership in the General System of Social Security in Health, 1990-2005.

There have been membership increases in all dimensions: in area of residence, region, gender or level of wealth, with progress being greatest in the poorest groups (graph 2).

Coverage data as of March 2010 (table 7) shows that 89.8 per cent of the

Colombian population has effective health coverage. In addition, there are a number of funded quotas for membership to the Subsidized Scheme, which, once assigned, will raise the health coverage to 95.1 per cent of the population.

Graph 2 | Membership in the General System of Social Security in Health, by wealth quintile, 1995-2005.

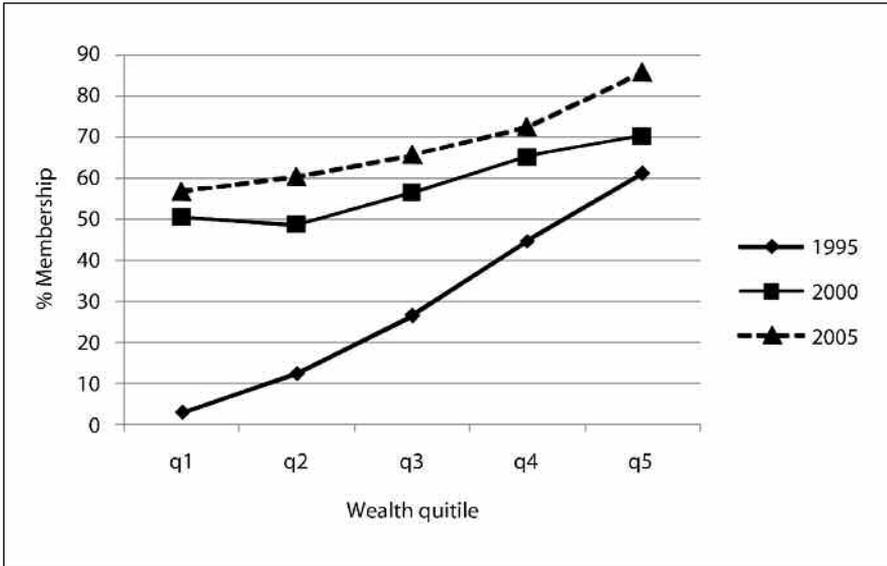


Table 7 | Population covered by the General System of Social Security in Health, 2009.

	Value	%
Country population*	45,399,789	100.0
Contributory scheme members**	17,687,031	39.0
Subsidized scheme members under contract	23,300,617	
of which BUAD subsidized scheme members	20,888,536	46.0
Special schemes***	2,192,197	4.8
Total members	40,767,764	89.8
Total financed	43,179,845	95.1
Unemployed population in the subsidized scheme	2,412,081	
Country population without financing	2,219,944	4.9

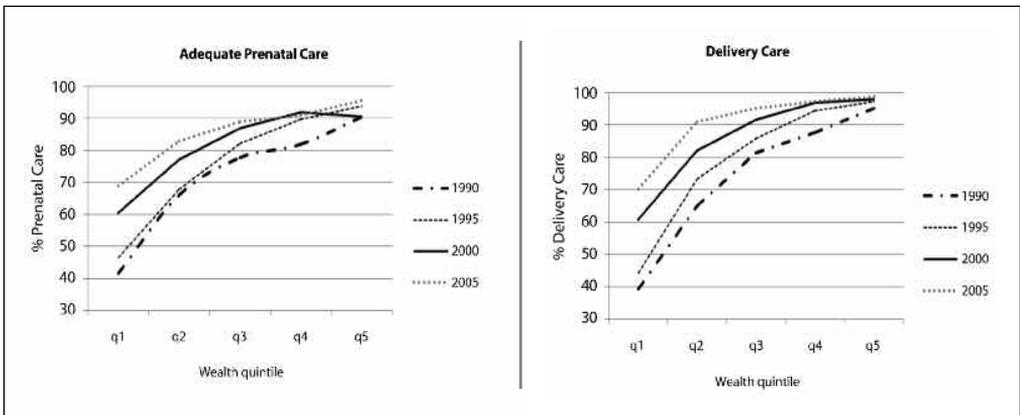
* Source: National Administrative Department of Statistics (DANE), Population projection, until March 24.
 ** Source: General Directorate of Planning and Policy Analysis, Average of members by compensation period.
 ***Source: Ministry of Social Protection, until December 2009.

Use of the Services: Professional Care

The Subsidized Scheme has facilitated the use of health services, especially among the poorest population and the rural population, which use 50 per cent more health services than the uninsured. Although inequities in the use of services

have declined, there were still cases of inequity in 2005 –primarily cases relating to the level of wealth (graph 3). Progress in terms of equity is related to the health system reform, and in particular to the Subsidized Scheme, since membership in the Scheme facilitates the use of health services by the poor.

Graph 3 | Adequate prenatal care and delivery care, by wealth quintile, 1995-2005.



Equity

As a result of the reform, the health subsidy received by the poorest segment of

the population increased from 6.2 per cent in 1992 to 49.2 per cent in 2003 for quintile 1 of the population (table 8).

Table 8 | Transfer as a proportion of income.

Quintile	1992 (Molina, Giedion, 1995) ^{xii}		2003 (This Study)		
	Total Population	Total Population	Members Contributory Scheme	Members Subsidized Scheme	Unaffiliated Population
1	6.2	49.2	20.9	120.1	45.4
2	3.7	16.2	7.5	40.4	13.4
3	1.8	8.7	2.7	24.4	7.0
4	1.0	3.7	-1.3	15.3	4.1
5	0.1	-2.9	-4.8	7.1	1.3
Average	1.2	1.9	-1.2	18.2	4.7

In 2003, the transfer of resources to the poorest segment of the population through the allocation of public resources and the solidarity of the overall system represented a 50 per cent increase in the income of these families.

Effects of the Scheme on Poverty

The net transfers made by the General System of Social Security in Health to provide health services have reduced poverty by more than two percentage points and inequality by more than three points. These results improve the level of equity since benefits are higher for the poorest segment of the population. The three measures of poverty (incidence, intensity and severity) decreased as a result of the transfers made by the System, with greater benefits for the poorest segment of the population.

(i) Degree of Coordination with Other Programmes

All programmes or systems seek to prevent, mitigate and overcome social and occupational risks, which as a whole are responsible for the greater or lesser degree of vulnerability of families and individuals and provide protection against the loss of employment, health, work capacity, a breadwinner, etc. There are direct interactions with the Contributory Scheme for the mobility of members between the two Schemes and the 1.5 per cent solidarity contribution. It is therefore essential to safeguard the existence of social protection programmes for all people, even those who

have the ability to pay, to ensure that they do not fall into poverty as they grow older and/or if their social or economic conditions deteriorate.

For the poor and vulnerable segments of the population, it is necessary to ensure that social assistance programmes (see the next section) are coordinated according to the health outcomes of the population and that they complement specific health measures in order to effectively influence health determinants and achieve better results in poverty reduction. Health measures should be the gateway to a social protection system guaranteed by the social assistance component.

(j) Situation of Beneficiaries after Passage through the Programme

The main contribution of the Subsidized Scheme is the reduction of poverty of its members through assuming out-of-pocket expenditures and thus enabling members to cover other necessary expenses, improve their socio-economic status and be eligible to enter the labour market.

When there are articulation and coordination between social assistance programmes, there are a greater increase in work capacity and a sharper decline in poverty levels as a result of the introduction of health measures.

Similarly, ensuring mobility between schemes, continuing to guarantee social protection benefits to workers, and progressing in the extension of income protection and better health benefits for the poor will ensure that beneficiaries progress

towards the improved living conditions that are vital for the entire population.

B. THE SOCIAL ASSISTANCE SYSTEM

The Social Assistance System has various mechanisms to provide subsidies to those who do not have the capacity to contribute and help them to lead a dignified life, especially during the critical life stages:

- **work training.** The system provides, through the National Training Service (*Servicio Nacional de Aprendizaje, SENA*), technical training to employees or the underemployed to enable them to enter the labour market. It also conducts business, community and technology development activities. The National Training Service is funded with the 2 per cent of revenues that constitute the fiscal contributions made by firms;
- **strengthening the family and protection of minors.** The Family Welfare System (*Servicio Público de Bienestar Familiar, SPBF*) is defined as a public service under the responsibility of the State and it is subject to a legal regime established by law.

The Family Welfare System strengthens family ties, enables families to access ongoing training and education on the rights and responsibilities of its members, and

provides children and young people with support on an ongoing and permanent basis for comprehensive development with the help of the family and the community.

The Family Welfare System gives priority to poor urban areas, rural areas, the most vulnerable, and the high risk of neglect, malnutrition, physical danger and/or psychological risks in children and young people;

- **“Familias En Acción” Programme.** This is an initiative of the national government to deliver nutrition or education subsidies to children from the poorest families, displaced families or families from indigenous communities. The Programme involves providing monetary support directly to the beneficiary mother, subject to commitments by the family in terms of education (i.e., ensuring school attendance) and health (i.e., guaranteeing that children will be taken to the scheduled medical check-ups for physical growth and development);
- **protection scheme for the unemployed.** Created as a mechanism for intervention in the critical times of economic cycles, this scheme consists of a temporary subsidy administered by the Ministry of Social Protection. It is distributed only when specified by the Government and after approval by the National Economic and Social Policy

Council. The financial resources of the scheme come from: (a) contributions allocated from the national budget; (b) resources given by local authorities for social protection plans, programmes and projects; (c) donations received; (d) financial returns generated by investing the resources mentioned above; and (e) financial yields on their excess liquidity and, in general, all other funds received in any capacity. These resources are deposited into the Employment and Unemployment Subsidy Fund, which is considered a special account under the responsibility of the Ministry of Labour and Social Security.

The programme offers services for unemployed workers who have previous links to the family compensation funds, which entitle them and their dependents or beneficiaries to the same access to education, training, and recreation and social tourism programmes (supported by the family compensation funds) as they had had before they left the scheme. This is valid for one full year from the time that workers are declared unemployed by the last fund with which they were affiliated.

In addition, workers who have contributed to the family compensation funds for 25 years or more and are pensioners are entitled to training and recreation and social tourism programmes at the lowest rates of each family compensation fund. There are also two schemes

for the unemployed, one of which is the support system for the unemployed with previous links to the family compensation funds. Under this scheme, the heads of households who find themselves unemployed after having been in the system of family compensation funds for no less than one of the three years preceding the request for support, are entitled – covered by the resources of the fund for employment promotion and unemployment protection – to the following benefits on a one-time basis until the resources are exhausted:

- (a) a subsidy equivalent to the amount of one and a half months of the statutory minimum wage, which is divided and paid out in six equal monthly instalments. These may be made effective through contributions to the health system and/or food stamps and/or education, depending on which one the beneficiary chooses. For this purpose, the funds reserve a maximum of 30 per cent of the resources that they manage for the promotion of employment and unemployment protection; and
- (b) training for the job placement process. For this purpose, the funds reserve a maximum of 25 per cent of the resources that they manage for the promotion of employment and unemployment protection;

- **support system for the unemployed without previous links to family compensation funds.** Through 5 per cent of the fund for the promotion of employment and unemployment protection, the family compensation funds have established a scheme of support and promotion of employment for heads of households without previous links to the family compensation funds. This takes the form of a subsidy equivalent to a monthly statutory minimum wage, paid out in six equal monthly instalments, which may be made effective through contributions to the health system and/or food stamps and/or education, depending on which one the beneficiary chooses. Priority is given to artists, writers and athletes who affiliated with the corresponding associations or who can prove that they hold one of these occupations. To access this benefit, one must prove that he or she lacks the capacity to pay in accordance with the terms and conditions set out in the regulations.

Out of the parafiscal contributions intended for the National Training Service, 25 per cent of the resources that the Service receives from contributions is reserved for the training of the unemployed population, as set out in the terms and conditions determined by the Government for the management of these resources as well as the content of these programmes.

The largest problem with these so-called “other protections” destined to provide assistance to poor and vulnerable populations is their lack of internal coordination, which makes it difficult for beneficiaries to access these protection measures.

FUTURE IMPROVEMENTS AND CHALLENGES

The challenges facing the General System of Social Security in Health (SGSSS) are to:

- ensure its sustainability by finding mechanisms to shield resources from the instability of the economy. Currently, each of the capitation payment units is supported by three sources that must be sustainable in the long run: solidarity resources from the contributing population; the General Participation System from national taxes; and the funding from local and provincial taxes. When assumptions of employment growth are not satisfied, the second-largest source of financing, the Solidarity and Guarantee Fund (FOSYGA), is threatened;
- guarantee the portability of the subsidized insurance scheme in order for people to be able to exercise their right to protection regardless of their movement between areas;
- implement automatic mechanisms

that enable people to switch from one type of membership to another should they lose or gain the ability to contribute to the social security system; this requires that the modus operandi of the schemes be very similar; and

- recognize and publicly disseminate results of the progress and achievements of the System since it is necessary to build and strengthen it through a solid health communication strategy designed to improve people's sense of belonging to the System and enhance communication with users about decision-making processes.

^{xii}Molina, C. G., Giedion, U., Rueda, M. C. and Alviar, M., "El Gasto Público en Salud y Distribución de Subsidios en Colombia", *Estudio de Incidencia del Gasto Público Social*, FEDESARROLLO, Departamento Nacional de Planeación, Santafé de Bogotá, 1994.

ⁱ World Bank, *World Development Indicators 2008*.

ⁱⁱ WHO, Global Health Observatory, 2008.

ⁱⁱⁱ WHO, UNICEF, UNFPA and World Bank, Global Health Observatory, 2005.

^{iv} World Bank, *World Development Indicators 2008* and *Global Development Finance 2008*.

^v Intergremial Commission, 2009.

^{vi} National Administrative Department of Statistics (*Departamento Administrativo Nacional de Estadística*, DANE), 2010.

^{vii} DANE, 2009.

^{viii} National Planning Department, 2009.

^{ix} Ibid.

^x UNDP, *Human Development Report 2009*.

^{xi} Colombia Health Sector Reform Project, *Report on Colombia Health Sector Reform and Proposed Master Implementation Plan*, Harvard School of Public Health, Boston, 1996.



Ecuador

Area	272,045 km ²
Population ⁱ	14,204,900
Age structure (%) ⁱⁱ	
• 0-14 years	31.5
• 15-64 years	62.2
• 65 years and over	6.4
Infant mortality rate (per 1,000 live births) both sexes ⁱⁱⁱ	21
Life expectancy at birth (years) female	78.2
Life expectancy at birth (years) male	72.2
Maternal mortality ratio (per 100,000 live births) ^{iv}	210
GDP per capita	
• Current USD ^v	4,056
• PPP (current international \$) ^{vi}	8,014
• Constant local currency	1,745
Public social security budget as % of GDP ^{vii}	8.41
Total social protection budget as % of GDP ^{viii}	10.6
Unemployment rate ^{ix}	7.44
Human development index (HDI) rank ^x	80
HDI poverty indicators – Human poverty index rank	38
Minimum wage per month in \$ ^{xi}	240

Towards a Universal Pension Protection Scheme

Ruth Alicia Lucio Romero

10

Ecuador

Summary

2010: Process of establishing a social security system that will allow the fostering of a universal, equitable and financially sustainable pension system:

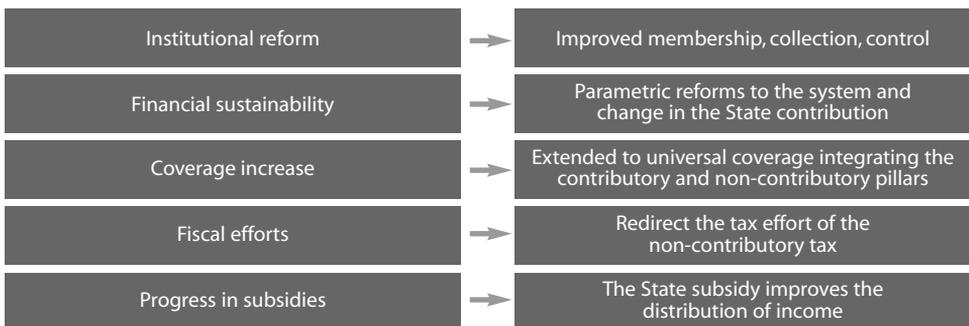
- basic universal pension system;
- a contributory scheme. For approved exceptions only, a non-contributory scheme in which the State subsidizes the contributions of the poor;
- financing: individuals and employers. The initiative proposes a progressive and equitable State subsidy based on the income level of the contributors.

Milestones

1. Work with the President and the Cabinet for approval of the proposed reform.
2. Creation of the National Secretariat of Social Security.
3. Organic Law on Social Security.
4. Establishment of the Single Service for Registration, Affiliation and Collection of Social Security.
5. Generation of administrative and organizational institutional conditions for the incorporation of the Ecuadorian population into the system.

Key actors: Government ministries, institutes of social security, trade unions and business organizations.

Coordination of actors: Carried out by the Ministry of Coordination and Social Development until the establishment of the Regulatory Institution.



Information on the Author

Ruth Alicia Lucio Romero, Team coordinator of social security reform in Ecuador, health expert for the Ministry of Health, coordinator and liaison with the Ministry of Health and the Ministry for the Coordination of Social Development.

BACKGROUND

SOCIAL SECURITY SCHEMES AND COVERAGE

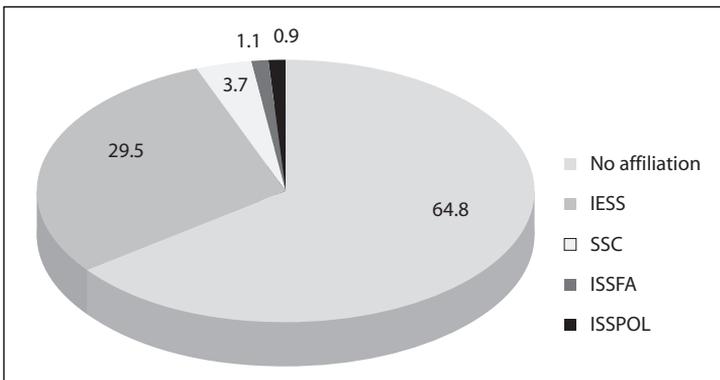
Currently, only one fifth of Ecuadorians or one third of the economically active population is covered by one of the four social security schemes: the Ecuadorian Social Security Institute (Instituto Ecuatoriano de Seguridad Social, IESS),¹ Farmers’ Social Insurance (Seguro Social Campesino, SSC), the Social Security Institute of the Armed Forces (Instituto de Seguridad Social de Fuerzas Armadas, ISSFA) and the Social Security Institute of the National Police (Instituto de Seguridad Social de la Policía Nacional, ISSPOL). Each scheme works independently and there is no coordination among them (graph 1).

The protection is largely guaranteed to those in formal employment. It does not cover the family except for very basic coverage in the case of the police and

armed forces and farmers’ social insurance. Family coverage consists of access to health services within the network of the institute to which the contributing member belongs. In the case of the Ecuadorian Social Security Institute (IESS), membership is individual and has only recently been extended to children under six years of age and spouses, enabling them to access health-care services.

The principal challenge of the Ecuadorian social security system is its low coverage rate. Of the economically active population, the proportion of premium payers hovers around 35 per cent (table 1) so that out of 100 economically active persons, 65 do not pay social security premiums.

In the field of social protection for the poor, the State also provides (since 1998) a conditional cash transfer programme known as the Human Development Bond (Bono de Desarrollo Humano, BDH) for the elderly who do not have a pension



Graph 1 | Affiliated economically active population, 2009.

Source: Social Security Institutions, 2009, National Institute of Statistics and Censuses of Ecuador (INEC).

¹IESS administers the following programmes: the farmers’ social insurance (health-care and old-age benefits); individual and family health insurance, including cash benefits; job risk insurance; and general insurance for disability, old age and death.

Table 1 | Structure of the population covered by social security, 2009.

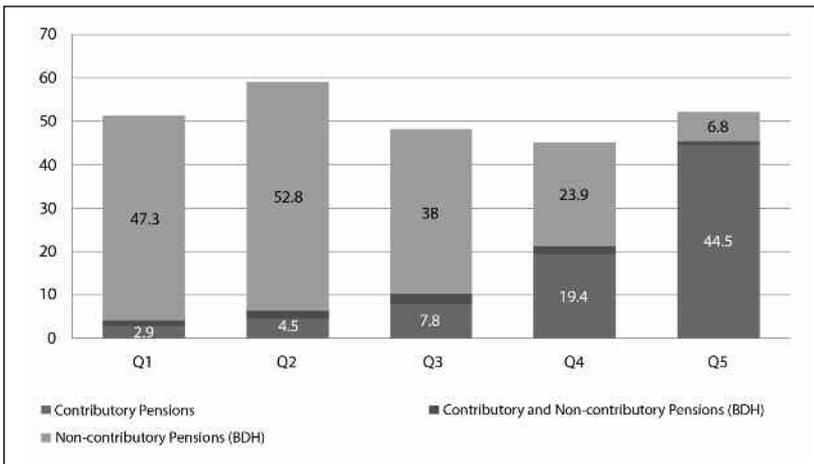
Membership Scheme	Affiliated Population	Population with Health Coverage	%
Ecuadorian Social Security Institute (IESS) - Farmers' Social Insurance (SSC)	2,367,305	3,602,713	89.26
Social Security Institute of the Armed Forces (ISSFA)	74,674	223,058	5.53
Social Security Institute of the National Police (ISSPOL)	56,352	210,531	5.22
Total number of affiliated people	2,498,331	4,036,302	100.00
Affiliated population/total population of Ecuador, 2009			17.8
People insured/total population of Ecuador, 2009			28.8
Affiliated population/economically active population			37.8

Source: Institutional records, National Institute of Statistics and Censuses (INEC). Elaboration: Ministry for the Coordination of Social Development (Ministerio de Coordinación de Desarrollo Social).

and who are recognized as living in conditions of poverty. In 2008, pension assistance increased substantially, rising to US\$35 per month per person and covering 371,000 elderly people.

Thanks to the incorporation of pension assistance, the number of people not covered by social security is now less

than 50 per cent of the total population. Nevertheless, the coverage gap remains significant, especially in low-income quintiles, as shown in graph 2. On average, 31 per cent of the elderly are covered by pension assistance, 18 per cent by social security pensions and 1 per cent by both systems.

**Graph 2** | Population covered by pensions, per income quintile, 2009 (as a percentage).

Source: National Institute of Statistics and Censuses (INEC), Employment and Unemployment Survey, 2009. Produced by the Ministry for the Coordination of Social Development.

FINANCING, PROGRESS AND SUSTAINABILITY

As currently applied, the State subsidies for social security are highly regressive since they are concentrated in the wealthiest deciles of Ecuadorian society

(table 2). The State transfers to the richest 20 per cent (9th and 10th income deciles) US\$370 million annually as subsidies to pensions.

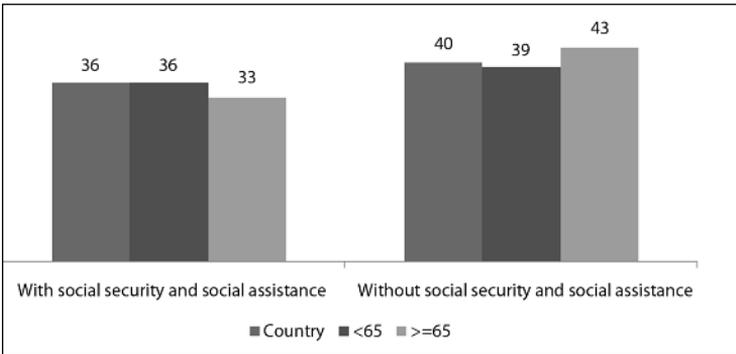
Therefore, for the Ecuadorian reform process, it is of primary importance both to increase coverage and to define a progressive system that will allow the funnelling of subsidies to precisely those segments of the population in greatest need of assistance, thereby ensuring a more equitable system.

Another important issue relates to ensuring, through social protection measures, that population groups do not slip into poverty. In an analysis of the impact of social protection on poverty through its two main components, social security and social assistance (the Human Development Bond, BDH), it was reported that, under current policies, in 2009 the

Table 2 | Distribution of pension subsidies per income decile, 2009.

Income Decile	Average Amount per Month (in US\$)	Total amount per Year (in US\$)	%
1	27	1,644,348	0.3
2	37	3,271,176	0.6
3	46	4,500,828	0.9
4	74	8,851,764	1.7
5	74	12,774,360	2.5
6	72	14,539,224	2.9
7	98	34,612,596	6.8
8	114	57,439,956	11.3
9	123	110,805,492	21.7
10	176	261,191,844	51.3
All	128	509,631,588	100.0

Source: National Institute of Statistics and Censuses (INEC), Employment and Unemployment Survey, 2009. Produced by the Ministry for the Coordination of Social Development.



Graph 3 | Poverty rate, 2009.

Source: National Institute of Statistics and Censuses (INEC), Employment and Unemployment Survey, 2009. Produced by the Ministry for the Coordination of Social Development.

country prevented about 11 of every 100 adults over 65 years of age from falling into poverty (graph 3).

Social Security Contributions

Currently, the financing of existing social insurance systems in Ecuador is borne by members and employers, and, in terms of pensions, it rests on a wide range of State

contributions to civilian and police and Armed Forces schemes.

To maintain the level of required contribution, the 2010 social security budget has put forward a projection of 8.4 per cent of gross domestic product (GDP). This historic budget implementation, however, notes that between 20 and 30 per cent of what is planned in the budget

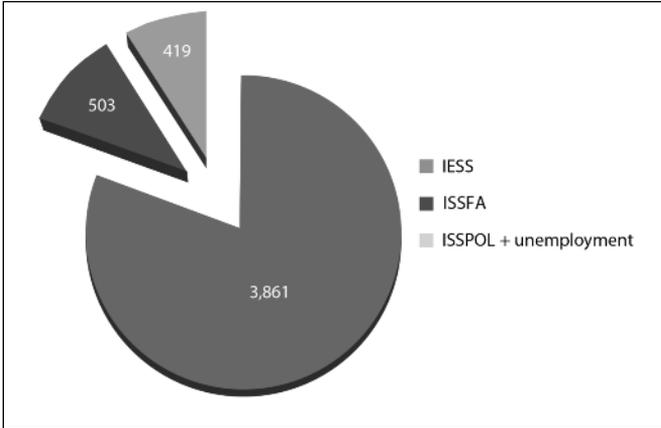
Table 3 | Rates of contributions to social security, 2010 (as a percentage).

Contributions over Wages (Stated Income)	Ecuadorian Social Security Institute (IESS)	ISSFA Armed Forces Scheme	ISSPOL Police Force Scheme
Pensions			
• Invalidation, Old Age and Death	from 9.74 to 11.74		
• Retirement, Invalidation and Death		25.55	23.27
Dismissal Indemnity	3.00	12.50	15.75
Sickness and Maternity	5.71	9.20	5.50
Occupational Hazards	0.55	0.30	0.15
Reserve Funds	8.33	8.33	8.33
Life			1.01
Funeral Services		0.40	0.38
Housing Fund		1.05	2.40
Contingency Fund			0.50
Professional Indemnity			0.14
Total Individual Contribution	9.35-11.35	23.00	23.10
Total Employer Contribution	17.48-19.48	34.33	34.33
Total Individual and Employer Contribution	26.83-30.83	57.33	57.43
Contributions over Total Pension			
State Contribution to Total Pension	40% of total pension of civil system	60% of total pension of military system	60% of total pension of national police system

Source: Law and Regulation Institutions. Produced by the Ministry for the Coordination of Social Development.

every year is not executed because of bureaucratic inertia.² Furthermore, the health expenditures via the National Health System, projected at 2.2 per cent of GDP, should also be added to the social

security budget. This brings the total budget for 2010 (graph 4) to 10.6 per cent of GDP. If 1.2 per cent is added for the Human Development Bond (BDH), the total becomes 11.8 per cent of GDP.



Graph 4 | Social security budget, 2010 (in millions of US\$).

Source: Institutional Budget. Produced by the Ministry for the Coordination of Social Development.

Within the social security budget, the highest percentage of the budget (about

52 per cent, on average) is concentrated on the pension sector (table 4). The het-

Table 4 | Social security budget per scheme, 2010 (% of total).

	Ecuadorian Social Security Institute (IESS)	Social Security Institute of the Armed Forces (ISSFA)	Social Security Institute of the National Police (ISSPOL)	Social Security Budget
Pensions	48.24	77.79	57.66	51.78
Sickness and Maternity	34.40	8.80	15.23	30.71
Dismissal Indemnity	11.21	13.09	24.22	12.13
Occupational Hazards	2.08	0.52	2.89	1.97
Farmers' Social Insurance	4.06			3.42
Total	100.00	100.00	100.00	100.00

Source: Institutional budgets 2010. Elaboration: Ministry for the Coordination of Social Development.

²Bureaucratic inertia is responsible for the gap between what is planned and what is executed, particularly in sectors such as health care where the planned health services are not implemented. This is changing rapidly thanks to improvements and changes in the bureaucracy in some regions. For example, in the regions of Pichincha, Santo Domingo, Tsachilas and Esmeraldas, where the local administrations have recently changed, the problem of the delays in the payment of millions of dollars to service providers has been solved in one trimester.

erogeneous figures for each scheme reflect the non-existence of a uniform social security system.

THE INITIATIVE FOR SOCIAL SECURITY PROTECTION: TOWARDS A UNIVERSAL PENSION MODEL

The initiative to expand the social protection system was not an unfamiliar topic in the debates of the last decade in Ecuador, but it was not until the new government came into office in 2008 that a Constitutional provision for a universal model was implemented.

The new Constitution includes among its main guidelines the establishment of social security as an inalienable right. Executing and upholding this right constitute the duty and primary responsibility of the State, which is also responsible for legislating, regulating and controlling activities relating to social security and ensuring that it is a public and universal system.

Following the new legal and policy framework, President Correa and the political movement that supports him are the drivers of the social security reform in Ecuador today. In order for the reform to be successful, it is necessary to put forward the creation of an organic law to incorporate the different laws that govern each system, allowing the changes that had been needed by the Ecuadorian social security system in the last several decades to take place. Within this frame-

work, a key element among those necessary to guarantee continuity in time is maintained, although the political conditions for approval are just developing.

The purpose of the social security system, through mandatory universal insurance, is to provide coverage to the entire population – regardless of employment status – for contingencies such as sickness, maternity, paternity, occupational hazards, dismissal indemnity, unemployment, old age, invalidity, disability and death.

POLITICAL FEASIBILITY

In Ecuador, this is the first time in several decades that a government is able to come to power and promote a comprehensive structural reform of social security. This being a topic whose definitions are usually anchored in lobbyist groups, the majority of past governments chose not to alter even minimal elements of the system's structure. The government of Rafael Correa counts among its assets the following: the President's popularity; the evident political will to reform the country; the experience in implementing and reforming other complex issues in Ecuadorian society; and the emergence of previously unseen conditions such as a majority in parliament and independent and reliable technical institutions. These factors make the approach seem serious, relevant and politically feasible.

PROCESS TO ACHIEVE THE PENSION PROTECTION SCHEME

It is necessary to point out that the guidelines outlined below are only preliminary guidelines that will probably still be subject to a number of changes during the technical analysis phase by the Office of the President, other members of the Cabinet and their technical teams.

COVERAGE INCREASES

At present, there are 1.8 million employees covered by the Ecuadorian Social Security Institute (IESS) while the Social Security Institute of the Armed Forces (ISSFA) reaches 37,700 affiliates and the Social Security Institute of the National Police (ISSPOL) 39,300.

The initiative to reform the social security system seeks to extend social protection in order to include all those who do not have access to social security. This initiative has two strategies: to aggressively increase the wage-earning contributory population (i.e., those who are not affiliated although their affiliation is compulsory) and to include contributory independent workers and poor people. The objective is to achieve universal coverage; in order to do so, compulsory and persuasive strategies and incentives have been carefully and specifically designed, with the aim being to impact Ecuadorian society as a whole.

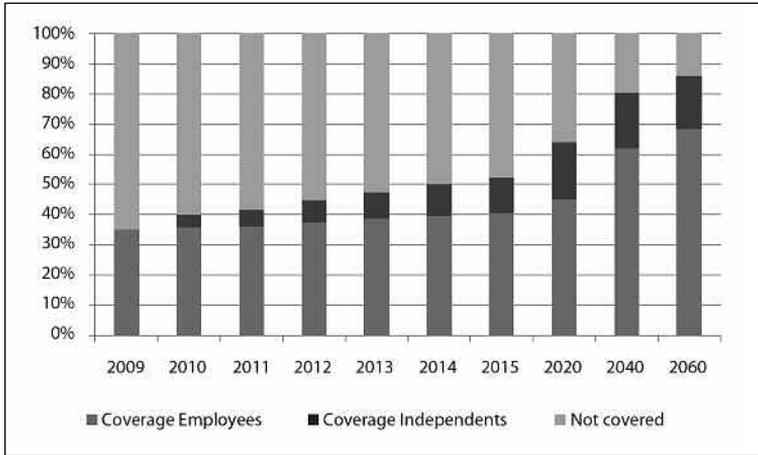
Historically, the social security coverage has been expanding, especially for

those layers of the population that have better working and living conditions given the institutional, administrative and legal designs in force in the institutions in charge of the issue. In the last two years in particular, the involvement of wage earners has been strong and estimates foresee the inclusion of between 5 and 10 per cent more people per year in the future.

In the current view, the progressive expansion of coverage towards universal coverage is seen as a key objective of the reform. Therefore, plans have been drawn up for the inclusion of independent workers in the social security system at a rate of coverage extension of 5 per cent per year in order to cover 70 per cent of independent workers, starting with a population of independent workers of 10 per cent in 2010. The possibility of setting more aggressive goals to complete the process in the next decade is also analysed.

On the other hand, an increase in the minimum coverage of the poor at a rate of 5 per cent per year has been planned in order to reach a coverage rate of at least 85 per cent of the poor population. However, since this part of the population is already included in the census, this group will become an easier one to target and recruit. This will consequently imply developing an effective mechanism to incorporate these new members into the system in a timely manner.

It should be noted that the developed modelling is far less ambitious and considers the inclusion of members as a



Graph 5 | Progressive coverage of the Ecuadorian population by the social security system.

Source: ILO actuarial models and specialized studies. Elaboration: Ministry for the Coordination of Social Development.

medium-term process of at least two decades (graph 5). Obviously, if the incorporation proceeds at a faster pace, this will only improve the likelihood of sustainability of the social security system.

In any case, the initial strategies to increase the population covered by social security predict the prioritization of interesting and flexible mechanisms that reflect an understanding of the groups that are to be included and their efficient recruitment. By 2040, it is hoped that at least 75 per cent of the Ecuadorian population will be included in the social protection system and that it will be possible to maintain this coverage in the following decades.

CONTRIBUTIONS

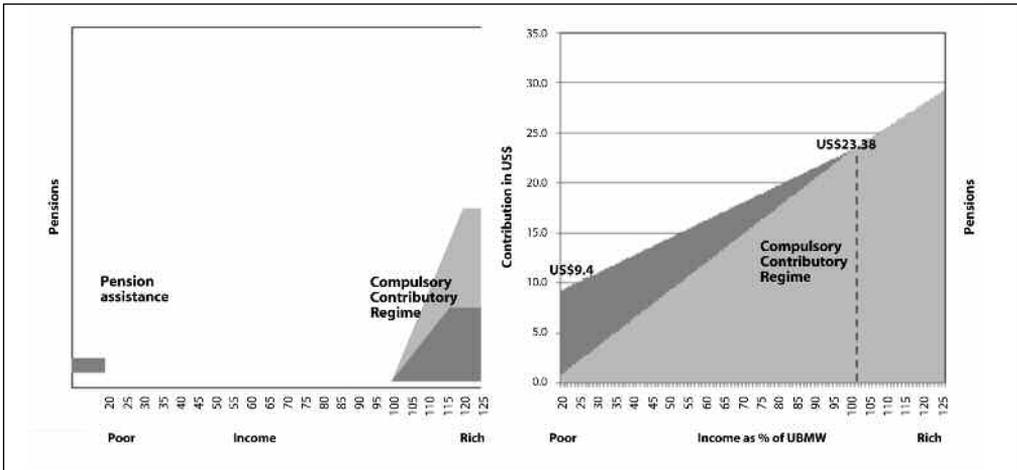
The proposal establishes the universalization of rights and contributions, therefore proposing to extend the contributory system by mandatorily incorporating the largest part of the population, even that part that lives in poverty and can con-

tribute only minimally to a future retirement pension (graph 6). Only in the case of indigents would the State consider subsidizing 100 per cent of the contributions. In summary, the proposal puts forward a contributory scheme and, for approved exceptions only, a non-contributory scheme in which the State subsidizes the contributions of the poor.

The initiative establishes that, within the social security system, financing of the contributory pension scheme rests on individuals and employers. This highlights the possibility of eliminating, for the first time in decades, the 40 per cent State contribution to the system. It proposes a progressive and equitable State subsidy, based on the income level of the contributors, and whose approach will be examined at a later time.

The current contribution of the State to the pension scheme amounts to 40 per cent of total expenditure on pensions, which is equivalent to about 5.62 per cent of payroll. It will be replaced by the

Graph 6 | Towards a universal and equitable model.



Note: UBMW = unified basic minimum wage.

current employer contributions for health insurance (3.41 per cent of payroll). The remaining 2.21 per cent of the required contribution is under analysis to delegate the contributions of employee, employer or State because the system requires the same general average premium (5.62 per cent) to adequately cover the financial needs of the fund pension.

In addition, in striving for balance in the social security system, the full financing of the health sector would become the sole responsibility of the State, which would commit to financially covering the amount needed for health coverage. This responsibility is made explicit in the Constitutional framework.

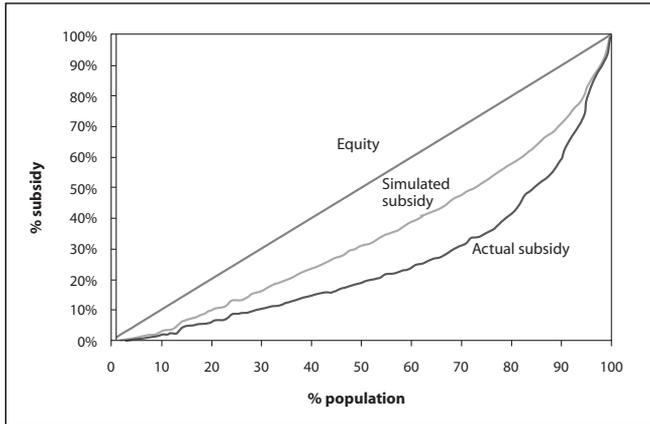
As well as implementing a supplementary contribution for pension coverage in general, the State should also contemplate the implementation of an equitable subsidy for those independent workers who are not able to earn an average income at least equal to the unified

basic minimum wage (UBMW) – US\$240 in 2010 – and whose minimum declared earnings correspond to 20 per cent of the UBMW.

Through the contribution meant to complement the declared income in an inversely proportional way and reach the minimum contribution quota, the State hopes to significantly impact the regressive nature of the subsidy, thereby achieving a significant improvement with respect to equity in Ecuadorian society as a whole (graph 7).

With regards to the social security schemes of the police and the Armed Forces, the proposal discussed above analyses the possibility of homogenization of these pension systems so that they will be comparable to the civilian scheme both in terms of contributions and benefits. However, it should be clear that, since these are closed systems with small population groups, the proposal will have to consider that State contributions are necessary

Graph 7 | Subsidies from the State pension system (actual and simulated).



for the systems to be sustainable.

After evaluating financial sustainability, the State will have to be transparent in revealing how much it contributes to each scheme in order for the Ecuadorian people to know the specifics of contribution amounts. If this option is implemented, it remains to be seen what the required transition period would be to unify contributions and what would happen to the individual contribution of soldiers and the national police, which at this point are higher than civilian contributions.

HOW COULD THE STATE SUBSIDIZE THE SYSTEM?

The first thing to consider is that a new

obligatory regimen is being created for the independents. In this initiative, independent workers contribute to the system only if they earn an amount equal to at least 20 per cent of the unified basic minimum wage (UBMW). This is what will be recognized as the minimum income contribution (MIC) (= \$48 in 2010). However, to calculate the subsidy (i.e., the complementary part), a presumed income must be estimated, which will be at least 40 per cent of the UBMW (= \$96). The presumed income will be the basis on which to estimate the amount of subsidies to be received (table 5).

In addition, with the purpose of making the system equitable as a whole, a general contribution of 9.74 per cent has been established, whose division between employer and employee is currently being analysed.

In order to make the system equitable, an equal minimum pension for employees and independent workers cannot be established. To be able to comply with the principle establishing that the

Table 5 | Examples of the calculation of State subsidies for independent workers (in US\$).

Declared Income	Presumed Income	Total Contributions	Personal Contributions	State Subsidies
20% of UBMW	40% of UBMW	9.74% of 40% of UBMW	\$1.00	\$8.35
25% of UBMW	43.75% of UBMW	9.74% of 43.75% of UBMW	\$1.88	\$7.83

higher the contribution the higher the pension, the minimum pension is scaled depending on the number of contributions. According to this definition, in order to calculate the pensions of independent workers, a “presumed income” will be taken as a reference point, and it is on this basis that the values of the State

subsidy and the pension are estimated, which directly recognizes the greater or lesser effort of the contributor, rewarding contributory efforts as a basic principle.

To understand the model proposed for the subsidy and estimations realized, the required variables and the subsidy formula are presented in table 6.

Table 6 | Subsidy formula.

	Abbreviation	Variable	Formula
0	UMW	Unified basic wage	Issued and adjusted by the Government
1	SMA/MIC	Minimum salary or income of contribution	$20\% \text{ UMW minimum} = 0.2 * 240 = \text{US\$48}$
2	Y	Income declared	
3	YMP	Minimum income presumed	$40\% \text{ UMW minimum} = 0.4 * 240 = \text{US\$96}$
4	YP	Income presumed	$Y + (\text{YMP} - \text{MIC}) * \text{PR}$
5	PR	Relative weight	$\text{PR} = (\text{UMW} - \text{Y}) / (\text{UMW} - \text{SMA})$
6	9.74%	Total rate of contribution (TAT)	TAT (issued and adjusted by law)
7	TYMP	Individual rate of contribution with income	$\text{US\$1} / \text{YMP} = \text{US\$1} / \text{US\$96} = 1\%$
8	TSMP	State rate of contribution (subsidy)	$\text{TSMP} = (\text{TAT} - \text{TYMP}) * \text{PR}$

On the basis of these formulas, a system is established in which the State subsidy is progressive and related to citizens' efforts in making their contribution. The State contribution will be proportional to the level of income of the employees and higher for those layers of the population with fewer resources. Pensions are determined also by individual effort, therefore constituting a direct reward for the effort made. However, in an attempt to maintain not only an equitable system but also a fair one, the pension amount is established through estimation formulas in order to have a minimum pension that

enables people to adequately carry on with their lives.

PARAMETRIC REFORM

In addition to the issue of the reconfiguration of contributions and financial responsibilities, the possibility of establishing a set of minor parameter changes has been discussed. The aim of this would be to make the reform sustainable, taking into account the labour market structure and the labour history of Ecuador as well as international conventions. The proposal that has been worked

Table 7 | Parametric reform.

Parameter	>= 45 years of age (Actual Scenario)		< 45 years of age (New System)	
	Conditions for access to pensions	40 years of contributions		30 years of contributions /60 years
	30 years of contributions	/60 years	30 years of contributions	/60 years
	15 years of contributions	/65 years	15 years of contributions	/65 years
	10 years of contributions	/70 years		
Calculation base	Average of the best 5 years		Average of the last 10 years of contributions	
Replacement rate formula	43.75%+1.25%*(# of contributions-5)		50%+0.67%*(# of contributions-15)* Average (10 years of contributions) Present value	
			50%+0.67%*(# of contributions-15)* Average (years of contributions) Reduced pension	
	50% of UBMW	10 years of contributions		
	60% of UBMW	11-20 years of contributions	Formula proposal for minimum pensions for employees 50%+0.67%*(Number of contributions-15)* UBMW	
	70% of UBMW	21-30 years of contributions		
	80% of UBMW	31-35 years of contributions	Formula proposal for minimum pensions for employees 50%+0.67%*(Number of contributions-15)* 40% UBMW	
	90% of UBMW	36-39 years of contributions		
	100% of UBMW	40 years +		

out to date is summarized in table 7.

FINANCIAL FEASIBILITY: FISCAL EFFORTS

The parametric reform discussed in the previous section predicts significant

results in the national economy. Above all, however, it entails the possibility of rearranging the tax sources, which will contribute to the sustainability of a more comprehensive and less expensive social security system – less expensive for the

State and therefore for the Ecuadorian population (table 8).

With the changes that will be intro-

duced, it is projected that the tax burden will be balanced in such a way that from 2030 onwards and with the help of the

Table 8 | State contribution pension, Ecuadorian Social Security Institute (IESS) (as a percentage).

	2009	2010	2011	2012	2013	2014	2015	2020	2040	2060
Current scheme										
Total (% of GDP)	1.0	1.0	1.0	1.0	1.1	1.1	1.2	1.3	2.5	5.0
New Scheme										
Total (% of GDP)	0.3	0.3	0.5	0.6	0.6	0.7	0.7	0.9	1.1	0.7

new model, the tax effort will increasingly distance itself from what would otherwise be required if a broader reform were not undertaken.

The reform thus proposes balance and ensures the sustainability of the pension system of Ecuador's civilian population.

Thus, the reform is crucial not only for guaranteeing the fiscal sustainability of the universal social security system but above all for building a progressive system that protects the Ecuadorian population as a whole.

TECHNICAL FEASIBILITY AND ADMINISTRATIVE CAPACITY

Ecuador has at its disposition the skills and knowledge, developed by the main institutions of its social security system, that are needed for the reform process. The analyses carried out to achieve advances towards a social security protection scheme have established the require-

ment of incorporating the existing social security institutions and articulating them in a single social security system. The analyses have also established the procedures that result in adaptations and extensions of functions carried out today to strengthen the system's administrative capacity.

Therefore, Ecuador has the equipment and tools required although it will in time need more of these resources. Obtaining this boost in resources is feasible in the short term because of the existing human and financial resources. However, in the medium term, there is a clear need for human resources trained and specialized in the field of social security, which will be critical for driving the structuring and maintenance of the social security system.

INSTITUTIONS AND ACTORS INVOLVED IN THE REFORM

One of the positive outcomes of the system reform was the consolidation of the

technical discussion within a coordinator ministry, in this case the Ministry for the Coordination of Social Development. This allowed for a social vision and a positive response to the call for meetings and open dialogue among the financial, political and economic institutions of the country and the same institutions administering insurance, which traditionally have been difficult to engage with in dialogue.

This outcome also became a cornerstone for the future implementation of an organic law, which will implement the substantive elements proposed by the reform since the environment of technical consultation has already been generated. In the transition towards a social policy of guaranteed rights, this environment enables the consolidation of an institutional system with redefined roles and functions that establish the difference with the previous system and ensure the systemic functionality that is required.

The social security system was designed according to the following:

- the establishment of a national secretariat to enable the policy direction and guidance necessary for the consolidation of a real social security system as well as efficient management of each sub-system or scheme administrator;
- the creation of a single body administering the national database, whose registration as well as collection functions enable the necessary coordination (which was previously nonexistent); and

- requirements for monitoring and quality control that will be implemented in existing institutions, enhancing their control and monitoring role by facilitating efficient management of social security resources.

CHALLENGES

In conclusion, social security is the basis and foundation on which social protection is articulated in Ecuador and on which all other human development programmes can establish levels of support and/or complementarity. Therefore, a successful reform is a strategic priority for the social policy of the country, which aims to deliver sustainable and equitable development for the decades to come.

One of the key challenges is the fact that although the reform is currently starting to be implemented in Ecuador, the preparation needed to achieve universal insurance, based on a segmented market, requires a close relationship between the model of economic growth and adjustments of the labour market that are generated by the model.

In addition, Ecuador's major challenge will be to organize the system and avoid duplication of activities and subsidies so as to expand the coverage achieved by optimizing resources and ensuring that public funding is committed to those who need it the most in a redistribution operation unprecedented for the country

Finally, the key challenge will be to

create, in a very short amount of time, a culture of contribution and respect of the law and not merely of public assistance since the practice of favouritism is still prevalent in Ecuador, particularly in the field of social security. This will require society to commit to a new learning period of co-responsibility and not patronage. The fostering of such a culture, through the fundamental pillar of education on social security, will make the proposed reform significantly more viable.

The long months of preparations and analysis have yielded many lessons, which focus largely on anchoring arguments in proven technical analyses. In this endeavour, having an open mind to collaboration with experts on this issue and the appointment of specially trained teams have been particularly important elements in taking decisive and technically adequate steps to meet these challenges.

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ⁱⁱⁱ WHO, Global Health Observatory, 2008.

^{iv} WHO, UNICEF, UNFPA and World Bank, Global Health Observatory, 2005.

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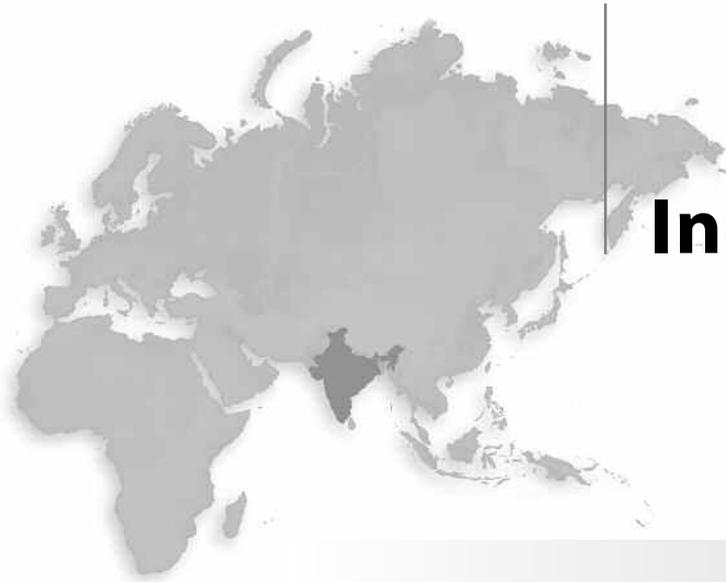
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^{ix} Central Bank of Ecuador, September 2010.

^x UNDP, *Human Development Report* 2009.

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ⁱ National Institute of Statistics and Censuses (INEC)-Economic Commission for Latin America and the Caribbean (CEPAL), 2003.



India

Area	3,287,263 km ²
Population ⁱ	1,173,108,018
Age structure	
0-14 years	31.3%
15-64 years	61.3%
65 years and over	7.4%
Infant mortality rate (per 1,000 live births) both sexes ⁱⁱ	52
Life expectancy at birth (years) female	65
Life expectancy at birth (years) male	62.1
Maternal mortality ratio (per 100,000 live births) ⁱⁱⁱ	450
GDP per capita	
Current US\$ ^{iv}	1,017
PPP (current international \$) ^v	2,946
Constant local currency	31,663
Per capita total expenditure on health (PPP current international \$) ^{vi}	109
Private expenditure on health as percentage of total expenditure on health	73.8
Unemployment rate ^{vii}	10.7%
Labour force	467 million
Percentage of workforce in informal economy	94%
Human development index (HDI) rank ^{viii}	134
HDI poverty indicators – Human poverty index rank	88
HDI health indicators – Life expectancy at birth rank	128
HDI education indicator – Adult literacy and gross enrolment in education	120

Rashtriya Swasthya Bima Yojana

Anil Swarup
Nishant Jain

11
India

Summary

Target group:	Population below the poverty line.
Target population:	300 million by 2012.
Benefits:	Coverage of Rs 30,000 (US\$650) for a family of five for one year; Transportation charges of Rs 1,000 (US\$22) per year; Pre-existing diseases covered from day 1; One day pre-hospitalization and five-day post-hospitalization covered; No age limit.
Funding:	Central and State governments pay the premium to the selected insurer; Beneficiary pays Rs. 30 as the registration fee per year.
Delivery process:	Each enrolled beneficiary is provided with a biometric smart card; Beneficiary can visit any empanelled hospital across India; Beneficiary is provided cashless treatment; Hospital submits paperless claims to the insurance company.

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BACKGROUND

There has been a growing belief among decision makers that the absence of a meaningful social security arrangement was not merely a problem for individual workers; it had wider ramifications in the economy and society. Consequently,

definite initiatives were taken towards inclusive growth wherein marginalized sections of society could participate in as well as benefit from development. Providing social security to the entire workforce, especially unorganized workers, emerged as one of the major concerns in the country.

The high growth rate (averaging around 8 per cent per annum during the past couple of decades) provided an opportunity to undertake various social protection initiatives for the population. It also created the necessary fiscal space for taking such steps. The Unorganized Workers' Social Security Act, 2008 was legislated to provide a framework for social protection to this huge workforce segment (430 million). The initiatives also included facilities such as life and disability insurance, employment guarantee, and pension.

Health care in India is financed through various sources, including individual out-of-pocket payments, central and State government tax revenues, external aid and profits of private companies. National Health Accounts data from 2004-2005 show that central, State and local governments together account for only about 20 per cent of India's total health expenditure. More than 78 per cent of the health expenditure comprised unpooled, out-of-pocket expenditures – one of the highest rates in the world. External aid to the health sector accounted for a negligible 2 per cent of the total health expenditure.

The Government of India recognized inequities in its health delivery and financing infrastructure and introduced various measures to overcome them. One measure was to increase the budgetary allocations for health care. The Government is planning to increase its spending on health care from the current 1.1 per cent of gross domestic product

(GDP) to 3 per cent of GDP. However, increasing the budget for health care is not a solution in itself. There are indeed limitations in the absorptive capacity of the public health-care system apart from the manner in which these funds are used.

WHY RASHTRIYA SWASTHYA BIMA YOJANA (RSBY)?

In the last four to five years, the governments in India have introduced various demand-side financing mechanisms to provide financial security for vulnerable segments of society. Examples are health insurance schemes such as the Universal Health Insurance Scheme (UHS) launched by the Ministry of Finance in 2003 and State-level health insurance schemes launched by the States of Punjab, Kerala and Assam. However, most of these central or State government-funded schemes have had problems due to poor policy design, lack of clear accountability at the State level, lack of sustained efforts in implementation, weak monitoring and evaluation, unclear roles and responsibilities of different stakeholders, and poor awareness about the schemes among beneficiaries. However, there are exceptions such as the Arogyasri scheme in the State of Andhra Pradesh.

The national government felt that there was a need for a national-level health insurance scheme in the country that would provide financial security to society's vulnerable segments. Learning

from the experiences of other major government and non-government health insurance schemes in India, it decided to launch a health insurance scheme that later came to be known as Rashtriya Swasthya Bima Yojana (RSBY). The population below the poverty line was considered the first target of this scheme. Understanding the characteristics of the target group was imperative. At the outset, since the targeted beneficiaries were poor, they could not be expected to pay cash in advance and take reimbursement later. Therefore, the scheme had to be cashless. Second, the beneficiaries were largely illiterate. Hence, they were not in a position to be involved with documentation. The scheme therefore needed to be paperless. Third, some members of the target population were migratory so they required a scheme that was able to provide benefits anywhere in India. The scheme therefore had to be portable across the country.

WHAT IS RASHTRIYA SWASTHYA BIMA YOJANA?

Rashtriya Swasthya Bima Yojana (RSBY) is a health insurance scheme that was launched on 1 April 2008 by the central Ministry of Labour and Employment. The primary objective of RSBY is to provide financial security to beneficiaries below the poverty line for hospitalization-related expenses and improve access to quality health care. Another objective is to empower the beneficiaries by giving them the choice to select any public or

private health-care provider for treatment. The scheme aims to cover all the people below the poverty line, estimated to number approximately 300 million, by 2012. The families below the poverty line are estimated through a rural household survey conducted by different States.

RSBY provides hospitalization coverage up to Rs30,000 (approximately US\$650) per annum for a family of five on a floater basis. Transportation charges are also covered up to a maximum of Rs1,000 (approximately US\$22) per year, with a limit of Rs100 (approximately US\$2.20) per hospitalization. In addition to these benefits, pre- and post-hospitalization expenses incurred one day before hospitalization and up to five days from the date of discharge from the hospital are covered. Another special feature of the scheme is that unlike general health insurance schemes where pre-existing diseases are excluded, all pre-existing diseases under RSBY are covered from day one. There is also no discrimination against the elderly since there is no age limit for eligibility under the scheme.

RSBY uses smart-card technology to enrol beneficiaries. A biometric smart card is given to each family below the poverty line, which enables the members to avail themselves of the benefits under the scheme throughout India. All the States and the Union Territories are likely to be covered in a phased manner by 2012.

A beneficiary enrolled under RSBY can visit any hospital that is part of the network of health-care providers. This network is being created across India

through empanelment based on predefined criteria. As of July 2010, around 6,000 hospitals (more than 70 per cent are private) comprised the RSBY delivery network. Providers are empanelled by the State-selected insurance company. A health-care provider empanelled by any of the insurers in RSBY is automatically empanelled by all the other insurers. For empanelment, hospitals must agree to install necessary hardware and software to be able to transact business through the beneficiary smart card. They must also set up a dedicated RSBY desk with trained staff. Once a hospital is empanelled, a nationally unique hospital identification number is generated so that transactions can be tracked at each hospital. Each empanelled hospital is connected to the district server of the insurance company. This facilitates transfer of data relating to hospitalization on a daily basis.

RSBY PROCESS FLOW

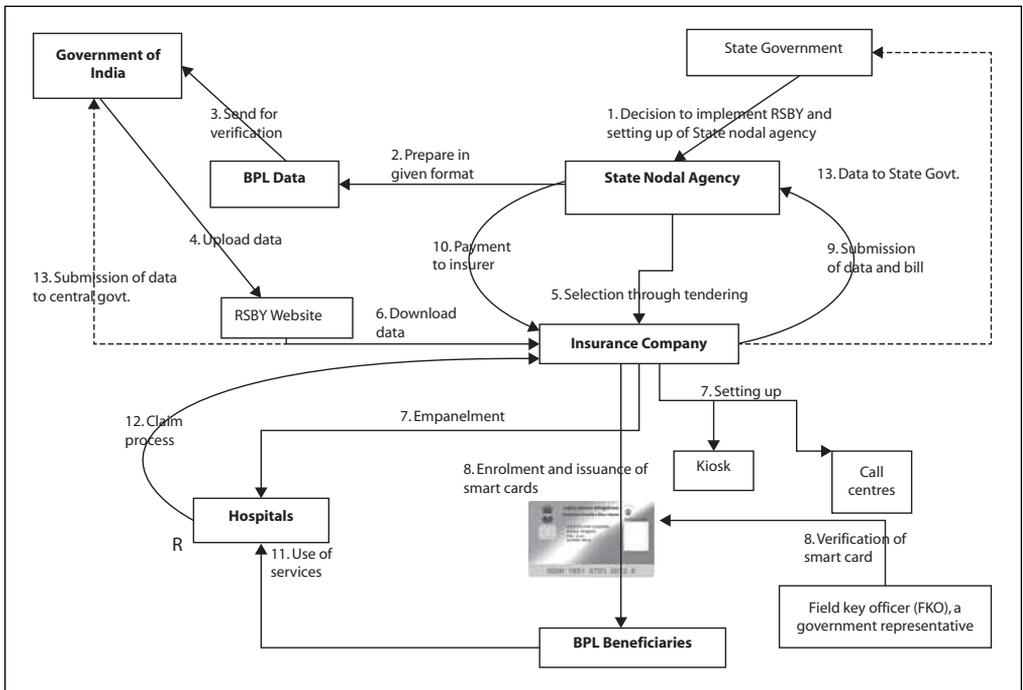
RSBY involves a set of complex but well-defined processes (fig. 1). The process flow for RSBY is as follows:

- Once the decision to implement RSBY is taken by a State government, an independent body, a State nodal agency, is set up.
- The State nodal agency collects/prepares below-the-poverty-line data in the specified RSBY format.
- Once these data have been prepared, an insurance company is selected through an open bidding process.
- Annually, an electronic list of eligible below-the-poverty-line households is provided to insurers by the State. An enrolment schedule for each village, along with dates, is prepared by the insurance company with the help of district officials. The insurance company is given a maximum of four months to enrol below-the-poverty-line families in each district.
- Insurance companies are required to hire intermediaries to reach out to the beneficiaries before the enrolment. In addition, the list of below-the-poverty-line families is posted in each village at the enrolment station and in prominent places prior to the enrolment camp. The date and location of the enrolment camp are also publicized in advance.
- Mobile enrolment stations are established at local centres (e.g., public schools) in each village at least once a year. These stations are equipped by the insurer with the hardware to collect biometric information (fingerprints) and photographs of the members of the household covered and a printer to print smart cards with photo. The smart card, along with an information brochure describing benefits, hospitals in network, etc., is provided to all enrollees once they have paid the ₹30 (US\$0.70) registration fees. The

process normally takes less than 10 minutes.

- A government official from the district (field key officer, FKO) needs to be present at the camp and must insert his own government-issued smart card and provide his fingerprint to verify the legitimacy of the enrolment. In this way, each enrollee can be tracked to a particular official. In addition to the field key officer, an insurance company/smart card agency representative is present at the enrolment camp.
- At the end of the enrolment camp, a list of enrolled households is sent to the State nodal agency by the insurer. The list of enrolled households is maintained centrally.
- Before commencement of the enrolment process, the insurance company empanels both public and private hospitals. Each empanelled household is provided with Hospital Authorization Cards (HACs) in the form of smart cards with unique identification numbers.
- A beneficiary, after receiving the smart card and after the start of the insurance policy, can visit any empanelled hospital across the country to avail himself/herself of benefits.

Figure 1 | RSBY process flow.



USE OF TECHNOLOGY UNDER RSBY

The use of technology under RSBY is one of the highlights of the scheme. RSBY is perhaps one of the few schemes in the developing world where technology has been leveraged for delivering social-sector benefits.

A smart card is given to each family below the poverty line at the time of enrolment in the scheme. The smart card is prepared and printed on the spot in the village by the insurer and handed over to the beneficiary. As noted earlier, this card can be used by the beneficiary in any empanelled hospital across India to obtain treatment. In addition to the smart card, biometric technology is used to provide more protection from fraud and to improve targeting. Fingerprints of all beneficiaries are collected during enrolment at the village level. One thumb impression of each of the household beneficiaries is stored in the smart card. This fingerprint is used to verify the identity of the beneficiaries at the hospital.

Another technology used to provide a secure environment for smart-card issuance and use is the key management system, which helps to reduce fraud and improve accountability. A government officer called a field key officer needs to be present at the enrolment station; his role is to verify each beneficiary family using his own smart card and fingerprints. This ensures that only the correct beneficiary is issued the card by the insurer. Similar key cards are used at each

place where a smart card is used.

RSBY has been able to position itself as a paperless scheme with the help of technology. Claims are submitted online by the hospitals, and insurers can make online payments to the hospitals. In addition, a robust back-end data management system is being developed for RSBY that will ensure the smooth flow of data from across India to both the State and central governments in real time.

The aim of the scheme is to use technology not only for controlling fraud and monitoring but also to find innovative solutions. For example, enrolment software has been designed to ensure that the wife is necessarily included in the list of those insured in the family.

FUNDING OF RSBY

RSBY is a government-funded scheme where the premium is paid from general revenues. The funding for the premium comes jointly from central and State governments: 75 per cent of the premium (90 per cent in the case of Jammu and Kashmir and Northeastern States) is contributed by the central government while 25 per cent of the premium (10 per cent in the case of Jammu and Kashmir and Northeastern States) is contributed by the respective State government. The insurance premium is determined at the State level. Registered insurers compete in the open bidding process.

It was also decided by the Government that the beneficiaries will also pay the

small amount of Rs30/ US\$0.70 as a registration fee. This was done so as to increase the sense of ownership of the scheme among the beneficiaries. This Rs. 30 is aggregated at the State level and is used to take care of the administrative cost.

RSBY DATA

After two years of operation, RSBY has been able to move from 2 States to 23 States in the country. The highlights of the performance of the scheme by the end of July 2010 are presented in table 1.

Table 1 | Highlights of the performance of the RSBY scheme by the end of July 2010.

RSBY Data	
Number of families enrolled	Approx. 18 million
Number of persons enrolled	Approx. 70 million
People covered as a percentage of total target population	24%
Number of States where RSBY is being implemented	23
% of States that have started RSBY implementation	80%
Number of hospitals empanelled	5,945
Number of persons who have received treatment	850,000
Average hospitalization rate	3%
RSBY Economic Data	
Total expenditure on premium subsidy of RSBY until 31 July 2010	Rs8,000 million US\$174 million
Expenditure on RSBY premium as a percentage of GDP	0.013%
Administrative expenditure on RSBY by Government of India	Rs50 million US\$1.09 million

Source: Ministry of Labour and Employment.

STAKEHOLDERS AND THEIR ROLES

RSBY is an example of how a scheme can evolve successfully through the cooperation of different stakeholders. In the initial stages of the scheme, there were organizations such as the World Bank and the German Agency for International

Cooperation (GIZ) that supported the development of the design and processes. There are six primary stakeholders in the scheme: the central government, State governments, State nodal agencies, insurance companies, hospitals and non-governmental organizations (NGOs). The roles of each of these stakeholders are clearly defined in the scheme (table 2).

Table 2 | Roles of stakeholders in RSBY.

	Central Govt.	State Govt.	State Nodal Agency	Insurer/ Third-party Administrator (TPA)	NGOs/ Other Partners	Providers of Care
Oversight of scheme	X		X			
Setting up of nodal agency		X				
Financing scheme	X	X				
Setting parameters (benefits package, empanelment criteria, below-poverty-line criteria)	X	X				
Hardware specifications (e.g., systems, smart card)	X					
Contract management with insurer			X			
Accreditation/Empanelment of providers				X		
Collecting registration fees				X		
Enrolment			X	X	X	
Financial management/planning	X		X			
Actuarial analysis				X		
Setting rate schedules for services/reimbursement rates	X		X			
Claims processing and payment				X		
Outreach, marketing to beneficiaries			X	X	X	
Service delivery						X
Developing clinical information system for monitoring/evaluation	X		X			
Monitoring State-level use and other patient information	X		X	X		
Monitoring national RSBY information	X					
Customer service				X	X	X
Training	X		X	X		

INITIAL IMPACT

RSBY has been in operation for just over two years but the impact is clearly visible. Data from RSBY and many external evaluations have revealed the following:

- **improvement in access to health**

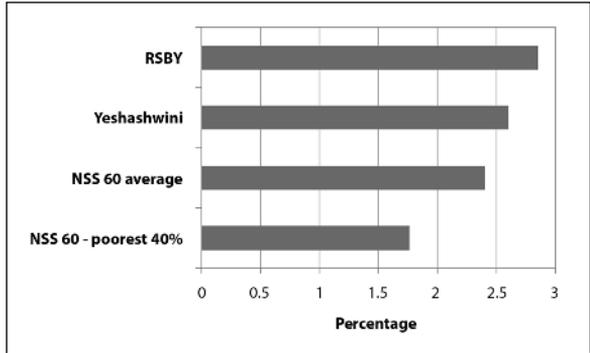
care. Access to health care for the targeted segment of RSBY has improved considerably in the past two years. Data from the studies show that the hospitalization rate in the initial 92 districts of RSBY is 2.8 per cent while it is only 1.75 per cent for the poorest-of-the-

poor population otherwise (as per the National Sample Survey Organization (NSSO) 60th Round Survey) (see graph).

Evidence is also emerging that an increasing number of women are accessing such facilities, in some districts outnumbering men.

- **reduction in out-of-pocket expenditure on health.** One of the objectives of the introduction of RSBY was to reduce the out-of-pocket expenditure on health by the poor population. Survey results of RSBY in Kerala State show that non-RSBY poor patients spend on average six times more money in the hospital than RSBY beneficiaries.
- **setting up of health infrastructure in rural areas.** Evidence is emerging that the private sector is finding value in setting up health-related infrastructure in regions that had hitherto been unserved. This is largely because RSBY is creating a demand for health services in the rural areas, which has provided an incentive for private players to set up hospitals.
- **high level of satisfaction.** Different surveys in the States of Kerala and Delhi have shown that more than 90 per cent of the beneficiaries who have taken treatment under RSBY are satisfied with the treatment and the services provided in the hospitals.

Percentage of RSBY members hospitalized.



CHALLENGES FACED

Various challenges needed to be met in establishing the RSBY:

- **stakeholder buy-in.** The first major challenge before implementing RSBY was to obtain the buy-in not only of officials within the central and State governments but also of the insurance and smart-card industries. Intensive meetings were organized with all the stakeholders to explain the scheme design and to obtain their agreement to it;
- **a supply of necessary hardware and software.** RSBY needed a supply of smart card-related equipment in large quantities. These machines were not available in the required quantities. The buy-in of the industry helped in its responding to the demand and importing the equipment to match the demand;
- **development of a key management system.** One of the main

features of the RSBY design was to provide a foolproof secure system to prevent any fraud or misuse. Therefore, it was a huge challenge to develop a key management system that could provide necessary security at different levels;

- **enrolment and awareness.** The printing and issuance of smart cards in the village constitute one of the most challenging aspects of RSBY. The smart cards are to be issued on the spot and in difficult terrain. Once the smart cards are issued, another challenge is to improve the awareness of the beneficiaries regarding their use; and
- **lack of capacities at different levels.** Building capacities at each level to implement a complex scheme such as RSBY was another challenge. These capacities were to be built among all the stakeholders, which included government officials, insurance companies, hospitals and NGOs.

SUCCESS FACTORS

Factors responsible for the success of RSBY are as follows:

- **partnership approach.** Right from the designing of the scheme, attempts were made to take the stakeholders into confidence. A partnership approach was adopted

with all the private players;

- **standardization.** A national scheme such as RSBY required a high degree of standardization so that it could work uniformly across India. In addition to all the key documents, all the software and hardware were standardized and guidelines were issued regarding their preparation, use and certification;
- **flexibility.** RSBY has evolved continuously since its inception. Different provisions and processes of the scheme have been revised in response to the realities on the ground;
- **attention to detail.** Each process and each step relating to the implementation of the scheme have been documented. Similarly, the roles of each stakeholder and their relationship with others have been clearly defined so as to avoid any ambiguity;
- **empowerment of the beneficiaries.** The beneficiaries, in this context the poorest of the poor, were empowered since they were now being given a choice of hospitals, public and private, across the country;
- **business model.** This was perhaps the first-ever business model on this scale for a social-sector scheme with insurance companies and hospitals finding "fortune at the bottom of the pyramid".

RSBY saves a life and many more...

Sudhir lives in a small village near Bijnor in Uttar Pradesh. He has a son, Santosh, who is mentally challenged. Santosh met with an accident and his left leg was severely burned. Sudhir, being a daily-wage worker, could barely make both ends meet, let alone afford treatment for his son in a good hospital, which forced him to settle for treatment with a local doctor who could do little to alleviate his son's misery. Santosh continued to suffer.

Being mentally challenged, Santosh could not even express his agony and discomfort. He turned into a lifeless being. The family had no option but to helplessly watch the suffering of Santosh, who could be crippled for life owing to the non-availability of timely treatment. Selling the small hut that they owned or taking a loan would have brought greater misery.

RSBY came to their rescue. When Sudhir was informed about the scheme, he was initially apprehensive. However, once he understood what a smart card could do, he enrolled himself. The scheme fortunately also covered the pre-existing conditions.

Not only did Santosh get quality treatment at Beena Prakash hospital, a private hospital situated in the small town of Bijnore in western Uttar Pradesh, with just the flash of the RSBY smart card, but he also did not have to pay a single penny for the treatment. In fact, he was paid Rs100 (US\$2.20) as reimbursement for travel expenses. The son recovered in due course. RSBY came as a saviour.

Today the general ward of Beena Prakash hospital and many other similar hospitals are bustling. Locals claim that this heightened buzz of patients is "unprecedented". What is even more unusual is that most of the patients belong to the population living below the poverty line. RSBY has made it possible for these people to visit these hospitals and obtain cashless treatment through the smart card.

ⁱ National estimates, 2010.

ⁱⁱ WHO, Global Health Observatory, 2008.

ⁱⁱⁱ WHO, UNICEF, UNFPA and World Bank, Global Health Observatory, 2005.

^{iv} World Bank, *World Development Indicators 2008* and *Global Development Finance 2008*.

^v Ibid.

^{vi} Government of India budget, 2009.

^{vii} National estimates, 2009.

^{viii} UNDP, *Human Development Report 2009*.

The Mahatma Gandhi National Rural Employment Guarantee Act

Amita Sharma

12

India

Summary

Wage employment programme, implemented in a phased manner (2006-2008).

Rights-based legal guarantee.

Target group: households in rural areas.

Employment provided: 52.5 million households (2009-2010).

Benefit: providing at least 100 days of employment in asset-creating public works programmes every year at the minimum wage for every rural household whose adults volunteer to do unskilled manual work for the enhancement of livelihood security.

Delivery process: Adult members of a rural household may apply to the local gram panchayat (local government at the village or small-town level) for registration and, in return, receive a job card, which is the basic legal document that enables a rural household to demand work. Employment must be provided within 15 days of demand within a 5-kilometre radius of the village (or else extra wages of 10 per cent must be paid) or else an unemployment allowance must be paid by the State at its own cost.

Funding: Under this Act, the central government meets the cost towards the payment of wages while State governments meet the cost of the unemployment allowance.

Information on the Author

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INTRODUCTION

The Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) was enacted on 7 September 2005 as *“An Act to provide for the enhancement of livelihood security of the households in rural areas of the country by providing at least one hundred days of guaranteed wage employment in every financial year to every household”*.

The objectives of MGNREGA are to:

- provide wage employment opportunities;
- create sustainable rural livelihoods through regeneration of the natural resource base, i.e., augmenting productivity and supporting the creation of durable assets; and
- strengthen rural governance through decentralization and processes of transparency and accountability.

MGNREGA was implemented in a phased manner with 200 districts, with the first phase being notified on 2 February 2006, followed by another 130 from April 2007, and the remaining districts going into effect from 1 April 2008. The Act is now effective in the rural areas of the entire country, covering 619 districts. The phased implementation was based on a criterion of backwardness that used a mix of demographic, social and economic indices, such as percentage of scheduled-tribe and scheduled-caste populations, agricultural productivity of the district, and the prevalent notified minimum wages for agricultural labourers in the State.

POLICY GENESIS

MGNREGA cushioned rural areas in the recent economic meltdown but was not a response to a specific crisis. Rather, it was part of a long-standing Government policy, embedded in the State's proactive role to alleviate poverty. While poverty in India declined from 36 per cent in 1993-1994 to 28 per cent in 2004-2005, close to 300 million people (27.5 per cent of the population) still live in chronic poverty on less than one dollar a day.

Unemployment and out-of-labour-force days of rural agricultural labourers total 104 (76 days for males and 141 days for females).ⁱ About 73 per cent of the poor live in rural areas, more than 77 per cent of India's total labour force is rural, and 85 per cent of women participating in the labour force are in rural areas.

Poverty is unevenly spread: scheduled castes, scheduled tribes and women-headed households are the worst affected. Extensive erosion of the natural resource base over the last 50 years has resulted in some of the worst natural disasters adversely impacting agricultural productivity and employment opportunities.

Growing poverty and unemployment have led to the fragmentation of land and an increase in the number of agricultural labourers. Agricultural labour increased significantly from 56 million during 1981 to 107 million during 2008. At the same time, the percentage of operational land holdings under small and marginal farmers rose from 70 per cent in 1971 to 82 per cent in 2001.

The policy response to a situation of poverty and inequality has focused on inclusive growth. The architecture of inclusive growth is defined by prioritizing key result areas through major programmes aimed at time-bound delivery of outcomes, namely, infrastructure (rural roads, housing, electricity and water sanitation), human resource development through basic education, and health and livelihood through skills development, income-generation and especially a wage employment programme (that is, MGNREGA). In addition, there has been a greater concern for social security measures through old-age pensions and life and health insurance.

There has also been a paradigm shift to rights-based policies, such as the Right to Information Act 2005, MGNREGA 2005, the Forest Rights Act 2009 and, most recently, the Right to Education Act 2009, with the Food Security Bill (in the offing). These recognize basic development needs as rights and entitlements of the citizens, compelling commitment of government resources and even challenging some of its existing systems.

MGNREGA evolved against the background of persistent poverty and inequality, embedded in the policy architecture of inclusive growth and rights-based policies, foregrounding State obligation *as law*. In 2004, the United Progressive Alliance (UPA), a coalition government led by the Congress party, came to power on a rural, agrarian-development vote with the following promise in its Common Minimum Programme: "The UPA Government will immediately enact a National

Employment Guarantee Act. This will provide a legal guarantee for at least 100 days of employment on asset-creating public works programmes every year at minimum wage for every rural household."

The coalition UPA Government with a dominant Congress share returned to power in June 2009, reinforcing its commitment to inclusive growth and its pro-poor programmes, led conspicuously by MGNREGA. A fair measure of public analysis identified MGNREGA as a critical factor in the return of Congress to power with greater strength, underscoring the fact that public policy focusing on vulnerable groups through social protection programmes stimulates equitable development and political gains.

THE MGNREGA DESIGN: CONTINUUM AND INNOVATION

Wage employment programmes have a long history in India, where they meet the daily subsistence needs of casual labour that forms a major share of the rural workforce. Income-generation programmes depend on external linkages and markets and take time to return benefits. The supplemental subsistence of wage employment programmes provides productive work and social security. The MGNREGA design benefited from past experience of wage employment programmes, using the instrumentality of labour-intensive public works, wages and self-selection. The significantly distinctive innovative feature of MGNREGA is

that it is a legal guarantee with a rights-based framework. This also guarantees the programme's sustainability.

The rights-based framework of MGNREGA has the following key components: workers' rights, transparency and accountability, and productive green jobs.

WORKERS' RIGHTS

- **Self-selection:** There are no eligibility criteria or prerequisite skills.
- **Demand-based:** Any rural households willing to do unskilled manual work may apply for registration in their local gram panchayats (local governments at the village or small-town level) if they want to be eligible for employment under the Act. Following registration, the applicants are entitled to receive job cards. The job card is the basic physical instrument that enables an applicant to demand work, and it is also the worker's record of rights. To obtain employment under MGNREGA, the holder of the job card must submit a written application for employment to the gram panchayat or to the Programme Officer at the block level, specifying the period for which employment is being sought.
- **Time-bound guarantee:** The worker's application for employment is acknowledged through a dated receipt issued by the village local body or the gram panchayat or the Programme Officer. This initiates the guarantee process in

response to the demand. The right to employment is guaranteed through timelines: 15 days to allocate employment, 15 days to make payments. An unemployment allowance is paid by the respective State government to the applicant in case of a delay in employment allocation.

- **Local employment** must be provided within five kilometres of residence or else transport and extra wages of 10 per cent must be paid.
- **Flexibility** is given to workers to participate according to need.
- **Wage payment** must be as per notified wages within a week and not beyond a fortnight.
- **No contractors or machinery** is permitted.
- **The labour-intensive works** have ratios of wage costs to material costs (inclusive of skilled and semi-skilled labour) that are 60:40.

TRANSPARENCY AND ACCOUNTABILITY

Workers' rights are safeguarded through transparency and public-accountability provisions:

- **legal documents** such as workers' job cards that record workers' entitlements and receipts;
- **right to information** through proactive public disclosure and free citizen access to information;
- **social audits** conducted by the

village assembly (*gram sabha*);

- grievance redressal mechanisms; and
- penalty of Rs1,000 (US\$22) as a fine on violation of the Act.

PRODUCTIVE GREEN JOBS

MGNREGA work helps to earn wages and creates productive assets. Permissible works under the Act as per Schedule I, in order of priority, include: (a) water conservation and water harvesting; (b) drought-proofing (including afforestation and tree plantation); (c) irrigation canals, including micro and minor irrigation works; (d) provision of irrigation facility, horticulture plantation and land development facilities on land owned by households belonging to the scheduled castes and scheduled tribes or families below the poverty line or to the beneficiaries of land reforms or to the beneficiaries under the Indira Awaas Yojana¹ of the

Government of India or to small farmers or marginal farmers as defined in the Agriculture Debt Waiver and Debt Relief Scheme (2008); (e) renovation of traditional water bodies including desilting of tanks; (f) land development; (g) flood-control and -protection works including drainage in waterlogged areas; (h) rural connectivity to provide all-weather access; and (i) any other work that may be notified by the central government in consultation with the State government and that currently includes the construction of village and block-level knowledge centres (Bharat Nirman Rajiv Gandhi Sewa Kendras) as a permissible work. Almost all works relate to natural resource regeneration, addressing causes of chronic poverty such as soil erosion, water scarcity and land degradation. Being green jobs, MGNREGA works constitute a strategy for climate-change adaptation and contribute to sustainable development.

Box 1. Vulnerability reduction through the National Rural Employment Guarantee Act

Climate change involves action for mitigation and adaptation. The National Rural Employment Guarantee Act (NREGA) contributes towards adaptation. The impact of climate change falls differentially on people, and the poor are the most vulnerable to its adverse impact. NREGA, by encouraging works on water harvesting, flood protection, afforestation and plantation, helps to insulate local communities from adverse effects of climate change. According to the findings of the pilot study conducted in Chitradurga District of Karnataka, there is an increase in groundwater level and in water percolation, and improvement in soil fertility leading to improved land productivity. The findings also suggest a reduction in water vulnerability and livelihood vulnerability in these areas.

Source: Environmental Services, Vulnerability Reduction and Natural Resource Conservation from NREGA Activities: Case Study of Chitradurga District, Indian Institute of Science, Bangalore.

¹Indira Awaas Yojana is a flagship scheme of the Ministry of Rural Development to provide financial assistance to the rural poor living below the poverty line for construction of a house.

IMPACT: EARLY TRENDS AND OUTCOMES

MGNREGA, in its four years of rapid expansion from 200 to 619 districts, has yielded such positive outcomes as the following: provided employment to more than 52 million households, which has increased their income; given economic opportunities to disadvantaged groups; decreased out-migration from villages; impacted positively on the geographical-ecological environment; and improved the connectivity of rural areas (better roads, information and communication infrastructure, etc.).

AUGMENTING EMPLOYMENT

Unskilled Labour

When MGNREGA covered the entire country in 2008-2009, it generated 2.16 billion person-days, and in 2009-2010, it generated 2.83 billion person-days. The scheme has provided employment to around 52.5 million households.

Skilled Labour

MGNREGA has opened up opportunities for large-scale employment of skilled manpower at the block and/or village level in rural areas through large-scale deployment of mates, engineers, village assistants, accountants, information technology personnel (at the gram panchayat level, for example, 0.18 million Gram Rozgar Sahayaks were appointed; at the block level, 23,102 technical assistants, about 6,966 accountants and 9,296 computer assistants were appointed).

Employment opportunities for the educated and skilled are being promoted both directly within the administrative system of the scheme and indirectly in the form of business avenues opened up by MGNREGA in the postal network, financial and information and communication technology (ICT) services.

ENHANCING INCOME

In the initial stages, wages under MGNREGA were linked to minimum wages for agricultural labourers. There has been an increase in minimum wages for agricultural labourers in most States. The average wage rate rose from Rs65 (approx. US\$1.40) per day to Rs91 (approx. US\$2) per day from 2006 to 2010.

EFFECTIVE TARGETING OF DISADVANTAGED GROUPS

MGNREGA is designed to allow women equity in access to work and in wage payment. The participation rate of the women's workforce surpassed the statutory minimum 33 per cent every year, reaching 48 per cent in the financial year 2009-2010 at the national level.

Independent studies point towards positive trends and women's empowerment as a result of economic opportunities under MGNREGA. This is evident in the emergence of women's identity; their growing contribution to their households' livelihood and decisions on its expenditure, especially on food, consumer goods, children's education and health care; and the offsetting of debts. Women have also started to appear more

actively in the rural public sphere as they take up their work and responsibilities. Factors motivating women's work participation include local work availability, reduction in risks associated with migration, flexibility in work choice and participation, notified wage rates and wage parity with men, easy working conditions vis-à-vis other hazardous options, and regularity and predictability of working hours. The abolition of contractors eliminates chances of exploitation and discrimination based on caste and community and so restores dignity and self-esteem.

MGNREGA is an example of the quantitative and qualitative difference experienced in a household because of the source through which the income flows in. If it is through the women, it enhances opportunities for their children, in turn positively affecting intergenerational change. The workforce participation of scheduled castes and scheduled tribes was 49 per cent in fiscal year 2009-2010. Independent professional studies corroborate that the marginalized groups have high workforce participation.ⁱⁱ

Box 2. In Villupuram, employment guarantee changes lives of women

NREGA also holds the promise of bringing major changes in the lives of women. More than 80 per cent of NREGA workers in Villupuram (or, for that matter, in Tamil Nadu as a whole) are women. As agricultural labourers, they earn a paltry Rs30 per day for four to five hours of back-breaking work. Today, however, they are earning the full minimum wage of Rs80 per day on NREGA. As Maheshwari of Poirasur put it: "When we work as agricultural labourers, we earn thirty rupees every day but it doesn't seem to get us anywhere. Since we started working on NREGA, we have been earning Rs400 at the end of the week. For the first time, we are able to save". She has set some of her earnings aside in anticipation of her daughter's delivery, due at any time. Krishnaveni of the village of Chinnanerikuppam (Block Mailam) has a similar story to tell. "Now we have the confidence to take loans", she said, "because we know that we will be able to repay." For the first time in her life, she has started contributing to a chit fund.

Source: Jean Drèze, The Hindu, 2 August 2007.

INCREASE IN WAGE RATES

Initially, wage rates were linked with minimum wages of agricultural labourers, resulting in minimum wages for agricultural labourers rising significantly in all States, from as low as Rs50 per day (about US\$1)

to Rs100 per day (about US\$2) in several States. The wage rate is to be indexed with the cost of living to give a real wage rate of Rs100 per day. Workers now have the assured wage rate under MGNREGA to bargain with private employers.

STEMMING MIGRATION

The findings of independent studies indi-

cate that the implementation of MGNREGA has decreased migration from villages.

Box 3. Scheme stops workers' migration to urban areas in Uttar Pradesh

Successful execution of the National Rural Employment Guarantee Act (NREGA) has stopped the rural masses from migrating to urban areas from Gorakhpur District and their native villages. "After the implementation of the NREGA in our village, we don't have to go to the cities in search of work. There are many types of work that we do here, which includes digging roads and working in brick factories and drains. This scheme has helped us a lot; now we can manage our families and farmland while working here in our village," said Murataza Hussain, a villager. He added that the NREGA provision of employment opportunities is also a welcome safeguard against food insecurity. The NREGA guarantees equal-opportunity employment, enabling women to work.

"The implementation of the NREGA has helped my fellow villagers. Now they don't have to shift to the cities in search of work; they get employment over here now. There are 360 job cards that have been issued in this village alone," said Indravati Devi, a village chief.

Source: <http://news.oneindia.in>

AUGMENTING PRODUCTIVITY

Typically, MGNREGA works have included digging ponds, small bunds, land development and afforestation. Studies validate that assets created under MGNREGA have been conducive to the geographical-ecological environment, that they have been useful and that they have contributed towards natural resource regeneration. Results have included: increased water availability; a positive impact on agriculture through improved access to irrigation resulting in crop diversity; and dual cropping, especially on scheduled caste/scheduled tribe/below-the-poverty-line lands. There has also been an increase in the net irrigated area as well as the gross cropped

area by retaining enough soil moisture and irrigation water for a second (or even a third) crop. Wells on MGNREGA individual lands make water-lending possible. This has increased the income for these households and helped to resolve the issue of drinking water scarcity. Maintenance of old structures has also been carried out under MGNREGA, providing an opportunity to redeem the tragedy of the commons.

An ecological act is an apt description of MGNREGA since it balances human action and natural resources. MGNREGA activities have the potential to provide environmental services and conserve and enhance natural resources.

Box 4. Water management through participatory rural appraisal

The village of Astapara, West Mednipur District, West Bengal suffers from a severe water shortage, which affects its farming. To benefit from NREGA, the villagers developed a participatory model for resource use. A village map was painted on the ground to help the villagers to identify and decide on what they saw as the priority for their community. After an analysis of the local ecosystem, the findings revealed that their water problems would be solved if they were to re-excavate and revive one of the silted water-harvesting bunds, Raibandh. A meeting was then held with the District Magistrate. For the first time, the people of Astapara presented their development plans and were able to decide what development works needed to be undertaken.

The administration sanctioned the project of over INR 9 lakh² (US\$19,000) under NREGA. The soil excavated from the project was of good quality and was used to improve the village roads without incurring any additional costs. The work involved active participation of the village Unnayan Committee as well as the Gram Panchayat. Additional facilities for labourers, including health camps, were set up at each of the work sites. Regular monitoring was also conducted to ensure better transparency and accountability of the work implemented under the scheme.

Before the roll-out of NREGA in their community, decisions had always been made by a few pressure groups and did not benefit the community as a whole. This participatory process has helped people to have a say in the decision-making and has empowered them.

Source: Rozgar Sutra 2009, Ministry of Rural Development. Story contributed by the government of West Bengal.

EXPANDING CONNECTIVITY

MGNREGA is improving rural connectivity in many ways.

Rural Roads

Fair-weather roads are connecting those hinterland areas left out of larger rural network programmes, particularly benefiting scattered tribal hamlets. Roads internal to the village along with side drains are also being started. This provides a critical link with markets, schools

and health services.

Financial Inclusion

Ninety million accounts opened in banks and post offices for MGNREGA workers for their wage disbursement make this the largest financial-inclusion scheme of the rural poor. These accounts have also encouraged thrift and saving among some of the poorest families. Wage payment through the workers' accounts has helped to reduce leakages in wage payment.

²In India and Pakistan, "lakh" means 100,000.

ICT in Rural Areas

Reaching far-flung areas and flattening management levels for efficiency and transparency have resulted in strengthening ICT infrastructure in rural areas. Currently, 92 per cent of block offices have computers and 55 per cent have Internet connectivity. States have been permitted to extend ICT facilities to the gram panchayat levels to make the newly proposed village knowledge resource centres ICT-enabled and to facilitate citizen use of ICT for accessing information and asserting rights. Towards this end,

MGNREGA has in recent years been most proactive in promoting ICT innovations, including biometrics and low-cost handheld devices, information-technology kiosks and automated teller machines (ATMs), all of which empower the rural poor to access their rights. Backed by financial resources and propelled by a legal guarantee pulsating towards yet-unreached areas, MGNREGA is emerging as an accelerated strategy for connecting the rural poor and rural areas with highways of opportunities.

Box 5. Information and monitoring: ICT for rights, governance and transparency

At the village council office, or the Panchayat Samiti, in the Suwarna block of the Bhilwara District of Rajasthan, the words of a song blare through a back room – *dhole gethi pavdo ladere nrega me chal bhara naam mandade re* (“buy me a shovel and stone-cutting equipment and take me to register for NREGP [National Rural Employment Guarantee Programme] works”) – as a group of NREGP workers queues up in front of a touch-screen information kiosk. The desire for information draws so many workers to the Panchayat office. Through biometric or fingerprint technology, workers are able to access, by means of an information kiosk, updated information on their application status, number of days worked, wage payments due and, importantly, information on works currently under way in nearby districts. Further, it serves as a convenient, quick portal to register villagers under NREGA. Any information needed by the worker can also be sent through a mobile phone via Short Message Service (SMS).

Rekha Devi, a 33-year-old NREGA worker, says, “Being able to get this information simply through my fingerprint makes me feel more independent. I do not need to rely on anyone for information on the scheme.” Close to 4,000 people have been registered across 10 villages using the biometric technology. According to Ranjeeta, ward member, Swana Gram Panchayat, the potential impact on governance is significant. “The ability to access information so easily will do away with a lot of fears about corruption in NREGA. Our ultimate aim is that each worker be so aware of his or her entitlements that he/she can simply go to the site supervisor or mate to demand information”, she said.

Source: Innovation Pilot Project in Bhilwara, Rajasthan.

IMPLEMENTATION CHALLENGES

Prerequisites for effective implementation of the Act are:

- **capacity of people to demand their rights.** In this case, lack of literacy, organization and resources as well as existing structural hierarchies affects the assertion of rights;
- **capacity of the administrative system to plan, implement and enforce.** Existing institutional delivery mechanisms often tend to be constrained both in resources and capabilities;
- **accountability and transparency systems.** These are major challenges given the limited capacities of both the supply and demand sides; and
- **adequate budget.** A demand-based law challenges existing budget systems in terms of processes and funding capacity.

POLICY INNOVATIONS

Policy innovations have evolved to meet the operational challenges. MGNREGA design balances flexibility with a normative framework.

DECENTRALIZATION

To manage a large-scale programme spread across 2.6 lakh villages, decentral-

ization has been the core principle of administration, with the principal role played by Panchayati Raj institutions or local bodies in planning, implementation and monitoring. The village-level body or gram panchayat involves the local community in identifying projects and in social audits through gram sabhas or village assembly meetings. Under MGNREGA funds, functions and functionaries have been given to gram panchayats. In fiscal year 2008-2009, the average funds available per gram panchayat were Rs15 lakh (about US\$33,000) for MGNREGA works; the average expenditure per gram panchayat was Rs11 lakh (about US\$244,000).ⁱⁱⁱ This was a 90 per cent increase over the amount that a gram panchayat had received in the previous wage employment programmes. MGNREGA has helped to strengthen local governance.

Decentralization has resulted in the mobilization of local bodies to implement MGNREGA. In terms of cost under MGNREGA, at least 50 per cent of the work is implemented through the gram panchayats. In most States, almost 90 per cent of the work is being executed by the gram panchayats. This involvement of gram panchayats in MGNREGA implementation has mobilized the local workforce. Since the villagers are involved in the planning, implementation and execution of these projects, they feel a greater sense of ownership of the projects.

SOCIAL MOBILIZATION

Social-mobilization initiatives include multimedia and local cultural communi-

cation processes, village assemblies, door-to-door surveys, workers' conventions and drives to disseminate awareness of the Act.

OPENING WORKS ON A LARGE SCALE

Chief among the strategies for workers' mobilization and the generation of awareness about MGNREGA has been the strategy of opening works in every gram panchayat and village. For this, funds must be readily available with gram panchayats to enable the prompt opening of works.

WORK-SITE INNOVATIONS

A number of work-site innovations have evolved for better work management. Work time-and-motion studies to formulate realistic schedules of rates for labour-intensive works in different geo-morphological conditions have been conducted to enable appropriate wage earnings. Local persons, including women, have been trained as work-site mates to improve work execution and wage earnings. Work-site demonstrations on work execution and measurement have been introduced in some districts to educate workers.

Box 6. Jalore, Rajasthan ensure better transparency in the implementation through women mates

Nearly 1,000 female work-site supervisors (known as mates) have been trained and deployed at work sites in Jalore District to ensure better transparency in the implementation of the National Rural Employment Guarantee Act. This has been a real breakthrough since the district has the lowest literacy rate in the State, with only 28 per cent of women knowing how to read and write. Initial monitoring of the Act and work-site inspections have shown that the average wage in Jalore was much below Rajasthan's minimum wage: Rs45 instead of Rs73. Payment of wages in the State is according to work output. If the combined measurement of a work site was less than that calculated according to the Schedule of Rates and number of labourers, it resulted in lower average wages. Through participatory observation, it was found that the work distribution on sites among the labourers was unequal and the prevalent work culture allowed some of the workers to perform below par. These workers were reducing the collective output of the group. The real issue was to ensure that honest labourers received the wages that they deserved.

The district introduced a group-wise task measurement system. Under this system, labourers at a work site were divided into groups of five and the measurement was done for each group. Such a system would guarantee that the defaulters in the group would be identified and encouraged to work. However, such a system required close monitoring, and with limited personnel, a daily inspection for each work site was not feasible.

Mates were entrusted with the task of monitoring and measuring daily work output. The administration also decided to give precedence to women in the recruitment of mates. Women who had completed grade five were selected and trained through systematic orientations,

Box 6. Jalore, Rajasthan ensure better transparency in the implementation through women mates (cont'd.)

workshops and on-site demonstrations. They were also given calculators to facilitate worksite calculations. These capacity-building workshops not only provided efficient management skills but also helped to build the confidence of these women.

The results were immediate and significant. From May to December 2007, the average wage in the district increased from Rs45 to Rs70. In addition, the women mates were better able to maintain records and take daily attendance and measurements. It has been a real breakthrough for those women.

Source: <http://www.nrega.nic.in>

WORK-SITE FACILITIES

Work-site facilities are mandated to have crèches, drinking water and first aid.

FOCUS ON SUSTAINABLE DEVELOPMENT

Sustainable development is sought through at least four key components.

Activities That Regenerate Natural Resources

Permissible works intrinsically recharge soil and water, contributing to land productivity, water availability and rural connectivity – three main development needs of rural areas. The Indian Institute of Science (IISc) Bangalore, in its study,^{iv} describes MGNREGA works as desilting soil “fail-safe” works that regenerate natural resources and restore the ecological balance needed for sustainable development.

Maintenance

Maintenance of assets and repeated activ-

ities to sustain benefits created are permitted under the Act.

Individual Ownership

Encouraging individual ownership and linking with farm work helps in augmenting agricultural productivity and value addition. MGNREGA work can be taken up on the individual land of scheduled caste, scheduled tribe and below-the-poverty-line families and small-scale and marginal farmers. This has positive results, indicated in cropping patterns and higher yields. Typically, land development, dug wells, plantation and labour are MGNREGA inputs; pump sets, seeds, pesticides, etc., come from other schemes or farmers' own savings/credit.

Convergence

MGNREGA offers a good base for planned convergence of investments. Convergence guidelines have been issued with programmes on forests and environment, water resources, agriculture, and watershed and roads. Convergence

includes firming up primary earth-work under MGNREGA; spatial planning; integrating multiple activities under different programmes such as watershed or horticulture; value addition such as fisheries in MGNREGA tanks, vermicomposting and mushroom cultivation; and sericulture on land developed, irrigated and planted under MGNREGA, especially individual lands taken up under the Act.

Focus on NREG Workers as Beneficiaries of Additional Social Benefits

The proposal to provide health coverage under the Rashtriya Swasthya Bima Yojana (RSBY), a national scheme for health insurance for specific beneficiary categories, to all NREGA workers is under consideration. The Ministry also hopes to identify one person per household as a suitable candidate for skills development

Box 7. Betul, Madhya Pradesh managing resources for the future through effective afforestation

Under NREGA, the tribal community of Deopur Kotami village has developed 45 hectares of forest land to plant fruit trees and vegetables. The afforestation work has been undertaken by four self-help groups, with 40 members in total. Water ponds and other harvesting systems have also been created to ensure an adequate water supply. Each member managed about one hectare of land and was able to sell its production to the local market.

The villagers have been able to sell Rs30,000 of vegetables in the local market and they have also established linkages with the local government schools through the midday meal scheme. In addition, the groups have been trained in new cultivation techniques and have learned to grow flowers and silk bushes.

For the people of Betul, they not only found work in their own villages but they also guaranteed themselves a sustainable source of income.

Source: Rozgar Sutra 2009, Ministry of Rural Development. Story contributed by the government of Madhya Pradesh.

and a placement programme under the National Livelihood Mission. Convergence between NREGA and the Integrated Child Development Scheme (ICDS) for women and child welfare at work sites is also being encouraged.

ADMINISTRATIVE SUPPORT

The centre has the power to determine

administrative expenses, which it fully funds. Currently, States can incur administrative expenses up to 6 per cent on their total scheme costs for personnel and processes such as monitoring; training; information, education and communication; social audits; and management information systems.

TRANSPARENCY AND ACCOUNTABILITY

Transparency has been mandated in the Act through documents and processes:

- In terms of processes, there are at least three ways in which the Right to Information has been integrated with MGNREGA. First, the Act mandates that all information be proactively placed in the public domain. Second, any information demanded is to be given free of cost. Third, social audits by the village assembly (gram sabha), which go beyond the Right to Information, fix accountability and seek correctives measures. The Comptroller and Auditor General also audits the schemes.
- For grievance redressal, district ombudsmen are being set up as independent grievance-enquiry authorities empowered to direct the State government to redress and penalize as well as to file a first information report against defaulters. Although the ombudsman does not have judicial powers, it will, however, generate greater awareness about rights among the people and bring pressure on the administrative system to deliver.

A WEB-BASED MANAGEMENT INFORMATION SYSTEM

A Web-enabled management information system (MIS), www.nrega.nic.in, systematizes a vast swathe of field func-

tionaries, officials, local bodies and workers via a coherent, centralized workflow engine spanning the entire country. A tight coupling of inputs eliminates arbitrary entries. The MIS software also works offline and can be customized to local requirements and local language.

The MIS is a household database that records details of employment demand, work done, amount earned and days worked. Funds can be tracked from the point of approval at the centre to the point of expenditure at the village. A list of gaps and breach of guarantees alerts administrative action. A sound- and icon-based option enables workers to interface.

KNOWLEDGE RESOURCE CENTRES

Physical infrastructure is necessary for a transparent transaction of rights where obligations must be fulfilled in a time-bound manner. This is being facilitated by including among permissible works the construction of knowledge resource centres at the gram panchayat and block levels, with ICT facilities, aimed at providing infrastructure resource support for citizen-centring of MGNREGA processes.

DOORSTEP FINANCIAL SERVICES FOR RURAL AREAS

Efforts are under way to expand the business correspondent model to unbanked areas and to introduce biometrics through hand-held devices for enabling an end-to-end solution for workers from marking their application and attendance to payment.

MONITORING AND EVALUATION

MGNREGA is closely monitored through internal and external monitoring mechanisms.

Internal Monitoring

Feedback on programme implementation is discussed and analysed with State governments through a quarterly Performance Review Committee meeting and periodic State-level reviews and field visits.

External Monitoring

Independent national-level monitors regularly monitor MGNREGA. The Central Employment Guarantee Council, a statutory institutional mechanism, also monitors the scheme. The Comptroller and Auditor General (CAG) audits media reports, which are tracked on a day-to-day basis for follow-up with States. Innovative appraisal methods include the following:

- **The Professional Institutional Network** is a network of institutions, including Indian Institutes of Management, Indian Institutes of Technology, agriculture universities, think tanks, civil society organizations and other professional institutes. The Network is an integrated structure for training, concurrent monitoring, appraisal, diagnosis of implementation constraints, and recommendations on remedial action and sustainable interventions.
- **100 eminent citizens** have been

identified for the monitoring of the scheme.

- **The ICT-based National Helpline** is used for registering complaints and redressing them effectively and promptly.

FINANCIAL SYSTEMS

Central Share in Financial Assistance

The pattern of assistance from the centre as laid down in the law is a major incentive to States to implement the programme. The centre bears 90 per cent of the cost, in addition to 100 per cent of the administrative expenses up to the permissible limit, for implementing the Act.

Demand-based Labour Budgets

The budget is based on the principle of demand rather than fixed allocations. An initial budget provision is made, which is open to augmentation according to the labour demand that may rise. Labour budgets prepared by districts are discussed to assess fund requirements for an estimated labour demand and the shelf of projects needed to meet that demand. The labour budget projections are on the MGNREGA website and accessible to all. For the initial release of central assistance, the labour budget estimates are tentative as up-front funding for six months. As the work season progresses and the actual trends of the demand emerge, central assistance is released based on those trends as well the trends in the previous working seasons.

State Funds

States have also been encouraged to set up State funds to be managed by an authorized agency (such as a registered society) so that the funds from the centre can be released into the State funds to be then further released to districts in accordance with their demand.

Commitment of Budget Resources

The legal guarantee has compelled a commitment of financial resources to the programme; even when the economy slowed down as a result of the global meltdown, budget support to MGNREGA did not diminish. The budget support is Rs40,100 crore³ (about US\$8.77 billion) for fiscal year 2010-2011, which maintains the budget provision of Rs39,100 crore (about US\$8.55 billion) for fiscal year 2009-2010. The rate of increase over previous wage employment programmes is between 139 per cent and 156 per cent, the average outflow per district going up to Rs81 crore (about US\$17.73 million) under MGNREGA from Rs31 crore (about US\$6.79 million) under former wage employment programmes.

Incentive-disincentive Structure

Central assistance is for providing employment. The unemployment allowance, in case States fail to provide employment, is to be borne by the State.

STUDIES, DOCUMENTATION AND KNOWLEDGE-SHARING

Independent studies have been conducted, available on www.nrega.nic.in. Case studies document exemplar practices for replication. Films and primers contribute to knowledge resources for peer learning. The E-Knowledge Network has been set up for connecting practitioners/policy-makers for operational queries, problem-solving, dissemination of best practices and local solutions.

SIGNIFICANT LESSONS THAT EMERGE FROM MGNREGA

MGNREGA demonstrates that a social protection programme with a rights-based legal guarantee can evolve as a platform for social empowerment and sustainable development, mitigating future risks not just by reducing vulnerabilities to economic and natural adversities but also by building resources that empower people to make more equitable and liberating choices. There are some significant lessons that emerge from MGNREGA.

POLICY IMPETUS AND FRAMEWORK

- Political ownership and political will are necessary.
- A social protection framework should be part of an inclusive

³In India and Pakistan, a crore is 10 million. It equals 100 lakhs.

growth policy and not just a crisis response.

- A rights-based legal framework with operational flexibility accelerates State action for the most vulnerable groups.

GOVERNANCE

Administrative Strengthening

- Professional support needs to be ensured at each level.
- High-quality training should be stressed for all.
- Personnel should receive tenure stability.
- Process re-engineering and procedure demystification and simplification are necessary. ICT, NGOs and professional networks help to achieve these aims.
- Strong internal and external monitoring systems, along with concurrent studies, help in diagnostic-remedial measures.
- Assured budget commitments and adequate fund transfers are necessary.
- Decentralization helps in transparency, accountability and stakeholder participation. It should be accompanied by overarching standards and norms and structural integration of different agencies, with role clarity and coordination mechanisms.

Accountability and Transparency

- Independent professional networks

create public space for performance watch.

- Social audit, for transparency and public accountability, is effective, and worker participation should be ensured.
- ICT demystifies as well as demediates stakeholder participation.
- Unbundling functions between agencies for implementation and adjudication promotes efficiency and accountability.
- Independent mechanisms for redressing grievances should be integral to the design.

Sustainability

- Equity should be the basic principle reflected in processes of selection, work and wages.
- The capacity of workers to avail entitlements should be built into the design.
- For planning feasible projects, participatory processes and appropriate technologies should be integrated.
- Wage employment programmes should be aligned with other employment and social protection policies.
- A convergence process involving natural resources, productivity, human development (health, education), risk coverage (life, health) and skill sets should be part of the project design.
- Programmes need to be rationalized by integrating strategies and resources for affordability and quality.

National Overview of MGNREGA

	(FY 2006-2007) 200 Districts	(FY 2007-2008) 330 Districts	(FY 2008-2009) 615 Districts	(FY 2009-2010) 619 Districts
Employment provided to households	21.0 million	33.9 million	45.1 million	52.5 million
PERSONDAYS (in millions)				
Total	905	1,435.9	2,163.2	2,825.8
SCs	229.5 [25%]	393.6 [27%]	633.6 [29%]	863.1 [31%]
STs	329.8 [36%]	420.7 [29%]	550.2 [25%]	585.7 [21%]
Women	367.9 [41%]	611.5 [43%]	1,035.7 [48%]	1,374.0 [49%]
Others	345.6 [38%]	621.6 [43%]	979.5 [45%]	1,376.9 [49%]
Average persondays per household	43 days	42 days	48 days	54 days
FINANCIAL DETAIL				
Budget Outlay (in Rs billions)	113	120	300	391
Central Release (in Rs billions)	86.41	126.10	299.40	335.07
Total available fund (including OB) (in Rs billions)	120.74	193.06	373.97	495.30
Expenditure (in Rs billions)	88.23	158.57	272.50	379.38
Average wage per day	Rs 65	Rs 75	Rs 84	Rs 91
WORKS DETAIL				
Total works taken up (in millions)	0.84	1.79	2.78	4.60
Works completed (in millions)	0.39	0.82	1.21	2.09
Water conservation	[54%]	[49%]	[46%]	[51%]
Provision of irrigation facility to land owned by SC/ST/BPL/S & MF and IAY beneficiaries	[10%]	[15%]	[20%]	[17%]
Rural connectivity	[21%]	[17%]	[18%]	[17%]
Land development	[11%]	[16%]	[15%]	[14%]
Any other activity	[4%]	[3%]	[1%]	[2%]
Note: BPL = Below the poverty line; IAY = Indira Awaas Yojana; SC = Scheduled caste; ST = Scheduled tribe; S & MF = Small and marginal farmers.				

ⁱ National Commission for Enterprises in the Unorganized Sector, Report on Conditions of Work and Promotion of Livelihoods in the Unorganised Sector, Government of India.

ⁱⁱ A list of MGNREGA studies commissioned by the Ministry of Rural Development, including inks, is available at: <http://www.nrega.net/pin/pin-members-and-coverage/>.

ⁱⁱⁱ <http://www.nrega.nic.in>

^{iv} Environmental Services and Vulnerability Reduction through NREGA, Prof. Ravindrnath, Indian Institute of Science, Bangalore.



Mexico

Area	1,959,284 km ²
Population ⁱ	108,400,000
Age structure	
• 0-14 years	29.1
• 15-64 years	64.7
• 65 years and over	6.2
Infant mortality rate (per 1,000 live births) both sexes ⁱⁱ	14.2
Life expectancy at birth (years) female ⁱⁱⁱ	77.8
Life expectancy at birth (years) male ^{iv}	73.1
Maternal mortality ratio (per 100,000 live births) ^v	53.3
GDP per capita	
• Current USD ^{vi}	10,232
• PPP (current international \$) ^{vii}	14,570
• Constant local currency	83,955
Total public social protection expenditure as % of GDP ^{viii}	7.4
Unemployment rate ^{ix}	5.3
Size of informal economy ^x	28.8
Human development index (HDI) rank ^{xi}	53
HDI poverty indicators – Human poverty index rank ^{xii}	23

A Social Protection Floor

Blanca Lila Gracia Lopez

13

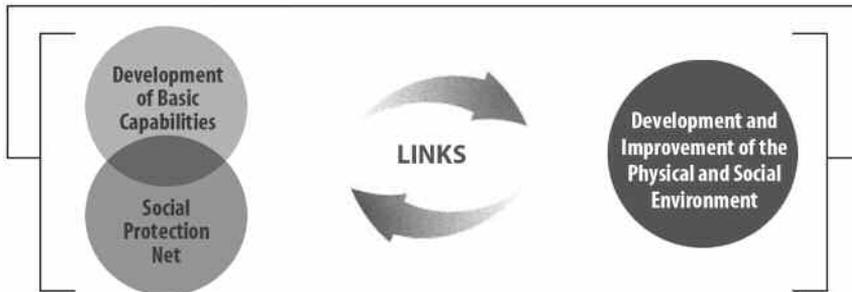
Mexico

Summary

In 2008, an integrated social strategy of inter-institutional coordination, the Live Better (Vivir Mejor) Strategy, was launched by the Government. The strategy takes into account the entire life cycle of individuals and their families, with a focus on sustainable human development to eradicate poverty and structural causes that generate it. It has fostered achievements that have strengthened the social protection system and contribute to nurturing greater citizen participation.



Vivir Mejor



Development of Basic Capabilities

Included in the development of basic capabilities are actions that guarantee equal opportunities and conditions for social development. All programmes that provide access to education, health, food and decent housing for Mexico's poorest families are considered.

Social Safety Net

The social safety net is comprised of all tools and programmes that enable citizens to better deal with the contingencies and risks that may arise throughout life (natural disasters, catastrophic illnesses and job loss). Also included are actions targeted at specific groups of the population who are vulnerable.

Linking Economic and Social Development

Economic and social development are linked by those actions that aim to promote and facilitate the access to a formal and well-remunerated job.

Information on the Author

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INTRODUCTION

This case study documents the evolution of the social protection policies in Mexico, using data from a questionnaire that considered two dimensions of social policy: social institutions and social strategy. It explores these programmes and draws some conclusions about the development of a social protection floor.

Experience shows that social protection policies require a solid institutional framework. It is not so much a matter of the type or number of programmes but rather of how the programmes are articulated in a national strategy that guides and focuses social development goals.

CONTEXT

Social protection in Mexico has been shaped throughout the years by various social, economic and political factors. Today it is part of a comprehensive social policy strategy that, supported by a legal and institutional framework, coordinates and complements all government social programmes in order to promote social welfare for all and ensure protection for vulnerable groups of the population.

MAIN FEATURES OF SOCIAL PROTECTION

In Mexico, social protection has a long history, dating back to the social rights established in the 1917 Constitution, which also includes social security in Article 123 regulating labour relations. According to this Article, employers have the obligation to

provide workers with pensions, housing, health and other services.

Social security came into full force in Mexico in the 1940s with the creation of the Mexican Social Security Institute (Instituto Mexicano del Seguro Social, IMSS), which aimed to protect private-sector workers. Years later, in 1960, the State Workers Security and Social Services Institute (Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado, ISSSTE) was created.

Social security rests on these two systems: the IMSS and ISSSTE. Besides these, other social security systems exist that belong to the federal bodies of the States, the government-controlled sector and the development banks.

Notwithstanding the significant achievements in social security in Mexico, its development was uneven and privileged the most organized sectors of the population: salaried and unionized employees. In this way, a significant proportion of the population, not bound to the labour and contributory regimes, remained outside the social security system. Peasants and informal workers were among the most negatively affected groups.

This social security model did not face major problems during the period 1940-1981 since the economy experienced sustained growth at an average rate of 6.3 per cent per year. However, after 1982, the landscape changed owing to an economic crisis. Between 1982 and 1988, Mexico experienced a real rate of growth in gross domestic product (GDP) of 1.8 per cent, which corresponds to an average annual

rate of 0.23 per cent. This led to the loss of employment, a fall in real household incomes, increased poverty and proliferation of the informal economy. Later, in the period 1989-1994, the economy recovered somewhat and achieved an average rate of annual GDP growth of 1.99 per cent.

Mexico maintained low growth rates and experienced recurrent economic crises in 1982, 1995 and 2009, which have exacerbated existing gaps in ensuring minimum levels of welfare for all Mexicans. Nevertheless, the State began its experience in fighting poverty in the late 1970s with the first targeted welfare programmes. These included the Programme of Public Investments for Rural Development (Programa de Inversiones Públicas para el Desarrollo Rural, PIDER), created in 1973; the General Coordination Plan for Depressed Areas and Marginal Groups (Coordinación General del Plan Nacional de Zonas Deprimidas y Grupos Marginadas, COPLAMAR) in 1977; the Mexican Food System (Sistema Alimentario Mexicano, SAM) in 1980; the National Solidarity Programme (1990-1995); and the Education, Health and Nutrition Programme (Programa de Educación, Salud y Alimentación, PROGRESA), launched in 1997, which became the Programme for Human Development (Oportunidades) in 2002.

These programmes led to significant but insufficient achievements. Experience has shown that the magnitude of poverty is beyond the scope of a government programme and requires instead an institutional framework and a concurrence of bodies and different levels of governmental powers working together to design a comprehensive State social policy.

In 2000, a process was started to lay the foundations for a State social policy. It incorporated the experience accumulated and created new instruments to tackle poverty. In January 2004, the Social Development Law (la Ley General de Desarrollo Social, LGDS) came into force, guaranteeing the full exercise of social rights enshrined in the Constitution, thus ensuring access to social development for all. The instruments created guarantee the budget and ensure the continuation of social-programme evaluation and transparency in the expenditure of financial resources. The national system of social development was established, which identifies the institutions responsible for social development and mechanisms to ensure the participation of different levels of government and sectors of society.

DIMENSIONS OF POVERTY¹

Mexico is a country of great contrasts. It is the second-largest economy in Latin

¹According to the methodology used to estimate income poverty, "poverty" is defined as follows:

- (a) **food poverty**: Failure to obtain a basic food basket even if all household disposable income is used to buy only the assets of this basket;
- (b) **capability poverty**: lack of disposable income to purchase the food basket and make the necessary expenditure on health, adequate housing and education, even if the total household income were dedicated only for this purpose; and
- (c) **asset poverty**: lack of disposable income to purchase the food basket and to make the necessary expenditure on health, clothing, housing, transport and education, even if the entire household income is used exclusively for the purchase of these goods and services.

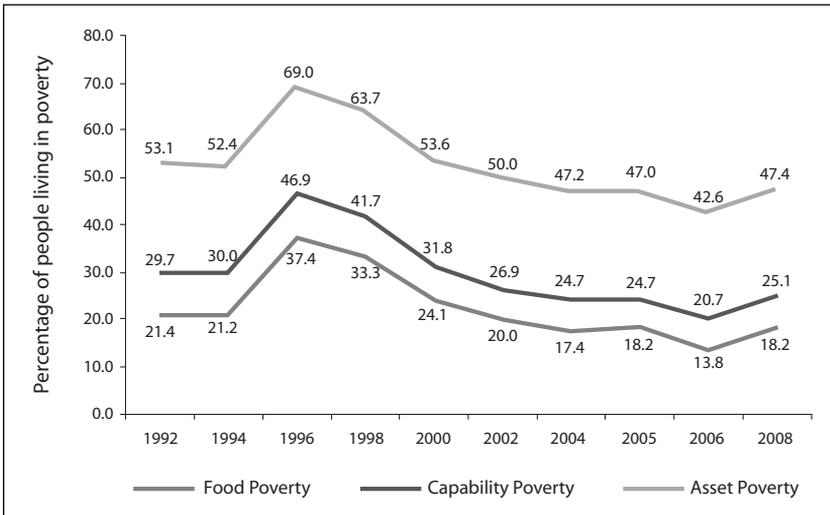
America and has a per capita income of \$10,232 (World Bank, 2008), which places it at the level of a high-middle-income country. However, significant inequality and poverty prevail.

In the period 1994-1996, Mexico suffered a severe economic crisis that resulted in an increase in asset poverty,² which went from 52.4 per cent to 69.0 per cent. However, in subsequent years, the country achieved a significant reduction in poverty levels. Indeed, in the period 1996-2008, the percentage of people recorded in asset poverty was reduced by 22 percentage points, dropping from 69 per cent to 47 per cent. This means that about 13.4 million people escaped poverty. Similarly, during the same period, food poverty went from 37.4 per cent to 18.2 per cent, representing a reduction of 15.1 million people. This positive change

was due to macroeconomic stability coupled with the implementation of a sound social development policy.

The measurement of income poverty between 2006 and 2008 shows an increase in the incidence of asset poverty, which rose from 42.6 per cent to 47.4 per cent (graph 1). In turn, the incidence of food poverty increased from 13.8 per cent to 18.2 per cent. In absolute terms, the increases were 5.9 million people (asset poverty) and 5.1 million people (food poverty), rising from 44.7 to 50.6 million people and from 14.4 to 19.5 million people, respectively.

This situation must be understood in the context of the global food and economic crisis that hit Mexico, causing a decrease in the rate of GDP growth of 3.6 per cent in 2007, 1.4 per cent in 2008 and -6.5 per cent in 2009.



Graph 1 | Evolution of income poverty, 1992-2008 (as a percentage of the population).

Source: National Council for the Evaluation of Social Development Policy (CONEVAL) estimates based on the household survey, Encuesta Nacional de Gastos de los Hogares (ENGH), of 1992-2008.

²Mexico produces a series of poverty lines based on income per capita that reflect food poverty, asset poverty and capability poverty. Capability poverty includes access to adequate housing, health and education. See <http://www.coneval.gob.mx/>.

BUILDING A SOCIAL PROTECTION FLOOR

The impact of the recent crisis on the most vulnerable groups of the population has been less than might have been expected given the size of the decline in GDP, owing, inter alia, to the institutionalization of a social development policy and to the creation of a social safety net and in particular to the important role played by the human development programme, Oportunidades (Oportunidades).

According to Gustavo Merino, Under-Secretary for Planning and Evaluation of Social Development of the Ministry of Social Development (Secretaría de Desarrollo Social, SEDESOL) (August 2008-July 2010):

"An effective social policy is revealed by comparing the impact of economic crisis we are currently going through with the 1994 crisis, which is of similar magnitude in terms of GDP. At that time, the number of poor increased by 17 million – from 52.4% to 69%. In contrast, between 2006 and 2008, asset poverty increased from 42.6% to 47%, which leaves us at levels similar to those of 2005 and, although the figures do not reflect the full impact of the crisis, no serious estimate signals impacts as high as in 1994. CONEVAL indicates that without programmes such as Oportunidades, the extremely poor would have increased by 2.8 million between 2006 and 2008, since these programmes, while attacking the structural causes of poverty, also protect households

against income shocks" ("Política social economía y combate a la pobreza", *El Universal*, 4 May 2010).

To address the effects of the 2008-2009 crisis and return to a steady and continual reduction of poverty, the federal government not only increased social spending but also strengthened social programmes by expanding their coverage and improving the interaction between social and economic policies.

In this process, the implementation of the Live Better (Vivir Mejor) Strategy in March 2008 should be stressed as a social policy strategy that supports a broader approach to social protection that emphasizes the development of basic skills, the link between a social context that determines both access to employment and income-generation possibilities, the environment, and protection from loss of income, poverty and social exclusion that put people in situations of vulnerability and social risk.

This strategy seeks to combine the fight against poverty and inequality while at the same time promoting social cohesion.

From 1996 to 2008, the foundations were laid for the institutionalization and strengthening of the Oportunidades human development programme, which evolved out of PROGRESA. The objective of the Oportunidades programme is to cover 5.8 million families in 2010, registering an increase from the 300,000 families with which PROGRESA began in 1997.

In this way, a social protection system was built — designed as a mechanism for the coordination and implementation of various social programmes that bring together traditional social security and the provision of social services in conjunction with a conditional cash transfer. This system takes into account the life cycle of the individual and his or her family, from the pregnant mother to the elderly, and incorporates a gender perspective that considers the many expressions of poverty. As a result, Mexico now has a social protection floor that has been built up over several decades.

Experience shows that social protection policies require a solid institutional framework. It is not so much a matter of the type or number of programmes but rather how the programmes are articulated in a national strategy that guides and focuses social development goals.

INSTITUTIONALIZATION OF SOCIAL POLICY: MAIN TOOLS

GENERAL LAW OF SOCIAL DEVELOPMENT

The effectiveness and direction of any social programme, beyond its optimal design, depend largely on the institutional framework underpinning it. The institutional framework concerns a set of factors that facilitate a constantly evolving and improving long-term social policy.

In Mexico, the General Law of Social Development (le Ley General de Desarrollo Social, LGDS) lays the founda-

tion for a State social development policy, institutionalizes various processes of public policy, supports the coordination between different levels of government and institutions of executive power, and promotes evaluation and transparency.

This Law states that the national social development policy must include different dimensions in order to overcome poverty through the following: education; health; food assistance; employment and income-generation; self-employment and training; social security and welfare programmes; regional development; basic social infrastructure; and the promotion of the social sector of the economy.

The LGDS considers the systematic evaluation of social development policy in order to periodically review compliance with the social objectives of the programmes, goals and actions of the Social Development Policy. For this purpose, the National Council for the Evaluation of Social Development Policy (CONEVAL) was created. The Law governs all social programmes and activities of the institutions and sectors of society.

The main features of the institutional framework are:

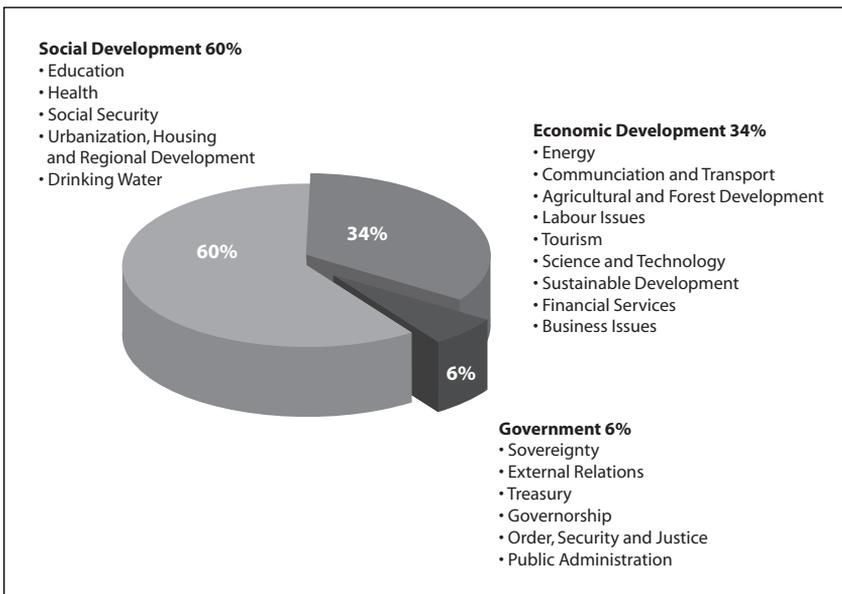
- (a) **General Law of Social Development.** Implemented in 2004, the Law stabilizes social policy and guarantees the full exercise of social rights, ensuring access for all people to social development, and institutionalizes certain activities such as:

- the definition and measurement of poverty;
- the evaluation of programmes;
- the integration of the lists of beneficiaries;
- the responsibilities of the three tiers of government;
- the creation of the National System for Social Development as a mechanism for participation and coordination among levels of government, the legislative branch, and the social and private sectors;
- the protection of the budget allocated for social development;

(b) **the Budget.** Adopted annually in compliance with the General Law of Social Development, the Federal Law on Budget and Fiscal Responsibility, and the Budget of

Expenditures of the Federation.

The federal budget for social spending cannot be lower, in real terms, than the budget of the previous fiscal year. This expenditure should be increased at least in the same proportion as that forecast for GDP growth. The financial resources come mainly from taxes paid by citizens and income from the sale of goods and public services. The federal government expenditure in 2010 is distributed as follows: 60 per cent for social development (education, health, social welfare, urbanization, housing and regional development, water supply and sewerage, social assistance); 34 per cent for economic development; and 6 per cent for government expenditure (graph 2). The primary objectives guiding expenditure for 2010 are: combating poverty, higher economic growth and strengthening public safety;



Graph 2 | Social expenditure, 2010.

(c) **inter-institutional coordination.**

This feature recognizes the need for participation and coordination mechanisms among the government, legislature, civil society and private initiatives in order to achieve social development goals.

At the federal government level, there is the **Social Cabinet**, a body created as a result of the General Law of Social Development and headed by the President of the Republic. The Social Cabinet examines, discusses and monitors the measures relating to social-sector programmes.

Another authority is the **Inter-Ministerial Commission for Social Development**, composed of 14 federal agencies chaired by SEDESOL. This is the vehicle to guide social policy development.

Moreover, there is an explicit commitment to strengthen the coordination mechanisms between different levels of government and the Legislature by promoting the greater involvement of these actors in developing programmes and strengthening budgets that ensures their concurrent participation in development activities. The **National Social Development Committee** has been established, comprising representatives of the Federal Government, State governments and municipal governments as well as representatives of the Chamber of Deputies and Senators.

The private sector and civil society organizations collaborate through

the **Advisory Council on Social Development**, which is chaired by SEDESOL and engages academics, businesses and civil society;

(d) **definition and measurement of poverty: tools to guide and evaluate social policy.**

The year 2002 witnessed the first official exercise in defining and measuring three different types of income poverty. With the results of this exercise, it is possible to diagnose the magnitude of the problem at the national level in both rural and urban areas.

Furthermore, these measures can be used as a tool for targeting and allocating resources. Poverty is measured every two years. Both the methodology and the databases are public, giving credibility to the exercise and its results.

In February 2010, CONEVAL presented the methodology for measuring multidimensional poverty, which is now the official methodology for measuring poverty in Mexico (table 1). The measurement of multidimensional poverty incorporates three aspects of the population's living conditions: the economic context, social rights and the territorial context.

According to this new concept, a person is considered in a situation of multidimensional poverty when his/her income is insufficient to acquire the goods and services required to meet his/her needs and the person also is lacking with respect to at least one of the

following six indicators: education, access to health services, access to social security, quality and areas of housing, basic services in housing and access to food.

With this new measurement, CONEVAL responds to the mandate assigned by the General Law

of Social Development with regard to the definition and measurement of poverty. Moreover, it contributes to the generation of information on issues of poverty and social inequalities that persist in Mexico. The data and methodology are published at www.coneval.gob.mx;

Table 1 | Measurement of multidimensional poverty, Mexico, 2008.

Incidence Indicators	Percentage	Number of People (in millions)
Multidimensional poverty		
Population in multidimensional poverty conditions	44.2	47.19
• Population in moderate multidimensional poverty	33.7	35.99
• Population in extreme multidimensional poverty	10.5	11.20
Vulnerable population by social deprivation	33.0	35.18
Income-vulnerable population	4.5	4.78
Population not poor multidimensionally and not vulnerable	18.3	19.53
Social deprivation		
Population with at least one social shortcoming	77.2	82.37
Population with at least three social shortcomings	30.7	32.77
Social deprivation indicators*		
Education gap	21.7	23.16
Access to health services	40.7	43.38
Access to social security	64.7	68.99
Quality and space of housing	17.5	18.62
Access to basic services in the dwelling	18.9	20.13
Access to food	21.6	23.06
Welfare		
Population with incomes below the minimum standard of living	16.5	17.64
Population with incomes below the standard of living	48.7	51.97

* Percentage of the population with social shortcomings.

Source: Estimates by CONEVAL based on Socioeconomic Conditions Module (MCS) and the National Household Income and Expense Survey (ENIGH) 2008.

- (e) **external evaluation of the programmes.** External evaluation is essential for the design and redesign of social programmes. All social programmes are subject to external evaluations undertaken by CONEVAL. The results are sent to the House of Representatives and are mainly published on the websites of the social-sector ministries. Depending on the results of the evaluation, criteria are established to help to improve the design of programmes and hence the responsiveness of government;
- (f) **register of beneficiaries, targeting key actions.** In 2002, the consolidation of a register of beneficiaries began to improve the targeting of social programmes. The register is public and available on the Internet. In this way, the register encourages transparency and accountability and facilitates inter-ministerial coordination. SEDESOL has an identity card with information about each beneficiary and his or her family, which is used to track and meet their demands through the programmes under its responsibility. Currently, work is being done to consolidate a single register of beneficiaries;
- (g) **rules of operation of the programmes, a mechanism for transparency and accountability.** Currently all programmes in Mexico must, according to the law, define their rules of operation to avoid having the design and implementation of social programmes left to the discretion of responsible officials. These rules of operation include: target coverage, target population, eligibility criteria, types and amounts of support, participating agencies, modus operandi, rights and obligations of recipients, evaluation indicators, and issues relating to complaints and allegations from the population. All this information is public. Currently, all federal programmes have rules of operation, updated and published annually in the Official Journal of the Federation;
- (h) **an electoral shield to support the implementation of social rights.** Through this mechanism, the potential for any political manipulation of social programmes is avoided. Under this mechanism, specific actions are taken to prevent the use of social programmes during electoral campaigns: training for staff and beneficiaries, and information campaigns to raise awareness among the population and particularly the population targeted by the programmes about their possible misuse for political and electoral purposes. Moreover, the same Law regulates advertising the programmes.
- In this task, SEDESOL is working with three levels of government, autonomous public bodies, civil society and international organizations;
- (i) **accountability, an ally to avoid arbitrariness and promote transparency.** SEDESOL promotes transparency and accountability through various mechanisms: (i)

audits, where the resources expended through the programmes are supervised by the Superior Audit of the Federation (Legislature) and the Internal Control Body (federal government); (ii) quarterly budget reports, which document the results, progress and operations budget for social programmes and are disseminated; and (iii) the dissemination of information.

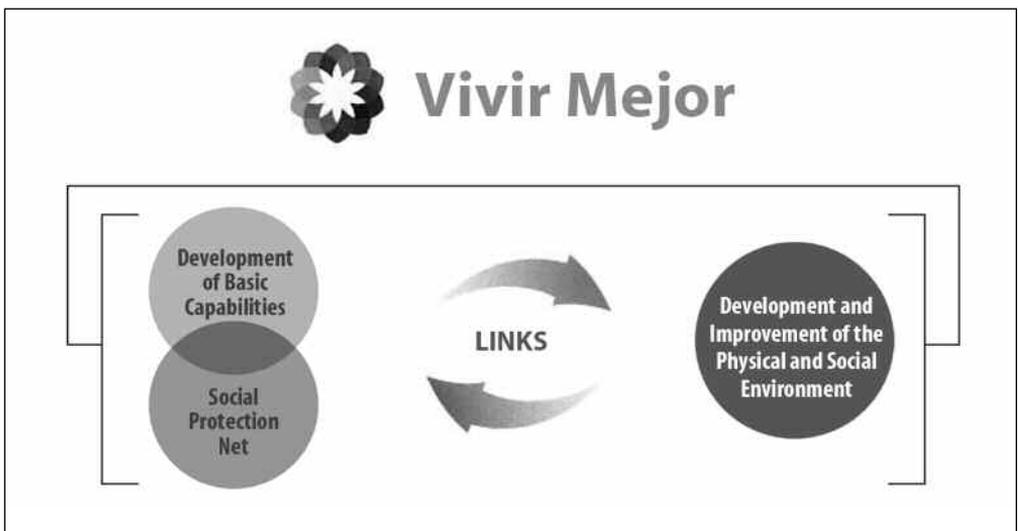
The information on social programmes is public and free, according to the provisions of the Federal Law of Transparency and Access to Public Government Information.

During the current decade, social development policy in Mexico has been successfully institutionalized. The federal government exercises its stewardship mainly through SEDESOL.

THE “LIVE BETTER” (VIVIR MEJOR) STRATEGY: EXAMPLES OF PROGRAMMES

One of the main goals and challenges set by the Government of Mexico is to improve living conditions, achieve human development and elevate the level of well-being of all Mexicans, but particularly those population groups that have fewer resources and are historically more vulnerable to adverse events such as economic crises, weather phenomena and climate change.

To achieve this goal, the Government is working hard to build a social safety net that would protect families that are affected by adverse contingencies, such as economic crises, job loss, natural disasters or disease that could negatively impact on their family assets and personal development.



To meet this objective, the Government of Mexico created the “Live Better” (“Vivir Mejor”) Strategy, which articulates in one single strategy the set of actions and programmes that integrate the social policy of the Government and, in general, the public policy of the current Administration.

THE VIVIR MEJOR STRATEGY

Vivir Mejor is a strategy that directs all the activities of the federal government towards the same goal, social human development, thus preventing any duplication and inefficiency and making the most of public resources invested.

The strategy promotes equal opportunities for poor people in order to strengthen social participation so as to reduce the gap between the country’s people as well as regions.

Its objectives are to:

- guarantee to all Mexicans access to adequate food, education, health, housing and basic services in their homes and communities;
- protect the population against conditions of vulnerability and risks such as sickness, unemployment or natural disasters;
- reduce inequality between regions and within them while strengthening community ties;
- guarantee more and better opportunities for employment and income; and
- carry out these actions in a

manner that respects the natural environment of communities.

The main challenge of this strategy is to ensure that every Mexican has the tools to improve his/her well-being through his/her own efforts and without compromising the heritage of future generations or being impeded by a lack of opportunities.

Vivir Mejor expresses a clear commitment to preserving the dignity of people, especially those who have fewer resources and those marginalized because of their age or disability or because of where they live or the lack of opportunities.

Through this strategy, actions are developed to enforce the basic rights of people in order for them to be able to fully enjoy the satisfactions of well-being and to facilitate their full integration into society and their ability to benefit from economic development.

The Vivir Mejor strategy seeks to promote the following:

- the development of capabilities in order to increase the assets of individuals and their productivity through the generation of equal opportunities for all Mexicans, especially girls and children, by ensuring access to food, education, health and a legal identity;
- a social protection network that seeks to preserve and restore physical and human capital, maintain access to basic social services and avoid any exclusion or marginalization that is brought about by

emergencies. It aims to provide protection against job losses, mitigate catastrophic health costs, and provide help in overcoming natural disasters and difficult economic circumstances for vulnerable people and groups;

- the establishment of bridges linking social policy and economic policy in order to enhance the skills and abilities of Mexicans so as to successfully include them in economic development; and
- the development of the environment or the improvement of the environment in which families live

in order to ensure a context in which to fully develop, improving the quality of housing, facilitating the acquisition of family wealth and important assets, and improving access to basic social infrastructure, all of which have a key impact on such areas as people's health, education and communication.

Vivir Mejor aligns all federal social programmes (table 2). It rests on inter-agency coordination, involving SEDESOL and other federal government agencies, such as the Ministry of Education, the Ministry of Health, the Ministry of Labour and Social Welfare, the Ministry of

Table 2 | Vivir Mejor and the programmes of SEDESOL, 2010.

Development of Capacities

- Oportunidades Human Development Programme;
- Food Support;
- Rural Supply Programme;
- Social Provision of Milk.

Social Protection Net

- 70 and Over Programme;
- Temporary Employment;
- Assistance to Migrant Farm Workers Programme;
- Support for State-level Women's Institutes to Implement Programmes to Prevent Violence against Women.

Socio-economic Bridges

- Child Day-care Centre Programme to Support Working Mothers;
- Production Options;
- National Fund for the Promotion of Handicrafts.

Development of the Environment

- Programme for Development of Priority Areas;
- Programme 3X1 for Migrants;
- Support for Asset-poor Citizens to Legalize Irregular Human Settlements;
- Habitat;
- Rescue Public Spaces;
- "Your House" Programme;
- Rural Housing;
- Social Co-investment Programme.

Note: Information on SEDESOL social programmes is available at: www.sedesol.gob.mx.

Economy, and the Ministry of Agriculture, Livestock and Rural Development. Additional information is available at www.presidencia.gob.mx/vivirmejor/.

OUTSTANDING PROGRAMMES COORDINATED BY SEDESOL

The Government of Mexico via SEDESOL has carried out programmes that, through internal and external evaluations, are recognized for their achievements in terms of the social and human development of Mexicans living in poverty. Foreign governments have taken note of these successful experiences, which include the Oportunidades human development programme, the programme on childcare facilities and the 70 and Over Programme.

Oportunidades Human Development Programme

The aim of the Oportunidades Programme is to contribute to breaking the intergenerational cycle of extreme poverty by expanding capabilities in education, health and nutrition for families living in poverty in the rural and the urban areas.

This year's Programme (2010) distributes the following benefits:

- **food support** (in cash and by delivery of food supplements) to improve the nutrition of the members of beneficiary families, with emphasis on children, and pregnant and lactating women;
- **scholarships** in cash for students of primary and secondary schools and high schools who remain in

school and complete these educational levels;

- **guaranteed access to a basic health package** to improve the health and nutrition of all members of the beneficiary families; and
- **additional support** to strengthen the development of children from 0 to 9 years of age to compensate families for increases in the cost of food and energy, improve the quality of life of adults 70 years old and over, and encourage study and completion of upper-level secondary education.

To receive support from the Programme, eligible families must comply with various conditionalities or co-responsibilities, which include: maintaining a minimum school attendance, going to scheduled medical appointments, and attending various workshops on health, hygiene and nutrition.

The Programme started as a pilot project in 1997 under the name Programme for Education, Health and Nutrition (PROGRESA) and covered 300,000 families. Since 2002, it has adopted a wider and more integral approach, with a life-cycle perspective to address the needs of all members of the family from the pregnant mothers to the elderly. Subsequently, its name was changed to Oportunidades.

This process has strengthened the institutional architecture and the tools of the Programme, which has been placed under a scheme of inter-agency coordination with the Ministries of Social

Development, Education and Health. The budget is the highest among the programmes to combat poverty. In 2009, it was 47.575 million pesos (about US\$3.8 million) while in 2010, it is 62.335 million pesos (US\$5.1 million). It should be noted that Oportunidades has an operational cost of less than 3 per cent of each dollar invested, which makes of it one of the most efficient transfer programmes in the world.

In 2000, 2.5 million families received support through the Programme, whose objective is to cover 5.8 million families in 2010. This means that more than a quarter of the total population will receive support from Oportunidades. It should be noted that since 2009, a new model to better address urban poverty has been introduced.

The Programme has been adapted to the national and international contexts in recent years. In this period, the world witnessed two of the most severe crises that humanity has ever faced: the 2008 food crisis and the 2009 economic crisis, resulting in an increase in poverty in the world, from which Mexico was not exempt.

What has happened in Mexico? Extreme poverty has been moving from the countryside to the city and Oportunidades had increased its presence in the rural areas. Consequently, prior to the crisis, the country faced the need to expand the Programme in order to tackle extreme poverty in the suburban belts of the country. Therefore, in 2010, the Programme extended not only its cover-

age but also its support.

Oportunidades 2010 incorporates a new model of service in urban areas. The main characteristics of this model are:

- multidimensional targeting at the household level;
- access to greater coverage of health services that respond to the dynamics of cities and their epidemiological problems;
- increases in the amount of educational scholarships in consideration of the higher opportunity costs observed in urban areas;
- compensatory support to households with young children (0-9 years of age) for virtually universal coverage in elementary school;
- bonuses for scholastic achievement;
- a new scheme of co-responsibilities, providing greater flexibility in its implementation, considering the activities, transportation and time schedules of people in urban areas; and
- a method of electronic payment to facilitate banking unbanked beneficiaries and improve the transparency of the Programme operations.

In 2010, Oportunidades is increasing coverage by 600,000 families and raising the benefits for families, with support for each child under nine years of age. With this extension, the Programme will now reach 5,800,000 families, or one out of every four Mexicans.

To ensure that only families who really need support are included, advanced technology is used to enable the identification of eligible families in a few seconds, with an accuracy of 100 per cent.

The results of the evaluations (Impact Assessments 2003, 2004 and 2001-2006 INSP) show that the Programme has had positive effects on:

- **education in rural areas**, with the following results:
 - 85 per cent enrolment in the first year of high school,
 - rates of 42 per cent for boys and 33 per cent for girls regarding the probability of entering high school, and
 - an additional year in the expected schooling among students between the ages of 15 and 18 years;
- **health:**
 - increased preventive medical check-ups: 35 per cent in rural areas and 20 per cent in urban areas,
 - in rural areas, a reduction of 20 per cent in the average number of days of illness per family for the age group 0-5 years (equivalent to two days per year) and of 11 per cent for the age group 16 to 49 years (equivalent to 6 days per year), and
 - an 11 per cent reduction in maternal mortality and a 2 per cent decrease in infant mortality;

- **nutrition in urban areas:**
 - an increase in the absolute height of children. Children under the ages of 24, 12 and 6 months included in the Programme before turning six months old measured on average 1.42 cm more, and
 - increased total consumption of families: 22 per cent in rural areas and 16 per cent in urban areas;
- **other impacts:**
 - a 33 per cent increase in the probability that households engage in micro enterprise activities, and
 - a clear trend that more empowerment for women is a protective factor against violence.^{xiii}

A Positive Impact to Face the Crisis

- In 2008, the population living in conditions of food poverty or in extreme poverty totalled 19.5 million. However, according to estimates by CONEVAL, without transfers from the federal government, the population affected by food poverty would have increased by 2.6 million people, that is, it would be 22.1 million (13.5 per cent) today.
- SEDESOL, based on the National Household Income and Expense Survey (ENIGH) conducted by the National Statistics and

Geography Institute (INEGI), estimates that, without Oportunidades, in 2008, 9.6 per cent of the population would have been affected by food poverty, that is, 21.3 million people.

- These results show the importance of federal government transfer programmes and in particular the relevance of the Oportunidades Programme.

Programme on Childcare Facilities to Support Working Mothers

The Child Day-care Centre Programme to Support Working Mothers aims to reduce the vulnerability of households in which the head of a family, with boys or girls between the ages of 1 year and 3 years and 11 months, is a single working mother or father. However, it also seeks to support households in poverty or at risk of falling into poverty and that cannot rely on a second income, increasing their chances of participation in the labour market.

Today, 93 per cent of the beneficiaries are working, 3 per cent work and study, 2 per cent study, and 5 per cent are looking for work. These figures stress the importance of the fact that 55,079 women for the first time have a job thanks to the Network of Childcare Facilities, which supports working mothers. The Network has generated 43,139 direct sources of employment among managers and people in charge of the facilities, who care for their children and the children of their neighbours.

The 70 and Over Programme

The 70 and Over Programme began in 2007 and aims to contribute to the reduction of social inequalities faced by people age 70 and over through actions oriented towards promoting social protection.

As a non-contributory pension scheme, the Programme guarantees economic support of 500 pesos a month to older adults living in towns of 30,000 inhabitants and above. Moreover, additional activities are carried out for their welfare.

The Programme is coordinated with other social programmes and institutions in order to provide the target group, people over the age of 70, with access to other services and support.

Social Insurance through the Health Insurance Programme (Seguro Popular)

In the course of action taken by the Social Protection Network, the Seguro Popular (health insurance) package is exemplary. Administered by the Ministry of Health, this voluntary public insurance provides an explicit package of health services and reduces the number of families that become poor each year because of health-care costs.

The Programme targets lower-income people and those who do not have a job or who are self-employed.

The beneficiaries of Seguro Popular are entitled to treatment of diseases included in the catalogue, Universal health services, which covers 100 per

cent of the medical services provided in health centres (first level) and 95 per cent of services in hospitals (second level) and associated drugs. They are also entitled to treatment of diseases included in the Fund for Protection against Catastrophic Expenditures.

As of 31 October 2010, Seguro Popular had managed to recruit about 40 million people across the country. By 2011, universal health coverage should be achieved, reaching a target of 49 million people with access to medical services and free drugs.

CONCLUSIONS

Over time, Mexico has built up a social security system and social protection tools, with the goal of ensuring the welfare of all Mexicans. In recent years, the priority of the Government of Mexico has been fighting poverty through targeted programmes, income transfers and differentiated programmes.

In the twenty-first century, with the requirements imposed by the country's democratic transition, the integration into world markets and the internationally agreed Millennium Development Goals, the Government of Mexico has sought to generate positive synergies between economic growth and social equity. In the context of economic modernization, it has sought to innovate and design a social protection system that takes into account macroeconomic balances and promotes participatory and inclusive democracy.

In 2008, an integrated social strategy of inter-institutional coordination, the *Vivir Mejor* Strategy, was launched, which takes into account the entire life cycle of individuals and their families, with a focus on sustainable human development to eradicate poverty and structural causes that generate it. The Strategy has fostered achievements that have strengthened the social protection system and contribute to nurturing greater citizen participation.

Mexico has developed social security systems and social protection over a long period, achieving significant progress on institutional issues, improving the coverage and quality of facilities and services. Experience shows that, in order to really impact the causes of poverty and inequality and support the social policies that ensure compliance with social rights of all people and social protection for all (especially for the population at risk of job loss, old age, disease, natural disasters, etc.), it is necessary to insert these programmes into a comprehensive strategy and have an institutional architecture that gives stability to social policy.

In short, it appears that, in Mexico, the transfer programmes and other programmes that proved to be successful in reducing poverty and promoting human development are those that are embedded in a national strategy for social policy in an institutional framework that promotes the articulation of programmes, inter-agency coordination and the participation of all sectors of society.

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- ⁱ National estimates, National Population Council (Consejo Nacional de Población, CONAPO), 2010.
- ⁱⁱ Ibid.
- ⁱⁱⁱ Ibid.
- ^{iv} Ibid.
- ^v Ministry of Health (Secretaría de Salud), 2010.
- ^{vi} *World Bank, World Development Indicators 2008 and Global Development Finance 2008.*
- ^{vii} Ibid.
- ^{viii} Organisation for Economic Co-operation and Development (OECD), 2005.
- ^{ix} National Institute of Statistics and Geography (Instituto Nacional de Estadística y Geografía, INEGI), second trimestre 2010.
- ^x Ibid.
- ^{xi} UNDP, *Human Development Report 2009.*
- ^{xii} Ibid.
- ^{xiii} See study, *“El Programa de Oportunidades examinado desde el Género, Coordinado por María de la Paz López y Vanía Salles”*, Edit. UNIFEM, Colegio de México y Oportunidades, Diciembre de 2006.



Mozambique

Population ⁱ	22,382,533
Age structure (%)	
• 0-14 years	44.1
• 15-64 years	52.7
• 65 years and over	3.2
Infant mortality rate (per 1,000 live births) both sexes ⁱⁱ	93
Life expectancy at birth (years) female	48.7
Life expectancy at birth (years) male	47.1
Maternal mortality ratio (per 100,000 live births) ⁱⁱⁱ	520
GDP per capita	
• Current USD ^{iv}	473
• PPP (current international \$) ^v	981
• Constant local currency	7,223
Human development index (HDI) rank ^{vi}	165
HDI poverty indicators – Human poverty index rank	127

Setting Up a Social Protection Floor

14

Miguel Mause
Nuno Cunha

Mozambique

Summary

Mozambique recently approved the National Strategy for Basic Social Security (April 2010) and the Regulation for Basic Social Security (December 2009) that set the stage for a comprehensive model that can be seen as another step in the direction of a national social protection floor (SPF).

Earlier in 2007, the Social Protection Law (4/2007) took the first step, organizing the social protection system at three levels: basic social security, obligatory social security and complementary social security.

Therefore, the legal framework creates an inclusive juridical foundation, establishing a mix of funding mechanisms (both contributory and non-contributory) and offering a set of potential benefits and mechanisms aligned with the SPF definition. The Regulation is a step forward, protecting key rights, establishing universalization as a goal, but also noting that the expansion of social protection will be gradual in accordance with government capacity.

The Regulation for Basic Social Security divides basic social security into four areas of intervention that are very relevant to the social protection floor:

- *direct social action*. Managed by the Ministry of Women and Social Action, it comprises social transfers used to address the needs of the most vulnerable (older people, people with disabilities, those who are chronically ill, and households with orphans and vulnerable children) and to respond to situations of transitory vulnerability;
- *health social action*. Managed by the Ministry of Health, it assures the universal access of the most vulnerable populations to primary health care;
- *education social action*. Managed by the Ministry of Education, it promotes the participation of the most vulnerable populations in the education system; and
- *productive social action*. Jointly managed by different sectors and including Social Inclusion through Work programmes, it targets female heads of households, people with disabilities and other people living in absolute poverty.

The approval of the Regulation for Basic Social Security constitutes a very significant step towards the implementation of the social protection floor in Mozambique, but it also raises a major challenge considering the institutional capacity of the national organizations involved.

Important items for discussion are efficiency of the programmes, definition of priorities, funding of the Strategy and fiscal space.

Information on the Authors

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INTRODUCTION

Mozambique has recently approved a strategy (the National Strategy for Basic Social Security) and a regulation (Decree nr. 85/2009) that establishes the Regulation for the Basic Social Security Subsystem. The latter, together with Law 4/2007 (the Social Protection Law) and the Regulation for Obligatory Social Security, creates the basis for a comprehensive model that can be seen as a step in the direction of a social protection floor.

This legal framework creates an inclusive juridical foundation, establishing a mix of funding mechanisms (both contributory and non-contributory) and offering a set of potential benefits and mechanisms aligned with the definition of a social protection floor. The Regulation for the Basic Social Security Subsystem is a step forward, protecting key rights, establishing universalization as a goal, but also noting that the expansion of social protection will be gradual in accordance with government capacity.

Indeed, as a result of the approval of the new Regulation, Mozambique now has a very comprehensive set of legal instruments. On one hand, the Social

Protection Law establishes three pillars of protection: non-contributory basic social security, contributory or obligatory social security, and complementary private insurance. On the other hand, the Regulation for the Basic Social Security Subsystem defines four areas of intervention: direct social action (monetary and in-kind transfers), health social action, education social action and productive social action. In addition, the Regulation for Obligatory Social Security foresees the extension of the social insurance mechanisms to the self-employed.

The three pillars of protection provide a diversified range of solutions for the extension of social security coverage and for the development of a social protection floor. Nevertheless, it is important to recognize that while being an important step, the existence of a good legal framework is not a sufficient condition for the successful implementation of a social protection floor.

This case study will focus on the most recent advances in the area of basic social security that target the most vulnerable populations, establishing "a set of essential social rights and transfers" as specified in the definition of the Social Protection Floor Initiative.

Regarding the policy level, the National Strategy for Basic Social Security (Estratégia Nacional de Segurança Social Básica, ENSSB) defines three objectives: (a) extending the coverage and impact of the programmes, (b) increasing the efficiency of the system, and (c) assuring the coordination of different programmes and services. The strategy definition was steered by the Ministry of Women and Social Action (MMAS), which will be responsible for implementing the strategy. Implementation will nonetheless take place in strong coordination with other ministries as well as national and international partners.

Different mechanisms for coordination are in place. The Regulation creates the National Council for Basic Social Security, which will be led by the Ministry of Women and Social Action and involves the participation of ministers from other sectors that will be associated with the implementation of the strategy. At the policy level, the Poverty Reduction Strategy Paper (PRSP) Working Group on Social Action played a significant consultative role in defining the strategy. It also constitutes the main forum for policy discussion between the Government and its national and international cooperation partners. The Government and partners see the Working Group as an excellent space for the definition of common strategies promoting the agenda on the expansion of basic social protection. A second working group that supports the Food Subsidy Programme (Programa Subsídio de

Alimentos, PSA) focuses on developments at the operational level.

In the context of the social protection floor, it is important to highlight that Mozambique has one of Africa's oldest non-contributory schemes in the Food Subsidy Programme (PSA). The PSA is a government programme that, since approximately 20 years ago, has been implemented by the National Institute of Social Action on a national scale, making it the precedent for the current expansion of basic social security benefits. More details about this programme will be provided in a subsequent section.

Although this progress represents important achievements for the sector, widespread coverage remains a big challenge. The manner in which the sector will face the challenges brought on by the strategy in the coming years will be very important to the future of social protection in the country. Areas such as the efficiency of programmes, the definition of priorities, and discussions concerning the funding of the strategy and fiscal space will certainly be among the most important aspects of the work that the Ministry of Women and Social Action will undertake in the near future.

CONTEXT

GENERAL INFORMATION

Mozambique is located in southern Africa and occupies a territory of about 800,000 km². It has a coastline of 2,500 km on the Indian Ocean and is bordered

by six countries. With a population estimated at over 22 million, Mozambique is unanimously seen as a country with potential but also with several challenges. At the time when the civil war ended, in 1992, Mozambique was one of the poorest countries in the world, with destroyed infrastructure, a fragile economy, lack of qualified human resources and great fragility. In the decades that followed the first free elections in 1994, the country came to be highlighted as an example of good economic performance. It achieved substantial improvements in some indicators such as the human development index (from 0.195 in 1990, to 0.224 in 2000, to 0.284 in 2010) and a significant reduction of absolute poverty (69 per cent in 1997 to 54 per cent in 2003). The recent National Poverty Assessment report shows that no improvement was achieved in eradicating poverty between 2002 and 2008. The rate of absolute poverty remains high at 54.7 per cent, compared to 54.1 per cent in 2002; social inequalities have increased, and rural and informal work still has an extremely important role in the economy. As a consequence, a large proportion of the population is still excluded from social protection systems.

ECONOMIC GROWTH

Economic growth in Mozambique has lasted for over 15 years. Between 2001 and 2006, the gross domestic product (GDP) grew an average of 8.7 per cent per year.^{vii} Even though the country experienced a slowdown in growth in 2008,

the projections of the Government (Action Plan for the Reduction of Absolute Poverty (Plano de Acção para a Redução da Pobreza Absoluta II, the country's Poverty Reduction Strategy Paper) indicate that growth will remain constant in the coming years. This growth has been based on private investment in physical capital and high levels of public spending. A significant portion of this is the result of mega-projects such as the Mozal plant for the production of aluminium. Another important portion of these investments was related to the process of recovery and rehabilitation of infrastructure in the post-war period.

Presently, a big expectation for economic growth lies in the development of the extractive industry, with several major investments in the pipeline and some that have already started being carried out. As a consequence, one of the most important debates in government and in Mozambican society is on how the country should deal with opportunities. A particularly interesting discussion centres on the way in which these investments will be taxed. Some believe that the contribution of the mega-projects to the majority of the population has been limited. The way in which the Government has dealt with extraction contracts and has even rewarded some companies with fiscal exemptions is at the centre of the discussion. Finding the best balance between promoting economic growth and creating revenues from this growth is one of the challenges.

POVERTY AND VULNERABILITY

Data from the last national poverty assessment report (by the Ministry of Planning and Development, 2010) indicates that 54.7 per cent of the population live below the poverty line. After an impressive decrease of 15.3 per cent between 1997 and 2002 (from 69.4 per cent to 54.1 per cent), the most recent data show stagnation in poverty reduction at least in terms of consumption.

The Multiple Indicator Cluster Survey (MICS) conducted in 2008 also shows some interesting trends. For instance, child mortality had dropped by 15 points over the five preceding years, from 153 to 138 deaths per 1,000 live births (a 9.8 per cent reduction). Regarding nutrition, the study indicates that 44 per cent of children suffered from chronic malnutrition, compared to 48 per cent in 2003. Nonetheless, 18 per cent of children under five were still underweight for their age, according to the Survey.

This reduction was accompanied by an improvement in some indicators such as the HDI: from 0.224 in 2000 to 0.284 in 2010.¹ During that same period, the gross rate of schooling in the primary, secondary and tertiary sectors combined went from 37.3 per cent to 54.8 per cent. Finally, there was also a modest average gain of 0.8 per cent in longevity, measured as life expectancy at birth.^{viii}

Despite the recognition that important improvements have taken place, the distribution of these effects has not been felt uniformly throughout the country and among all social groups. Persistent inequalities between farmers and city dwellers, women and men, and the poorest and the richest caused by rapid growth might be contributing to reduce the positive impact of economic growth on poverty reduction.^{ix} Inequalities also exist between regions. For example, the City of Maputo has GDP per capita values that are, on average, three times higher than the national average.^x However, there are also inequalities in access to services.

The main risks affecting the poorest households in urban and rural areas are hunger, illness or death of a family member, unemployment and harvest loss.^{xi} Although poverty has shown higher reduction rates in rural areas, the poorest households continue to be found disproportionately in agriculture, being more vulnerable to climatic shocks, such as seasonal droughts and floods, and to seasonal variations in income.^{xii} More recent data from the 2006 Survey on Poverty and Vulnerability indicate continued improvements in access to public services, particularly in health and education. Poverty also has a strong gender component because, in general, women (especially in rural areas) have less access to opportunities for income-generation.

¹Based on a new calculation formula available at <http://hdrstats.undp.org/en/countries/profiles/MOZ.html>.

Another major threat that Mozambique is facing is HIV and AIDS. In 2010, the national HIV prevalence rate was 11.5 per cent (National Statistics Institute/Ministry of Health). The higher rates of infection are associated with increased labour mobility, urbanization and the phenomenon of feminization of the epidemic. If these factors are not addressed and treatment strategies are not expanded, there will be a growing number of orphans and vulnerable children as well as a huge loss of skilled people, leading to a reduction in the workforce.^{xiii}

THE SOCIAL PROTECTION LEGAL AND INSTITUTIONAL FRAMEWORK

One of the advantages that Mozambique has in the development of a national social protection floor is its broad and comprehensive legal framework. The first component of this framework is Law 4/2007 (the Social Protection Law), which establishes the foundations for the organization of the social protection system. The Law defines the main components of the social protection system and allocates responsibility for the delivery of social protection at three levels that are in alignment with the three steps of the social protection floor.² It also creates the basis for a different set of funding mechanisms (tax- and insurance-based) in line with the funding mix foreseen by the

Social Protection Floor Initiative.

Moreover, Law 4/2007 establishes a set of principles well aligned with the social protection floor: universality and solidarity. According to the Law, the Labour Consultative Committee (a tripartite body of representatives from government, workers, employers and civil society) is charged with the global coordination of the system.

The first level of the social protection system is basic social security. It aims to prevent situations of need and to promote the social integration of the most vulnerable groups. This level, whose distributive characteristics are based on the concept of national solidarity, is funded mostly by the State budget. The beneficiaries are the poorest households and also the elderly, people with disabilities, those who are chronically ill, and households with orphans and vulnerable children. The ministry in charge of social affairs (the current Ministry of Women and Social Action) is responsible for the coordination of this first level.

The second level, obligatory social security, incorporates the benefits associated with social insurance mechanisms or contributory mechanisms. The institution in charge of this level is the National Institute of Social Security (INSS), which falls under the tutelage of the Ministry of Labour. The INSS was created 20 years ago and has been covering wage workers

²The metaphor that emerges for the extension of social security coverage is the image of a social security staircase. The floor level comprises a set of basic guarantees for all. For people with tax-paying or contributory capacity, a second level of benefits as a right (defined and protected by law with respect to the minimum levels) can be introduced, and, finally, for those with the need or wish for high levels of protection, a "top floor" of voluntary private insurance arrangements can be organized.

in the private sector since then. The second level also covers a subsystem for civil servants, which is under the responsibility of the Ministry of Finance. The second level currently includes: old-age pensions, cash sickness and maternity benefits, hospitalization, cash death grants and allowances for burial expenses.

Social insurance coverage is restricted to salaried workers and its coverage is limited when compared to the number of economically active individuals. In 2008, only 234,311 contributed out of 730,934 workers registered in the system, who themselves are a small fraction of an estimated total of 9.7 million economically active individuals. Registered workers constitute 7.5 per cent of the economically active work force and contributing workers are merely 2.4 per cent of the economically active, less than one third of registered workers. Only 26,437 retirees received pension benefits.^{xiv}

At the juridical level, Law 4/2007 promotes further progress towards the extension of social security for workers in the informal economy. Both the Law and the Regulation approved for the compulsory social security level aim to extend its coverage to self-employed workers, who constitute the majority of the working-age population. Thus, both create a legal window of opportunity for the coverage of workers in the informal economy. Nevertheless, this extension still constitutes a major and complex challenge, implying a significant restructuring of National Social Security Institute (INSS) processes and mechanisms, which were designed to deal with wage workers

alone. Currently, the National Social Security Institute is engaged in an effort to move forward with the creation of conditions for allowing this category of worker to be part of the system.

The third level is complementary social security, which was created to cover the private mechanisms that complement the benefits at the compulsory level. This level, which falls under the responsibility of the National Insurance Authority, was designed mainly to include the private insurance of those who want to have coverage that is additional to that offered by the INSS.

With these three levels, the system allows for a diversified range of solutions for the extension of social security coverage and for the development of a social protection floor. Nevertheless, it is important to recognize that while it is an important step, a good legal framework is not a sufficient condition for the successful implementation of the social protection floor.

THE BASIC SOCIAL SECURITY REGULATION

Under the recently approved Basic Social Security Regulation (Decree nr. 85/2009), the system defined further details for the implementation of Law 4/2007 in matters associated with the basic social security subsystem. Consequently, this Regulation establishes the social protection rights of the most vulnerable groups, defines in general terms the types of benefits to comply

with these rights, and defines the implementation of the benefits as something to be done gradually in accordance with government resources.

The Basic Social Security Regulation creates four different areas of intervention, which are very similar to the guaranteed benefits framework of the social protection floor:

- **direct social action.** Managed by the Ministry of Women and Social Action, it comprises social transfers used to address the needs of the most vulnerable (older people, people with disabilities, those who are chronically ill, and households with orphans and vulnerable children) and to respond to situations of transitory vulnerability;
- **health social action.** Managed by the Ministry of Health, it assures the universal access of the most vulnerable populations to primary health care;
- **education social action.** This area, managed by the Ministry of Education, promotes the participation of the most vulnerable populations in the education system; and
- **productive social action.** Jointly managed by different sectors and including Social Inclusion through Work programmes, it targets female heads of households, people with disabilities and other people living in absolute poverty.

The Regulation also mandates the creation of a national council for basic social security. This will be an intra-ministerial group where participation might also be extended to partners from civil society.

THE NATIONAL STRATEGY FOR BASIC SOCIAL SECURITY

In the follow-up to the approval of the Basic Social Security Regulation, the need to unify and orient the efforts of various actors in the area of basic social security was identified. As a response, the Council of Ministers approved the National Strategy for Basic Social Security (ENBSS) for the period between 2010 and 2014. One of the main objectives of the Strategy is to promote an integrated approach to social protection in the area of basic social security. At the same time, the Strategy is intended to be a tool for reinforcing the linkages between basic social security and the socio-economic development efforts of the country.

The process of developing the Strategy was highly participatory, involving many consultations with partners (including international donors, agencies and national civil society organizations). The Action Plan for the Reduction of Absolute Poverty (PARPA) Working Group on Social Protection played an important role in extending the dialogue to other government partners and to civil society organizations and international partners.

In this context, the Strategy states that “Basic social security contributes to a more inclusive society where development benefits the poorest and most vulnerable populations, participating in this way in poverty reduction efforts”. As such, according to the Strategy, basic social security is viewed as one of the measures needed to enhance the integration of excluded members of society and it is intended to serve as a bridge between the excluded groups and the benefits of economic performance that Mozambique has been witnessing.

This vision presupposes acknowledging that economic growth has not spread equally to different sectors of the society and that some groups need particular attention, as can be shown by the most recent poverty evaluation.

Efforts at poverty reduction, which is central in the Government’s policy goals, may be at risk and a share of the population may become trapped in chronic poverty. Through the National Strategy for Basic Social Security, which shows the complementarities between basic social security and economic development, social protection is expected to be positioned within the major national development policies. The Strategy also recognizes that this is not an easy task and that efforts need to be made in the area of basic social security. In this context, the Strategy contains the following definition of its mission: “to unify and orient the efforts of the government and non-government actors in the processes of planning and implementing actions in favour of the most vulnerable individuals,

to make Social Security contribute in an efficient and effective way to the country’s poverty reduction efforts”. Once again, the important message is the contribution to the main national goals but, in this case, the focus is on the questions of coordination, impact and efficiency. These issues have been constantly pointed to as areas where significant progress needs to be achieved and their inclusion in the Strategy mission statement reflects this importance.

The Strategy defines a set of very important principles: universality, progressivity, equity, inclusion, multisectorality, efficiency, solidarity, subsidiarity, participation and accountability. These principles should guide the implementation of the different key actions in the various areas during the Strategy implementation period.

In short, taking into account its vision, mission and principles, it can be said that the National Strategy for Basic Social Security has three main objectives for the period 2010-2014. These are to:

- extend the coverage and the impact of interventions;
- increase the efficiency of the system; and
- assure the coordination of different programmes and services.

Following what the Regulation establishes, the Strategy moves a step further in determining the areas of intervention.

The area of direct social action is divided into three components:

- **regular, unconditional social cash transfers** (where transfers to households with elderly or children may be included). Taking the Food Subsidy Programme as its base, the Strategy identifies the need to develop an analysis of the best ways to proceed with the extension of this kind of benefit, taking into account patterns of vulnerability and institutional and financial viability as well as the complementarities with other mechanisms;
- **social transfers for a fixed period**, which include support in case of transitory vulnerability. The support can be either in cash or in kind. Two types of interventions are foreseen: one in which support is given once to help the beneficiary face a one-time situation, and the second type in which support is offered to help to deal with mid-term temporary situations;
- **social services.**³ The Strategy defines the need to map out social services (both governmental and non-governmental) so as to define regulations and guidelines for their supervision.

Direct social action also includes a reference to the right of beneficiaries to receive support in accessing the Civil Registry Services.

The Strategy foresees the need to define an operational plan for direct

social action in order to have a detailed plan of how to execute the key actions defined in the Strategy. Currently, the Ministry of Women and Social Action is working on the definition of this kind of benefit, developing a detailed costing exercise, collecting information from evaluation processes, and organizing debates within the Ministry and with partners. The goal is to already include some of the benefits in the Government Plan and Budget for 2011 and, if needed, to include further analysis under the Ministry plan for 2011.

Health social action comprises the actions aiming to improve the health of the most vulnerable populations, with a specific focus on the promotion of access to basic health care. This area is managed by the Ministry of Health.

Education social action consists of interventions directed at promoting the participation of children from the most vulnerable households in the education system. Managed by the Ministry of Education, it can include, for instance, school feeding programmes for children in primary school, direct aid for primary schools or support in the acquisition of primary-school materials for students.

Productive social action is associated with activities developed to promote the socio-economic inclusion of the most vulnerable individuals who are physically able to work. The Strategy foresees the creation of a national productive social-

³By "social services", the Strategy means the services provided to specific groups of the population by different organizations. This includes social units accommodating vulnerable people living in poverty who were abandoned or marginalized (i.e., units such as nurseries, old-age support centres and transit centres for the care of people with disabilities).

action programme that should fall under the responsibility of various ministries (Ministry of Women and Social Action, Ministry of Agriculture, Ministry of Public Works, Ministry of State Administration, Ministry of Labour). This programme should be designed as part of the answer to chronic food insecurity, which has been reinforced in recent years by structural risks and shocks as well as the impact of environmental changes. Implementation should take place at the district level, a move associated with broader efforts at decentralization. In this programme, a social transfer should be associated with public works in favour of the community through tertiary-road maintenance, irrigation mechanisms, water management, etc. It is also foreseen in the Strategy that the transfers might have a seasonal nature, preferably coordinated with the hunger season, and that they should be designed to target the most vulnerable.

One of the main objectives of the Strategy is to associate the social security policy with other major policy efforts in the country. Therefore, the Strategy takes into account, as mentioned earlier, the decentralization process and tries to establish district administrations as the implementing actors of some of the programmes. It also attempts to associate social security with the national efforts to reduce food insecurity. Moreover, an effort is made to show the link between basic social security programmes and risk mitigation (namely, in the scope of natural disasters). Owing to the high occurrence of natural disasters, the strategies for coping

and mitigating their impact are placed high on the national policy agenda.

Another area in which the Strategy exhibits progressive ideas is funding. It contains suggestions for some possible sources of funding for basic social security, namely, the creation of a social action fund and a sectoral working group with donors. The development of a study for analysing the different options is on the horizon.

THE FOOD SUBSIDY PROGRAMME

As mentioned earlier, one of the basic models for the extension of coverage to the most vulnerable populations in Mozambique can be found in one of the existing social transfers, the Food Subsidy Programme (Programa Subsídio de Alimentos, PSA).

The Food Subsidy Programme is the main programme under basic social security in terms of coverage and longevity. It constitutes one of the rare examples in Africa of a State-led, non-contributory social security programme with continuous funding over a period of almost 20 years. Established in 1990 as a response to the negative effects of the structural adjustment policies, the Programme evolved into its current institutional form in 1997. It is also the only basic social security programme in Mozambique with a legal status (Decree 19/93).

The Food Subsidy Programme can be seen as a welfare benefit with some of the

characteristics of old-age pensions and of social benefits for the disabled and the chronically ill. Originally, it was designed to meet basic food needs in the context of structural adjustment. Currently, however, many see the Programme as also having an impact on enhancing human capital and economic growth.

The Programme targets the extremely poor, that is, individuals who are unable to work and who therefore cannot meet the basic needs of their households:

- the elderly (age 55 years and over for women and 60 years and over for men, who are recognized as being permanently unable to work and who live alone or are heads of extremely poor households);
- people with disabilities (individuals of both sexes, 18 years of age and above, who are recognized as being permanently unable to work and who live alone or are heads of extremely poor households); and
- the chronically sick (individuals of both sexes, age 18 and above, who suffer from a chronic disease recognized by the medical services).

The Food Subsidy Programme also used to include malnourished pregnant women but its most recent procedures have been geared towards leading these beneficiaries to other National Institute of Social Action (INAS) programmes. The most recent data show that the elderly constitute the Programme's majority group, with 93.5 per cent of the beneficiaries. They are followed by people with disabilities (5.5 per cent) and by chronically ill patients (1 per cent). Women account for 63 per cent of the beneficiaries while 37 per cent are men.

cally ill patients (1 per cent). Women account for 63 per cent of the beneficiaries while 37 per cent are men.

The amount given to beneficiaries depends on household size (number of dependents per beneficiary). Monthly, the Food Subsidy Programme amount ranges from Mtn100 (about US\$2.85) for a household with a single person to a maximum of Mtn300 (about US\$8.50) for a household with five or more members. The Ministry of Women and Social Action is working with the Ministry of Finance on creating a mechanism that will automatically index the value of the Food Subsidy Programme to the minimum wage. This will reduce the impact of inflation on the beneficiaries' purchasing power, which has been considerable in recent years. Nevertheless, even if the amount is recognized as being inferior to household needs, there are some indicators that show that this small amount can have an impact on the well-being of beneficiaries, constituting a monetary complement to other forms of income.

The funding for the Food Subsidy Programme comes mainly from the Government budget. Since 2008, the national funds have been complemented by those of cooperation partners: the Department for International Development (DFID) and the Embassy of the Kingdom of the Netherlands.

The Food Subsidy Programme is implemented by the National Institute of Social Action (INAS). INAS is the executing body for policies defined by the Ministry of Women and Social Action. At

the community level, it works through local agents. These agents, known as "permanents" ("Permanentes"), are chosen by the community and work on a volunteer basis, receiving only an incentive monthly pay of Mtn300 (US\$8.50). Their role is to promote the linkage between INAS delegations and the community, to participate in the identification of vulnerable people as potential beneficiaries and to organize the payment posts on paying days.

INAS is also receiving technical and institutional support from the International Labour Organization (ILO) and the United Nations Children's Fund (UNICEF). Non-governmental organizations (NGOs) such as HelpAge International and Save the Children are also piloting new delivery modalities, contributing in this way to the discussion on how to increase the efficiency of the Programme.

The Food Subsidy Programme is currently implemented in all districts of the country through 30 delegations installed in all 11 provinces. Despite a great effort to extend it to rural areas, it has not achieved the full coverage of potential beneficiaries owing to the geographical spread of the population and to budget limitations imposed by the Ministry of Finance.

The Food Subsidy Programme can be used strategically as an important instrument in the fight against poverty and for mitigating the impact of crises (HIV and AIDS, financial, food and natural). Since an important share of the beneficiaries (the elderly) care for orphans and vulner-

able children, the Programme has the potential to play an important role in mitigating the impact of HIV and AIDS. In the hypothetical scenario of a universal social pension, it would have the potential to benefit more than 1.5 million children.

INAS is currently undertaking, with United Nations support, an evaluation in order to assess the real impact of the Programme. The results should contribute to creating growing awareness at the country level of the potential of social transfers as an effective poverty-reduction tool and of their capacity to enable local economic development through the impetus that they give to demand, thereby increasing the entry of cash into small community economies.

According to the most recent census, the number of households with elderly people is around 900,000. The elderly constitute one of the groups more prone to poverty. The official poverty headcount is around 54 per cent. Using a very rough estimate, it can be said that the Food Subsidy Programme is currently covering less than 35 per cent of the estimated elderly poor. Nevertheless, recent years have shown a positive trend in its coverage levels, increasing from 96,572 in 2006 to 217,471 in 2010 (an increase of more than 125 per cent in four years) and it is expected to cover around 254,000 in 2011. The Strategy set the number of people to be targeted by the Programme at 523,000 in 2014, which would represent 1.31 per cent of the government resources envelope. These figures still need to be discussed with the

Ministry of Finance and some extra calculations are now being done using the most recent demographic data.

Simultaneously, recent guidelines orient the targeting towards elderly living with children in order to mitigate the impact of HIV and AIDS. The benefit amount was also increased, particularly the portion that the beneficiary receives for having an extra dependant. Nevertheless, some information indicates that, at the field level, the Food Subsidy Programme has not been able to reach all household members. It is also possible that household selection has not included households with more children. Work is currently being pursued with the support of United Nations agencies to estimate the cost of covering potentially excluded children.

THE DIALOGUE PROCESS

One aspect that has been playing and that can play an even more important role in the process of extending social protection coverage in Mozambique is the increased dialogue between government and partners (donors, United Nations agencies, international NGOs and national civil society organizations). The way in which the different parties have been collaborating can be seen as a potential contributing factor in the development of a social protection floor in Mozambique. For instance, the creation of the National Council for Basic Social Security, in the scope of the recently approved Regulation, establishes a forum for high-level coordination. The plan is

to have ministers from different areas that are somehow related to the social protection sector participate and collaborate through the Council.

At a different level, the PARPA Working Group on Social Action (created as a result of the Poverty Reduction Strategy Paper) has been playing an important role by providing a forum for technical discussions. The Working Group was created under the framework of the Memorandum of Understanding (MoU) between the Working Group's programmatic donors (called the G19) and the Government. The Working Group is coordinated by the Ministry of Women and Social Action and operates with the participation of civil society members and international partners (both donors and United Nations agencies).

In the scope of the above-mentioned MoU, the Working Group is responsible, among other activities, for the development of a joint evaluation of the performance of the social protection sector. This evaluation includes an appreciation of the execution rates, compares the coverage targets with the objectives, and highlights the main progress and challenges. The production of the document is a joint process between government and partners, creating an opportunity for discussion and contributing to the creation of a shared vision among the sector's partners. It is also an opportunity for reinforcing the institutional capacity of the partners involved. The document will be shared with other sectors, thereby creating an opportunity for advocacy on a broader scale.

Other activities that are relevant are the regular meetings organized between the Ministry of Finance and the sectoral working groups. In these meetings, each sector (represented by government and partners) has the chance to present its analysis of the budget execution and of the budget for the coming year. Given that different stakeholders attend these meetings, they are an important forum for advocating for the expansion of the budget allocated to the social protection sector, as well as other technical aspects associated with the budget of the sector.

Independently of the meetings mentioned earlier, the Working Group on Social Action has also been used as a privileged platform for technical discussions. This was the case with the definition of the National Strategy on Basic Social Security, where many consultation meetings took place using the Working Group. The partners also use this platform as a means to promote coordination among themselves. To this end, a subgroup of partners, which meets every two months, was created. These meetings serve to update all the partners about progress in the social protection sector and to share information on the activities that each partner is carrying out in order to create synergies and avoid duplication.

One additional outcome from the efforts of this Working Group has been the reinforcement of the mutual trust between government and partners. The need to produce joint reports creates increased mutual knowledge and therefore an opportunity to align positions.

A second group has been formed on the basis of the MoU to support the Food Subsidy Programme. The National Institute of Social Action, the Ministry of Women and Social Action, UNICEF, ILO, DFID and the Embassy of the Kingdom of the Netherlands constitute this group. The group meets once every two months and deals with the more operational aspects of the Programme, such as monitoring and evaluation of implementation, analysis and discussion of financial and fiduciary issues, and discussions on processes associated with institutional change. Discussions on the information system, the support to the financial and management system, and the revision of the payment methodologies are within the main themes of discussion. Owing to the fact that the donors have become direct funders of the Food Subsidy Programme, INAS presents an annual report and plan. These documents are discussed and the continuity of annual funding depends on their approval.

In 2008, a civil society organization for social protection was created. It acts as an interlocutor for the Government, helps to organize civil society interventions, and can also play an important advocacy role.

CURRENT CHALLENGES AND OPPORTUNITIES

The social protection sector has gone through important developments and has had considerable achievements, as can be seen throughout this case study.

Nevertheless, there is still a great deal of work to do, given the gap between the number of people currently covered and the number of people in need of support as well as the potential role that social protection can play in the country. There is ample room to extend coverage and to improve the effectiveness and efficiency of the programmes, a fact of which all partners are aware. The National Strategy for Basic Social Security defines important goals and some of the key activities that will help to attain these goals. Beyond describing a final result, the Strategy and the Regulation are setting the agenda for the coming years, making it clear that challenges will be significant.

For instance, at the concrete level of implementation, programmes will need to be revised. Some will be realigned, others will terminate, and still other new ones will be created. Currently, the Ministry of Women and Social Action is using the technical support provided by some partners to analyse the best options for covering different vulnerable groups. Many options for targeting these groups are now on the table. The strategy development implied a first analysis of the cost of the different possibilities. Now a deeper analysis is being conducted and it is likely that some priorities will need to be selected. Technical committees are being created to discuss the different options but it is already emerging that particular attention will be given to households with vulnerable children.

Simultaneously, the National Programme of Productive Social Action

needs to be designed in order to cover the most vulnerable individuals who are able to work in an effective way. Linking this programme to other government efforts could be the solution for guaranteeing that funding exists on the scale required to cover a considerable share of the population.

In addition, the extension of the Food Subsidy Programme is under discussion as is the setting of an ambitious but realistic target. This extension should allow for the inclusion of all indirect beneficiaries (namely, the children that are part of the direct beneficiary's household), significantly increasing the developmental impact of the cash transfer.

At the same time, a dialogue with the Minister of Finance should also take place to find the best way to promote the creation of an automatic mechanism for indexing the subsidy amount to inflation. This is extremely important for guaranteeing that the impact of the transfer on the beneficiaries' well-being is not reduced every year.

There are also challenges to increasing the efficiency of the Programme at the institutional level. Efforts need to be made to achieve an even more transparent system and this implies, among other things, improving selection mechanisms, the information system and the guidelines for implementation at the field level. Another important aspect is the reduction of administrative costs by lowering the cost of delivering the transfers and increasing the amount available to beneficiaries. This implies a restructuring of the procedures.

Currently, a debate is taking place on the use of third-party payment.

Finally, two other challenges will be central to the debate throughout the coming years and they are interlinked. One is associated with funding limitations. Owing to the financial constraints on government resources, the Ministry of Women and Social Action needs to search for solutions in order to be able to fund the expansion that it proposes in the Strategy. In the Strategy, the creation of a social action fund is foreseen, which can include, at least in the short term, the use of donor funds. However, in the mid- to long term, the funding issue implies a discussion that goes beyond the scope of the intervention of the Ministry of Women and Social Action. It pertains to issues linked to the political economy, such as the increase of fiscal space. An interesting discussion is currently taking place regarding the taxation of the mineral industries and other mega-projects. In some countries, the revenues from these industries have been part of the funding solution.

This leads to the second issue, which is the role of social protection in the development strategies of Mozambique. The allocation of resources to this sector will depend on the level of priority attributed to social protection on the country's policy agenda. This will entail important efforts in raising awareness among the different stakeholders in the country, namely, among policymakers. The Strategy may include the development of an advocacy plan as one of its key deliverables. Touching different segments of

society will be important but this will also depend on the capacity to present concrete proof that investing in social protection is an efficient way to achieve poverty reduction.

Public and political perceptions regarding social protection, e.g., the issue of the risk of dependency, should be considered when policy proposals are discussed. Contradicting some of the perceptions surrounding social protection, the studies of the major international programmes do not show the existence of a negative effect on labour supply. To be successful in the expansion of social protection, it is crucial not to let the best be the enemy of the good and, taking public perceptions into account, build consensus around compromise in programme implementation and roll-out.

Despite all these challenges, the current moment can be seen as a moment of opportunities for social protection in Mozambique. After the approval of the Strategy and the Regulation for Basic Social Security, social protection is receiving a new emphasis in the first draft of the new PRSP. The new Memorandum of Economic and Financial Policies between the International Monetary Fund and the Government of Mozambique clearly states the need to build sustainable safety-net mechanisms through the implementation of the National Strategy for Basic Social Security. In particular, the area of productive safety nets has been raising interest among various ministries and international partners.

Indeed, the recent data on poverty reduction can be interpreted as a sign that the post-war model of economic growth and poverty reduction has been exhausted and is facing problems in reaching the poorest group of the population, suggesting that special measures oriented to this group are needed. The fact that an important share of the population feels excluded from the process of economic development is one of the main reasons for social instability. The riots of February 2008 and September 2010 should be analysed within the context of the major development challenges in Mozambique. Looking at the situation from another perspective, the social unrest that can result from the lack of progress in poverty reduction can have a negative impact on the business environment since social stability occupies an important position among the variables affecting the decisions of economic agents to invest in a country.

^{ix} World Bank, *Beating the Odds: Sustaining Inclusion in Mozambique's Growing Economy*, 2008.

^x UNDP, *Mozambique National Human Development Report 2007*.

^{xi} World Bank, *Beating the Odds: Sustaining Inclusion in Mozambique's Growing Economy*, 2008.

^{xii} *Ibid.*

^{xiii} *Ibid.*

^{xiv} National Social Security Institute (INSS), *Developing an Effective Pension System in Mozambique*, 2008, and USAID, 2009.

ⁱ World Bank, *World Development Indicators 2008*.

ⁱⁱ Multiple Indicator Cluster Survey, National Statistics Institute (Instituto Nacional de Estatística, INE), 2008.

ⁱⁱⁱ WHO, UNICEF, UNFPA and World Bank, *Global Health Observatory*, 2005.

^{iv} International Monetary Fund (IMF), *World Economic Outlook*, 2010.

^v International Monetary Fund (IMF), *World Economic Outlook*, 2010.

^{vi} UNDP, *Human Development Report 2010*.

^{vii} UNDP, *Mozambique National Human Development Report 2007*.

^{viii} UNDP, *Human Development Report 2010*.



Rwanda

Population ⁱ	10,117,029
Area	26,338 km ²
Age Structure ⁱⁱ	
• 0-14 years	42.2
• 15-64 years	55.3
• 65 years and over	2.5
Infant mortality rate (per 1 000 live births) both sexes ⁱⁱⁱ	72.0
Life expectancy at birth (years) female	52.0
Life expectancy at birth (years) male	48.4
Maternal mortality ratio (per 100 000 live births) ^{iv}	1,300
GDP per capita	
• Current USD ^v	458
• PPP (current international \$) ^{vi}	1,027
• Constant local currency	99,490
Human development index (HDI) rank ^{vii}	167
HDI poverty indicators – Human poverty index rank	100

Social Protection: An Ongoing Process

15

Rwanda

Theophile Ruberangeyo
Crispus Ayebare
Astrid de Laminne de Bex

Summary

In order to reduce poverty among the population and to achieve Millennium Development Goals (MDGs), the Government of Rwanda is elaborating and implementing different schemes and interventions in the social protection sector. This sector has developed and evolved a great deal in the last 10 years, with an increasing role to play in poverty reduction. After elaborating a social protection policy in 2005 and having commissioned a Public Expenditure Review (PER) in 2006, the Government identified social protection as one of the priority sectors in the Economic Development and Poverty Reduction Strategy of 2007.

Various programmes have been set up by different institutions to contribute to poverty reduction and the improvement of Rwandans' living conditions. In the health sector, different schemes co-exist and complement one another. For the formal sector, the Rwanda Health Insurance Scheme (la Rwandaise d'assurance maladie, RAMA), Military Medical Insurance (MMI) and private insurance companies cover, respectively, the civil servants, members of the Rwanda Defence Force and their immediate families, and employees of private companies. All formal-sector workers are also part of the Social Security Fund of Rwanda (SSFR) for occupational hazards. The informal sector and rural populations are members of other schemes, called community-based health insurance schemes (*mutuelles de santé*). These schemes cover 91 per cent of the population in 2010.

In the education sector, all Rwandans can benefit from free basic education (nine years). A programme is also supporting some vulnerable groups to access housing.

In addition to these schemes, there are some other social transfers. Among them, formal-sector employees contribute for their pension. A flagship programme was also developed as part of the Rwanda Economic Development and Poverty Reduction Strategy: the Vision 2020 *Umurenge* Programme (VUP). It has three components: public works, direct support and financial services. This Programme has shown results in reducing poverty among beneficiaries. Another Rwandan initiative is the *Ubudehe* programme and approach (community targeting/classification through social mapping). To support the genocide survivors, the Fund for the Support and Assistance to the Survivors of the Tutsi Genocide and Other Crimes against Humanity was established and supported them in different areas (housing, education, health, social assistance, income-generating activities). To contribute to the reintegration of demobilized soldiers, the Rwanda Demobilization and Reintegration Commission has developed programmes to support this specific group. A project also contributed to the improvement of livelihoods, soil fertility and nutrition status through providing a dairy cow to poor families.

Summary (cont'd.)

Other vulnerable groups such as the disabled and orphans and vulnerable children are also targeted by some of these interventions and also benefit from other interventions.

There are different coordination mechanisms at different levels in Rwanda to improve the efficiency and impact of interventions in the social protection sector.

A social protection strategy is being developed in 2010 and discussions are ongoing before its final approval. This case study focuses on several interventions centred on improvement and harmonization where possible to improve the social protection for Rwanda's population.

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INTRODUCTION

This case study presents the social protection sector in Rwanda and its development over the last five years. Following a description of the socio-economic situation in the country, the case study focuses on the evolution of social protection. Several main programmes are then discussed to show the current situation and implementation of social protection in Rwanda. The third part of the case study presents the new strategy and way forward for the next 20 years.

CONTEXT

Rwanda is a landlocked country with a population of about 10 million that is situated in central Africa. It is one of the continent's most densely populated countries, with up to 467 people per square kilometre. The population is comprised mainly of young persons; in 2005, people under 25 years of age accounted for two thirds of the population.

Rwanda is facing a challenge with its population growth. With a total fertility rate of 6.1 in 2005 combined with a decline in infant mortality, it has one of the highest population growth rates in Africa (around 2.7 per cent per year).

In May 2000, the Government of Rwanda adopted a decentralization policy and a strategy for its implementation. The administrative structure of the country entered its second decentralized phase in 2006, which led to the following organization: the country is divided into provinces, districts, sectors and cells. Districts constitute the main decentralized political administrative entity while sectors are their implementation units. The smallest political administrative unit is the cell, which is the link between communities and higher levels.

In the aftermath of the genocide against the Tutsi (1996-2000), real gross domestic product (GDP) grew at over 10 per cent per year as the economy recovered from a low base. This was followed by a period of stabilization (2001-2006) during which real growth fell to an annual rate of 6.4 per cent.^{viii}

Rwanda achieved good economic growth during the past decade. Between 2004 and 2008, average annual real GDP growth was 8.6 per cent, exceeding the Economic Development and Poverty Reduction Strategy (EDPRS) target of 7 per cent. However, alongside this impressive growth, Rwanda has made only modest progress in reducing poverty.^{ix}

Poverty rates fell from 60.4 per cent in 2000 to 56.9 per cent in 2006, a rate of reduction that is insufficient to meet either the targets set in Vision 2020 or the Millennium Development Goals (MDGs).^x Furthermore, 36.9 per cent of

the population in 2006 lived in extreme poverty. Also of concern is the fact that, owing predominantly to population growth, the absolute number of poor people grew from 4.8 million in 2001 to 5.4 million in 2006.^{xi}

The challenge of high poverty levels is exacerbated by rising and high levels of inequality. According to the EDPRS, "inequality as measured by the Gini coefficient rose from an already large 0.47 in 2000 to 0.51 in 2006".^{xii}

Poverty is concentrated among certain groups. In the initial *Ubudehe* survey of the mid-2000s, communities ranked the poorest and the most vulnerable categories of the population as "widows, landless, sick, the elderly and child-headed households".^{xiii}

Lessons from the evaluation of the Poverty Reduction Strategy Paper (PRSP) (2002-2005) suggest tackling extreme poverty through improved food security and targeted schemes of job creation and social protection. As a priority for the EDPRS,^{xiv} it is urgent that new employment opportunities be created for young people just entering the labour market.

The Government has put the MDGs at the centre of its policy framework. To achieve these Goals, it has launched a major effort to scale up MDG interventions through the Vision 2020 *Umurenge* Programme and other initiatives geared to attaining the set goals.

EVOLUTION OF THE DEVELOPMENT PROCESS

ROOTS OF SOCIAL PROTECTION IN RWANDA

The social protection sector and interventions have received more and more attention over the last five years. They are seen as a means by which to contribute to economic growth, to integrate people into the labour market, to slow down population growth, to improve human development through better access to health and education, and to reduce poverty.

In 2003, a new Constitution was adopted by referendum to replace the older Constitution of 1991. Article 14 stipulates that "The State shall, within the limits of its capacity, take special measures for the welfare of the survivors of genocide who were rendered destitute by the genocide committed in Rwanda from October 1st, 1990 to December 31st, 1994, the disabled, the indigent and the elderly as well as other vulnerable groups." The Constitution also focuses on children through Article 28: "Every child is entitled to special measures of protection by his or her family, society and the State that are necessary, depending on the status of the child, under national and international law."

SOCIAL PROTECTION POLICY IN 2005

In 2005, the Ministry of Local Government

developed a social protection policy through a participatory analysis of defining poverty, which helped to categorize degrees of vulnerability.^{xv} The process of developing the National Social Protection Policy started with collecting basic information and data and concluded with the drafting of two main reports:

- Inventory report on interventions and their practices in the area of social protection in Rwanda; and
- Rwanda: Preliminary estimate of risk, vulnerability and vulnerable groups.¹

The policy is oriented towards reducing vulnerability in general and the vulnerability of the poor and marginalized people in particular and towards promoting sustainable economic and social development centred on good social-risk management and good coordination of savings actions and the protection of vulnerable groups.^{xvi}

The National Social Protection Policy defines social protection as "a set of public and private initiatives enabling to provide transfers of income or consumption to the poor, to protect, in particular, the vulnerable and the marginalized against welfare risks and improve their social status and rights as a whole with the overall objective of promoting the welfare of the population" [section 1.3].^{xvii}

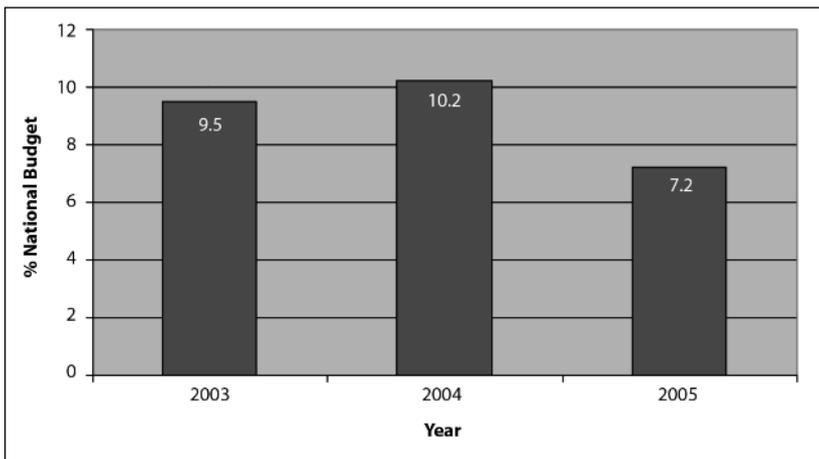
The Policy mentions the main groups

¹Prepared on the basis of results of surveys that had been conducted in the course of the previous four years and that focused mainly on the following: (a) Household expenditure survey of 1999-2001 (Enquête intégrale sur les conditions de vie des ménages, EICV); (b) the Census of population and housing of 2002 (General Population and Housing Census); and (c) the Core Welfare Indicators Survey of 2003 (Enquête sur les indicateurs de base du bien-être, QUIBB).

that have always held the attention of the Government: genocide survivors, orphans, minors in difficult situation, widows, people living with HIV and AIDS, youth from destitute families, demobilized soldiers, disabled people, repatriates, refugees, the elderly, victims of catastrophes and underdeveloped and marginalized victims of socio-cultural history, etc.^{xviii}

Social protection was not a strategic

area identified under the first Poverty Reduction Strategy Paper (PRSP) and it has suffered from the lack of a strategic plan, consolidated budget and monitoring framework. Despite this, it is estimated that between 7 per cent and 10 per cent of the national budget has been allocated to social protection-related programmes (e.g., funds for genocide survivors, people with disabilities) that specifically target the most vulnerable groups in Rwandan society (graph 1).^{xix}



Graph 1 | National budget spent on social protection.

Source: African Peer Review Mechanism, Country Review Report, June 2005, p.107.

It is likely that some progress has been made with these resources, but it is difficult to track it systematically. The adoption of a social protection policy at the end of 2005 was an important step but rapid development of a strategic plan was found to be important as well.

The overall objective of the social protection sector as set out in the policy document is to achieve effective and sustainable social protection for the poor and vulnerable, to reduce the risks to which

households are subject, to mitigate the potential consequences of those risks, and to help families that experience them to cope with the consequences. This group is defined as all those below the poverty line in the Household Living Conditions Survey 2005 (EICV2).

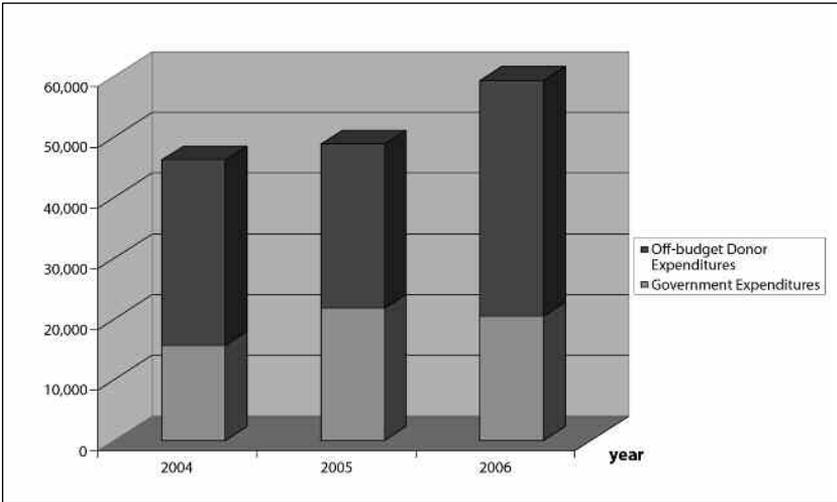
PUBLIC EXPENDITURE REVIEW IN 2006

In 2006, the first-ever review of public expenditure on social protection was con-

ducted. Commissioned by the Ministry of Local Government, Community Development and Social Affairs (MINALOC) and the Ministry of Finance and Local Planning (MINECOFIN), the study was designed to inform judgments on the future direction of public policy with regard to social protection and to help in drafting the social protection chapter in the Social Protection Public Expenditure Review Report (EDPRS)

(2006). The main findings show that social protection was one of the largest sectors in the EDPRS, representing 59 billion Rwandan francs (RF).

The social protection spending was found to be significant, with over 5 per cent from government, including off-budget support (graph 2). Social protection spending is equivalent to 4 per cent of GDP, with about 2 per cent going to food aid.



Graph 2 | Total social protection expenditures, by source, 2004-2006 (in billions of Rwandan francs).

Source: Social Protection Public Expenditure Review Report, 2006.

The major challenges identified in the review were:

- scattered interventions;
- poor alignment with the Aid Policy, where 75 per cent of the funds were coming from donor projects that do not go through the budget process and that were not aligned with national priorities;
- limited poverty impact of social protection programmes, where the

number of people reached by these programmes was extremely low, ranging from a few households for donor pilot programmes to a little more than 400,000 individuals for the Genocide Survivor Assistance Fund (Fonds d'aide aux rescapés du génocide, FARG);

- lack of coordination: the poverty impact was unknown at best; there was no systematic monitoring of the poverty impact and no coordi-

- nation between interventions; and
- inefficiency: overheads and duplication between donor projects were very large.

The recommendations that emerged from this report were integrated into the chapter that was developed in the Poverty Reduction Strategy Paper (PRSP).

ECONOMIC DEVELOPMENT AND A POVERTY REDUCTION STRATEGY

The Rwandan Economic Development and Poverty Reduction Strategy (EDPRS) is both a document and a process. As a document, it sets out the country's objectives, priorities and major policies for five years (2008-2012). It provides a road map for the Government, development partners, the private sector and civil society. It indicates where the country wants to go, what it needs to do to get there, how it is going to do it, what the journey is going to cost and how it will be financed. The Strategy provides a mid-term framework for achieving the country's long-term development goals and aspirations as embodied in Rwanda Vision 2020 (Republic of Rwanda, 2000)², the seven-year Government of Rwanda (GoR) programme (to bolster its economic activity) and the Millennium Development Goals.^{xx}

Within the EDPRS framework, the first priority for the social protection sector is to integrate and coordinate previ-

ously fragmented services provided by the Government, partners, the private sector and community-based organizations (CBOs) to ensure equitable distribution of social assistance packages among the extremely poor and vulnerable groups.

The second priority is to ensure that the social protection programmes are effective in reducing the percentage of the extremely poor.

To this end, a single, coherent social protection strategy would be designed to replace the current plethora of small programmes in this sector. The strategy would be fully aligned with the MDGs and Vision 2020 at the national level while also being integrated into Vision 2020 *Umurenge* at the local level.

The institutional framework of social protection will need to be reviewed and strengthened by putting in place a well-coordinated framework for social protection dialogue between the Government and development partners and establishing a sector-wide approach or joint funding arrangements for a more coordinated and impact-focused approach. The sector will support people who are able-bodied to progress out of extreme vulnerability and poverty into a more sustainable means of self-support through cash-for-work, micro-credit, income-generating activities, and the development of vocational and entrepreneurial skills.

²Vision 2020 identifies six main pillars closely related to one another that contribute to the construction of a middle-income country. Even though the document does not focus on social protection, some main elements are present in the pillars relating to the development of human resources in line with the objective of turning Rwanda into a prosperous knowledge-based economy. These elements include the importance of the welfare of the population and social security and their contributions to an efficient workforce and a high production level.

According to the EDPRS, "Success in assisting people out of extreme poverty and vulnerability will free up Government resources to help those who are not able to help themselves and will need to receive social assistance for the long term, or at least for a minimum period. People needing long term social assistance include: the unsupported elderly, people with disabilities and people incapacitated by AIDS. Other groups may only need social assistance for a shorter period of time such as orphans and vulnerable children, child-headed households and historically marginalised people. Genocide survivors fall into both these categories."^{xxi}

One of the three EDPRS flagship programmes is the Vision 2020 *Umurenge* Programme (VUP). The Programme was conceived during the high-level Government retreat of February 2007 as a social protection programme to enhance the attainment of Vision 2020 objectives by accelerating poverty reduction. The Vision document was developed by the Ministry of Local Government with support from the Ministry of Finance and Economic Planning. It combines a vision of nationwide social protection with a strong focus on promoting better coordination of services at the local level, ensuring that the poorest are reached.

The Vision was implemented fairly rapidly, starting with the public works component in which Rwanda had extensive experience while policy development continued on the direct-support and financial-services components that

began later on. The World Bank and the Department for International Development (DFID) supported the Government's vision by contributing funding and technical assistance, but the Government has remained the leading financial contributor.

CURRENT SITUATION: EXISTING PROGRAMMES

In this section, the various existing programmes and their links will be presented to draw a global picture of the social protection situation in Rwanda. The Ministry of Local Government, Community Development and Social Affairs, the Ministry of Health and the Ministry of Gender and Family Promotion are the lead ministries responsible for policy formulation, coordination, resource mobilization and capacity-building while implementation is the responsibility of a number of institutions across government and outside. Efforts are ongoing to coordinate all interventions and implement them as far as possible on budget and on plan. However, since it is not possible to present all the existing programmes in the social protection sector in Rwanda, this section focuses on the main ones, with others presented only briefly.

ACCESS TO HEALTH CARE

In Rwanda, according to the law from 2008, all Rwandans must be covered by health insurance. Various health insurance schemes co-exist; they are comple-

mentary, each of them focusing on different population categories. This diversity enables every category of the population to access health care. With these different schemes, Rwanda is now reaching nearly universal coverage. In June 2010, the health insurance coverage was 97 per cent (91 per cent for community-based health insurance and 6 per cent for other types of insurance).

Formal Sector: Rwanda Health Insurance Scheme (La Rwandaise d'assurance maladie, RAMA), Military Medical Insurance (MMI) or Private Insurers

Employers of each worker in the formal sector contribute to the Social Security Fund of Rwanda (SSFR) for the coverage of occupational hazards. The contribution corresponds to 2 per cent of the basic salary. This covers medical care, daily sickness allowances, incapacity social security benefits, incapacity lump sum benefits and survivor's benefits. SSFR is a public institution in charge of the social security scheme. It also aims at sensitizing people regarding sustainable social security, examining ways to extend social security and provide advice to government on matters relating to social security.

Formal-sector workers are covered by different health-care schemes according to their status.

- Civil servants and other public sector employees are covered by the Rwanda Health Insurance Scheme (La Rwandaise d'assurance

maladie, RAMA). RAMA was founded in 2001 and is financed mainly by monthly contributions (15 per cent of the member's base salary, 7.5 per cent of it paid by the employee and 7.5 per cent paid by the employer). The benefit package covers all services. Members have access to all public health centres, district hospitals and referral hospitals as well as private facilities that have been contracted by RAMA. RAMA membership also provides access to pharmacies. A co-payment of 15 per cent is due by the member at every health-care level. The current coverage of RAMA is around 2.5 per cent of the national population. The scheme is supervised by the Ministry of Finance and Economic Planning.^{xxii}

- Members of the armed forces and their immediate families are covered by Military Medical Insurance (MMI). The contribution to MMI is 22.5 per cent of the base salary of its members, of which 17.5 per cent is paid by the Government and the remaining 5 per cent by the member. MMI was created in 2005 and is supervised by the Ministry of Defence.^{xxiii}
- Other workers of the formal sectors are usually covered by private insurance. This coverage is organized by private insurance companies, which are regulated by a law on insurance in Rwanda.

Informal Sector: Community-based Health Insurance Schemes or Mutuelles de Santé

A community-based health insurance (CBHI) scheme, also called a *mutuelle de santé*, is a scheme designed to improve access to health care for the population of the informal sector and the rural population. Based on pre-payment and risk pooling, CBHI aims to provide financial access to health services in a fair and equitable manner. In order to avoid stigmatization, CBHI seeks to include all segments of the population, especially vulnerable groups.

Some CBHI systems were created in the 1960s. The extension of CBHI initiatives was developed in the 1990s, first through pilot projects and then through the generalization of CBHI countrywide. The number of CBHI schemes increased quickly from 6 in 1998 to 76 in 2001 and 226 in

2004. In December 2004, the Government adopted a national policy for the development of CBHI schemes. In 2005, CBHI schemes were extended to all 30 districts of the country thanks to the involvement of local authorities, health-care providers and awareness campaigns. CBHI is supervised by the Ministry of Health. Government efforts in CBHI development are key to the success of the system.

In June 2010, the CBHI system covered 91 per cent of the population of Rwanda. The strong will of the authorities at all levels to guarantee access to quality health care is crucial to achieving the coverage rate. Through the improvement of financial access to health care, CBHI also contributes to the well-being of families and the economic and social development of the country. An overview of CBHI is provided in the following box.

Community-based health insurance (CBHI)

Objective

CBHI aims to provide financial access to health services for the informal sector and the rural population, especially for vulnerable groups, through a health insurance system.

Characteristics

- Pre-payment (once a year);
- Solidarity;
- Risk pooling;
- Subsidization of most vulnerable/poor people through targeting mechanisms; and
- Supplementary to other health insurance schemes.

Vulnerable Groups among CBHI Members

In order to be affordable to the most vulnerable populations, the Government of Rwanda created financial mechanisms to support them. Thus, for the most vulnerable and the poor, their contributions are paid by a third party such as the Government, non-governmental organizations (NGOs) or development partners. In 2008, the Genocide Survivor Assistance Fund (Fonds

d'aide aux rescapés du génocide, FARG) supported around 270,000 vulnerable genocide survivors in their contribution to CBHI. In 2010, the Global Fund (GF) supported around 615,000 indigents and 1,450,000 poor people to access CBHI. The vulnerable in the population are targeted through a community-based poverty mechanism.

Financing

The system is financed by member contributions although districts, the Ministry of Health, other insurance schemes, etc., also contribute to the CBHI financing. The contribution to become a member is currently the same amount for everyone whatever their capacity to pay: RF1,000 per person per year (less than US\$2). On top of this amount, the Government matches these funds to cover health-care costs at higher care levels. In order to receive care, the member must pay a small co-payment at the health-care facility (a fixed amount or a percentage depending on the level of care).

Strengths of the CBHI System in Rwanda

- Strong political commitment;
- Global mobilization in favour of CBHI (local authorities, health facilities, etc.);
- Numerous awareness campaigns through media and community meetings;
- Ownership of the initiative by the population thanks to the understanding of the concept;
- Financial affordability;
- Presence of CBHI at every public health-care centre; and
- Accessibility to all levels of health care (health-care centre, district hospital and referral hospital).

Factors Supporting Implementation of a Health Insurance System by the Country

- Good functioning network of health facilities on the national territory;
- Political willingness and efforts to achieve universal coverage (CBHI is a priority for Rwanda);
- Coordination mechanism of health interventions at the national level;
- Traditional community targeting mechanism to identify poor and indigents; and
- Decentralization and representation of authorities close to the population.

Achievements

- Increase in the rate of use of health services (0.86 in 2009);
- High CBHI coverage rate of the population (91 per cent as of June 2010);
- Monthly reporting from CBHI at a decentralized level through a national database; and
- Coverage of the poorest people.

Challenges

- Financial sustainability; and
- Improvement of the Management Information System.

Way Forward

- Adapt the contribution to the capacity to pay of every household (categorization); and
- Creation of a database linked with other social protection activities to improve the efficiency in targeting.

The combination and complementarities of the different schemes (SSFR, RAMA, MMI, private insurers and CBHI) enable Rwanda to achieve a high level of health insurance coverage among the national population. This broad access to health services contributes to the economic growth and social development of the whole country. Indeed, access to health care for the most vulnerable population contributes to reducing the risks of exclusion due to catastrophic health-care expenditures and to the fight against poverty. In June 2010, the total health insurance coverage was around 97 per cent in Rwanda.

ACCESS TO EDUCATION

Some of the interventions under the responsibility of the Ministry of Education contribute to the improvement of social protection:

- The most important programme in the education sector is the provision of free basic education to all through a capitation grant to government and subsidized schools. This enables everyone to access the first nine years of education free of charge.
- The Ministry of Local Government, in collaboration with the Ministry of Education, signed an agreement to facilitate historically marginalized students in secondary school to study for free and took the initiative to integrate historically marginalized students into other government programmes.

- Genocide survivors are often among the most vulnerable and the poorest members of the population of the country. Thus, in order to support their access to essential educational services, the Genocide Survivor Assistance Fund (FARG) Programme supports the education costs of needy survivors at secondary schools and at university. In 2008 alone, 52,737 students were supported by FARG in secondary schools and 1,500 had completed university or higher education.
- The Government also provides bursaries to secondary-school scholars in the form of loans that must be partially reimbursed when the former scholars are working and financially able to do so.
- The Governments of Rwanda and development partners provide feeding in 300 schools. These schools were identified before and after the Comprehensive Food Security Vulnerability Analysis and Nutrition Survey (CFSVA) (July 2009).

ACCESS TO HOUSING

Because some population groups may not have access to housing, the Government provides shelter to the extremely poor and the most vulnerable groups, such as returnees, genocide survivors and disabled ex-combatants. Beneficiaries are targeted through the *Ubudebe* approach, a community-based participatory process where beneficiaries are selected by “who needs

what". Under *Ubudebe*, households are categorized according to one of six classifications, from extremely poor to the money rich. According to the needs among the community, the Government, via decentralized levels, provides materials for the building. Construction of these houses for the most vulnerable and extremely poor people can be done by the population through a participatory process or during *Umuganda* (community works), which takes place once a month. From 2008 to June 2009, 10,858 houses were constructed for the different vulnerable groups.

SOCIAL TRANSFERS

Pension

According to the website of the Social Security Fund of Rwanda (SSFR), "The pension branch of social security aims at helping workers who become old and incapable of working for a salary or invalid and incapable of earning his life by working."^{xxiv} It also supports survivors of the deceased worker. Former workers are entitled to an old-age pension after 15 years of contributions and at the age of at least 55 years. Other products offered by the pension branch are the following: anticipated pension, invalidity pension, and old-age lump-sum allocation. These products are offered by the SSFR.

Vision 2020 Umurenge Programme

The Vision 2020 *Umurenge* Programme (VUP) is a flagship programme of the Economic Development and Poverty Reduction Strategy (EDPRS), 2008-2012. As noted earlier, it was conceived during the Government retreat of February 2007

as an integrated social protection programme to accelerate poverty reduction and enhance the attainment of Rwanda's Vision 2020 objectives. Its purpose is to speed up the reduction of extreme poverty in target sectors, contributing to national targets to reduce extreme income poverty from 36.9 per cent in 2005/2006 to 24 per cent in 2012. It also contributes to improvements in other human poverty dimensions (such as education, health, food security and nutrition), community asset development, the environment and social participation.

The Programme objectives focus on two main areas:

- protection – stopping households from falling below survival levels, stopping households from selling productive assets, and building a buffer to manage future shocks; and
- production – reducing risk, encouraging risk-taking through predictable transfers and wages, creating employment opportunities as a base for savings, using credit, building community assets, developing an entrepreneurial culture and helping to monetize the local economy.

The lead ministry for the Programme is the Ministry of Local Government, Community Development and Social Affairs (MINALOC). At the sector level, which is the primary implementation level, there are two Vision 2020 *Umurenge* Programme staff in each sector: the Programme Manager and the Finance Officer.

The three main Programme components are public works, direct support and financial support, which are underpinned by training and sensitization. The Programme was initially piloted in 30 sectors (the poorest sector in each of Rwanda’s 30 districts); it scaled up to an additional 30 sectors in July 2009, and the Government intention is to continue scaling up to all 416 sectors nationwide.

Implementation of public works started in July 2008, direct support in January

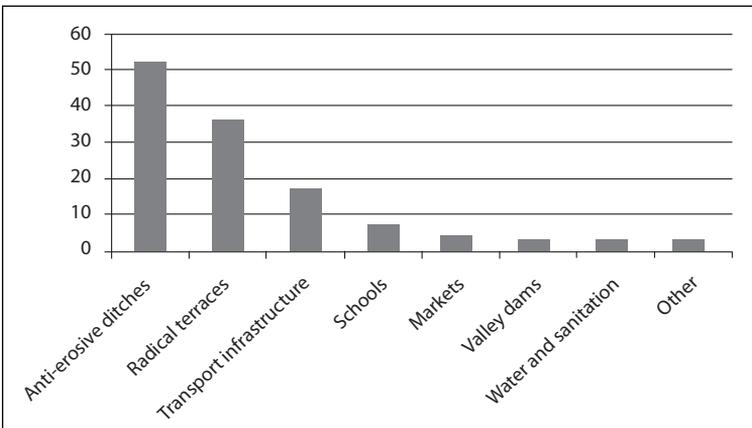
2009 and financial support in February 2010:

Public Works

This component of the Vision 2020 *Umurenge* Programme (VUP) provides work on community infrastructure projects (terracing, irrigation, building of classrooms, construction of access roads, etc.). Households eligible for VUP public works are extremely poor (in the bottom two *Ubudehe* categories) who are “land-

Table 1 | Beneficiaries of direct support and public works, 2008-2009/2010.

Component	2008		2009 (Jan.-June)		2009/2010	
	Operational Sectors	Beneficiary Households	Operational Sectors	Beneficiary Households	Operational Sectors	Beneficiary Households
Direct support	-	-	30	6,850	60	9,692
Public works	28	18,304	27	17,886	60	78,004



Graph 3 | Community assets built through the public works component of the Vision 2020 *Umurenge* Programme, 2009/2010.

Source: Social Protection Joint Sector Review, October 2010.

less” (less than 0.25 ha) but who have at least one adult (18 years+) able to do manual labour. In addition to benefiting individual households, the programme bene-

fits the community at large in the form of increased assets. Table 1 shows the number of households that have participated in public works to date, and graph 3 presents

the community assets built. In 2009/2010, 50 per cent of the participating beneficiary households are female-headed.

Direct Support

This component provides unconditional cash transfers to extremely poor households in the bottom two *Ubudehe* categories who are “landless” (less than 0.25 ha) and whose members are unable to work because of age, disability or illness and are without a household member qualifying for public works. This component aims to improve standards of living, access to essential social services such as education or health, and the ability of households to save and invest. Table 1 shows the number of households that have benefited from direct support transfers to date. In 2009/2010, 53 per cent of the beneficiary households are female-headed.

Financial Support

The financial-support component of the Vision 2020 *Umurenge* Programme complements the direct-support and public-works social protection elements of the Programme. It increases access by the poor to financial services infrastructure, encourages savings, and provides micro-credit in order to tackle extreme poverty and to promote entrepreneurship. The objectives are to enable people to move themselves out of extreme poverty on a sustainable basis and to graduate from the social protection programmes. The component started in 2010 and is implemented through the *Ubudehe* Credit Scheme.

Loans are made to individuals, groups and cooperatives selected on the basis of business proposals. Direct-support transfers and public-works wages have already had positive impacts on household welfare in the following ways: increased consumption (food, utensils, clothing), spending on human capital (education, health), income-generation (agriculture, business), asset accumulation (livestock) and financial services (savings, borrowing).

Ubudehe Programme

“*Ubudehe*” as such is not a new concept; the word is a reminder of collective action and participatory development that have been undertaken for decades in Rwanda. Previously, *Ubudehe* corresponded to social meetings in villages to discuss and try to resolve community issues.

In the context of Rwanda after the 1994 genocide against the Tutsi, infrastructure, basic services and property were destroyed and communities were divided (traumatized, lost trust in each other, etc.). The poverty level was very high and the challenge was to rebuild a nation and reinforce community cohesion.

In 2001, the Government of Rwanda chose a participatory approach to design poverty reduction for its PRSP. After a pilot phase in Butare, it launched *Ubudehe* to help the local population to create social capital, develop citizenship and build a strong civil society. “This process helps citizens to engage in local problem-solving using their own locally designed institutions, in voluntary association”.^{xv}

Ubudebe aims at promoting self-governance and greater citizen participation in governance at the local level. It started in 2005 and has already achieved some major successes:

- Nowadays, the entire country is covered by participatory poverty assessments (PPAs) in which citizens are truly in control of the process. Citizens are actively participating in the development of the social map and visual representation of their community (level of poverty and exclusion). In addition to the social maps, citizens in villages have actively defined their preferences and priority problems.
- Participation of citizens in this community process helped to bring people together in collective action to do something for their own community and to solve their common problems. This process of coming together and working together to solve problems played an important role in national healing and building of trust.
- This community process enabled the financial support of local initiatives such as livestock/breeding, construction of classrooms/roads/bridges/health centres, a water or electricity facility, radical terracing and development of small shops. Numerous villages benefited from financial support to solve problems identified among the community members. This mechanism of financial support at the local level has advantages such as lower administrative costs, resource

transfer directly to citizen groups, ownership of the initiative, support to proactive citizens and resolution of community problems.

In addition to the *Ubudebe* Programme, the *Ubudebe* targeting approach is a tool used to identify beneficiaries of Rwanda's social protection programmes. The *Ubudebe* approach is to become the national targeting approach for every social intervention. In 2007, a nationwide *Ubudebe* social mapping exercise was conducted. Social maps developed through the *Ubudebe* Programme are a key asset in the development of the social protection sector and in cases where the Vision 2020 *Umurenge* Programme is operational. All households in the *Ubudebe* categories were updated and used for the selection of households of the Vision 2020 *Umurenge* Programme sectors in July 2009 during the annual programme targeting operation. Indeed, those social maps and the process of participatory poverty assessments directly contribute to the targeting of other interventions such as community-based health insurance (CBHI).

In every sector, there is one *Ubudebe* facilitator under the supervision of districts. His main task is to control quality in the identification of beneficiaries of the different social protection programmes.

Fund for Support to Genocide Survivors

The Fund for the Support and Assistance to the Survivors of the Tutsi Genocide and Other Crimes against Humanity (Genocide Survivor Assistance Fund (Fonds

d'aide aux rescapés du génocide, FARG)) was established by Law No. 02/98 of 22 January 1998 to provide assistance to victims of genocide and massacres perpetrated in Rwanda from 1 October 1990 to 31 December 1994. This law was reviewed by Law No. 69/2008 of 30 December 2008 (OG. N° Special of 15 April 2009).

The resources of the Fund come from a government contribution equivalent to 6 per cent of its annual budget and other sources as identified by the Law in Article 22. This budget is spent on four key programmes: education, health, shelter, and social-assistance and income-generating projects.

In addition to the support in the health, education and housing sectors, the Fund provides social assistance and supports income-generating projects.

Rwanda Demobilization and Reintegration Commission

The Rwanda Demobilization and Reintegration Commission (RDRC) is a government agency in charge of implementing the Rwanda Demobilization and Reintegration Programme (RDRP). The goal is to contribute to the "consolidation of peace in the Great Lakes Region, especially in Rwanda and Eastern DRC, and foster Unity and reconciliation within Rwanda. We work towards this through Demobilisation and support to Social and Economic Reintegration of Rwandan Ex-Combatants".^{xxvi} In 2009, the Commission launched stage III of the RDRP, comprising various components:

- **demobilization.** In the demobilization centres, the RDRC conducted a Pre-Discharge Orientation Programme (PDOP) for all ex-combatants to introduce them back into civilian life (lectures and discussions on government policies, programmes, socio-economic development challenges and opportunities in the country, HIV and AIDS voluntary counselling and testing, etc.);
- **reinsertion.** This component covers both ex-combatants and dependants (cash payment, reinsertion kit, transport to home communities, food and non-food items for three months). Ex-combatants are also supported in the administrative process in the communities; and
- **social and economic reintegration.** This component comprises different significant interventions such as specialized training of health-centre staff and social workers in psychosocial support for ex-combatants with post-traumatic stress disorder (PTSD) symptoms and other community members; "reintegration grants" for income-generating projects with training in basic entrepreneurship; a specific rehabilitation course for child ex-combatants and reunification with their respective families; the determination of socio-economic vulnerability among disabled ex-combatants through screening, and the payment of monthly subsistence allowances for the one

in need of support; and specific support for female ex-combatants.

One Cow per Poor Family

The Girinka Programme (One Cow per Poor Family) was initiated by the President of Rwanda in 2006 and is part of the implementation measures of the 2020 vision, the Economic Development and Poverty Reduction Strategy (EDPRS) and the Integrated Development Programme (IDP). The objective of the Girinka Programme is to enable every poor household to own and manage an improved dairy cow to support the family to improve their livelihood (milk and meat) and soil fertility. In addition to improving the family's nutritional status, the cow will help to generate revenues through the sale of milk, meat or manure. The Programme can be implemented in two ways: the cow can be donated (free of charge) to a poor family or the Programme can provide a bank loan to a family to buy a cow. Some eligibility criteria are analysed before receiving the cow, such as the ability to construct a cow shed or the availability of a field planted with different pasture species for nutritional purposes.

This Programme was followed by other initiatives such as *Inka y'akaguru*, an initiative that aims to produce many cows in the community where the first owner remains with the calf and hands over the cow to another member of the community. Another initiative is called *Kuragiza*; in this initiative, the care of the cow is given by the owner to a neighbour and when the cow calves twice, the second calf is

given by the owner to the neighbour as recognition for his work.

Other Vulnerable Groups

Persons with Disabilities

Rwanda has made varying progress in supporting the rights of persons with disabilities and ensuring that people with disabilities benefit from and contribute to national development. The Government has committed itself through the adoption of the law to protect the rights of persons with disabilities (2007) and has passed eight ministerial orders in order to implement this law (2009). To be able to monitor the implementation of the ministerial orders that were passed, a national programme for persons with disabilities has been elaborated.

The Government established an umbrella organization for persons with disabilities, the National Federation of People with Disabilities (Fédération nationale des personnes handicapées, FENAPH), which has representation from the central government up to the grass-roots level.

There are government programmes to support vulnerable disabled ex-combatants in categories 1 and 2 who are given monthly subsistence allowances/transfers. This supports them in accessing medical rehabilitation and treatment through medical insurance, but payments also are made directly to service providers for services and medications that are not covered by insurance.

Besides these programmes, a national council of persons with disabilities is

being created and is in its early stages.

Civil society groups play an important role in supporting persons with disabilities and in helping the Government to achieve its objectives for people with disabilities. Some of these civil society organizations are, among others, Volunteer Services Overseas and the Rwanda Decade Steering Committee, which, in collaboration with their partners, have been active in ensuring advocacy by organizations that represent people with disabilities in the social protection sector and have also supported community-based income-generating activities.

However, it is very important to note that Rwanda does not have specific programmes for persons with disabilities; persons with disabilities have been mainstreamed into existing social protection programmes and initiatives such as “One Cow per Poor Family”, shelter initiatives, the *Ubudebe* Programme and the Vision 2020 *Umurenge* Programme, where they benefit under the components of direct support, public works or financial services depending on the selection criteria and many other schemes. There are also other parallel programmes that support disabled persons to have access to basic necessities

Another important initiative worth mentioning is the census of persons with disabilities, which is ongoing. It is being carried out to be able to know the actual number of disabled persons in Rwanda but most importantly to generate data for evidence-based planning. This is being done by the Ministry of Local

Government with the Ministry of Health, which will help in categorization so that those for whom the law provides benefits can access them.

Orphans and Vulnerable Children

Orphans and vulnerable children (OVCs) are reached by some of the interventions presented above, such as free basic education, community-based health insurance and the Genocide Survivor Assistance Fund (FARG). However, the Ministry of Gender and Family Promotion (MIGEPROF) is also implementing several interventions focusing on orphans and vulnerable children such as the payment of school fees and the purchase of scholastic materials for 18,620 orphans and vulnerable children (from 2006 up to 2010); the support of identification and data collection and management regarding orphans and vulnerable children (computers, registers, etc.); the financial support to set up income-generating activities for orphans and vulnerable children who completed vocational training; and the setting up of transit centres for children. In addition, various orders and instructions relating to orphans and vulnerable children have been prepared.

Child Protection/Gender-based Violence Committees (CP/GBV Committees) have been established at the district and sector levels by the Ministry of Gender and Family Promotion to identify, report and refer for appropriate support cases of child-rights violations and of gender-based violence.

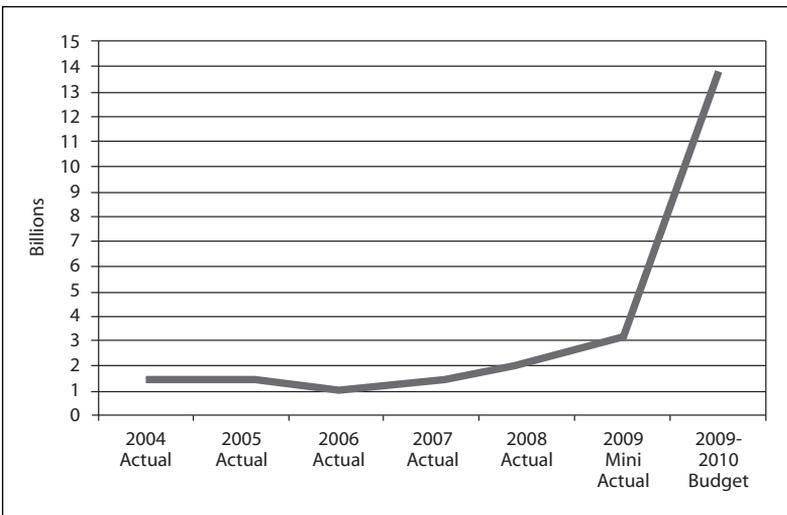
The Child Rights Observatory has been established within the National

Human Rights Commission. An observatory is set up in each district and sector of the country to monitor and report on cases of child rights violations. Reports are compiled and submitted to the National Human Rights Commission for examination, investigation of cases and filing of complaints.

REVIEW OF THE SECTOR

Since 2005, social protection has expanded significantly in Rwanda (graph 4) and there is a range of social protection programmes across government. Investment in the core social protection sector has been increased significantly by the intro-

duction of the innovative Vision 2020 *Umurenge* Programme, a flagship programme that has provided regular cash transfers to around 54,000 households, making a major difference to their lives. Yet investment in non-contributory, cash-based social protection is still low by international standards (although it is probably in line with that of other Central and East African countries). The Social Security Fund for Rwanda is an example of a well-managed contributory pension scheme, being actuarially sound and providing regular and significant benefits to members. In 2007, the Fund had a net replacement ratio of 76 per cent, which implies that, on average, pensioners received 76 per cent of their pre-retirement net earnings.

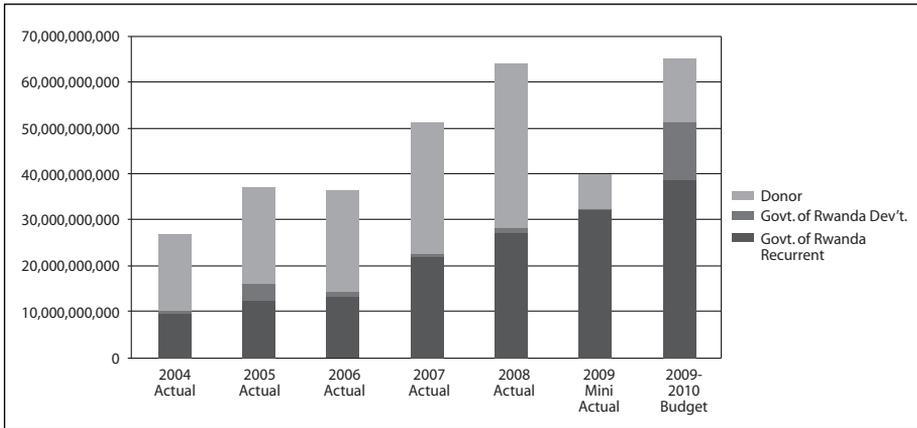


Graph 4 | Increase in social protection sector spending, 2005-2010.

Across other sectors, there have also been significant increases in commitments to social protection. For example, graph 5 shows the increase in spending on broad-based social protection, including health and education. This represents

an increase in real resources for the 2009/2010 budget period of 142 per cent over actual expenditure in 2004, including a 17 per cent real decrease in resources from donors and a 250 per cent real increase in government spending.

Graph 5 | Increase in broad social protection spending across government, 2005-2010.



Note: The data for this graph are taken from the 2010 draft Public Expenditure Review for Social Protection.

As discussed earlier, Rwanda has already achieved some important goals in the social protection coverage of its population.

Through community-based health insurance, Rwanda is covering more than 90 per cent of its population through health insurance. This is a great achievement considering the important proportion of the informal sector. Moreover, thanks to political willingness, this was achieved in less than a decade.

In addition, the country already has an approach to target its population by socio-economic level, commonly referred as the *Ubudebe* approach. This approach is a key asset for Rwanda in social protection to maximize the impact of the interventions and avoid overlapping. Indeed, targeting improvements will contribute to a better use of resources.

Evidence of the flagship programme, the Vision 2020 *Umurenge* Programme (VUP), has shown its benefits to benefi-

ciaries in terms of asset accumulation, entrepreneurship, infrastructure and social development. In the future, the VUP must be extended countrywide and this scaling up will have a positive impact in the whole country and increase the number of beneficiaries.

Coordination mechanisms are developed in Rwanda and contribute to the efficiency of the interventions. The coordination mechanisms of the social protection sector are directly under the Ministry of Local Government. However, as the social protection sector contributes towards the attainment of the objectives of the Economic Development and Poverty Reduction Strategy (EDPRS), the Ministry of Finance and Economic Planning has the overall responsibility of reporting on the progress of the EDPRS:

- At the sector level, the coordination is led by the Ministry of Local Government. A social protection working group has been established. This Working Group

brings together social ministries that deliver social protection, development partners, United Nations agencies, civil society organizations and NGOs to discuss developments in the social protection sector. Since its inception in 2008, the Social Protection Working group has helped to provide strategic orientation on how to reduce fragmentation, inefficiency, and reporting on the achievements and challenges. At the sector level, the chair of the Social Protection Working Group is the Ministry of Local Government, Community Development and Social Affairs (MINALOC), which is the lead ministry on social protection and an alternating co-chair of the development partners.

- Social protection Joint Sector Reviews are held twice annually before the start of the financial year to discuss the progress and challenges in the sector and inform the budgetary process. They are also held at the end of the financial year to review progress and set milestones. These Joint Sector Reviews are backward- and forward-looking.
- Social Cluster. The deliberations after the reviews are summarized under the Social Cluster, which is made up of all the social ministries. Under the head of the Cluster, they present the main achievements and bottlenecks to the Joint Budget Support Review that is chaired by the Ministry of

Finance and Economic Planning on the Government side and co-chaired by a development partner.

In 2010, the elaboration and development of the new strategy through a participatory process will contribute to better coordination and more efficient interventions in the social protection sector.

However, despite good progress and a strong upward trend in the commitment of the Government to social protection, it is clear that there are many challenges that need to be addressed.

The main challenge is that coverage is still low. There is a need to achieve national coverage of pilot programmes, such as the Vision 2020 *Umurenge* Programme (VUP), to obtain the desired impact. Furthermore, it is clear that there are many vulnerable groups in the population that do not have adequate coverage or support. For example, there is no national programme of support for the elderly or people with disabilities. Many of the most vulnerable children are in need of additional financial assistance, but such coverage has been beyond the financial means of the country. It is recognized that there is a need to work within the constraints of available finances, but the Government is committed to extending coverage to these groups over the next few years.

There are still too many small and overlapping government social protection programmes and funding lines. Wherever possible, there is a need to consolidate programmes to increase efficiency and put resources behind those

major programmes that have the greatest transformational potential. There is also a need to mainstream certain programmes that are directed at particular groups. For example, support for genocide survivors through the Genocide Survivor Assistance Fund (FARG) will increasingly be provided through mainstream government programmes, such as the Vision 2020 *Umurenge* Programme and Old Age Grants wherever possible.

In connection with coordination of social protection interventions, there is also a need to improve the monitoring and evaluation system in order to see impact and to have evidence-based results for all the programmes. Monitoring and evaluation data will also help to increase the efficiency of interventions.

NEW STRATEGY: THE WAY FORWARD

The Ministry of Local Government, with other stakeholders, is preparing a new strategy on social protection for the next 20 years. This document focuses on several interventions to improve social protection for the population of Rwanda. This strategy will be a complement to the other sector strategies. The vision for the next 20 years is to “build a system with a social protection for the most vulnerable households and individuals, continuing extension of access to other core public services for poor and vulnerable households and increase participation of the informal sector in the contributory social security system”.^{xxvii} In order to contribute

to the objectives of the Economic Development and Poverty Reduction Strategy (EDPRS), interventions are planned regarding its expected results. The strategy comprises protective, preventive and promotive interventions.

Among its objectives, the EDPRS aims to improve the coordination mechanism among the various existing programmes managed by the Ministry of Local Government and with programmes from other ministries.

Once the Social Protection Strategy is in place, a sector-wide approach for the sector will be developed. This will further enhance strong partnership with all stakeholders and ensure that their work contributes to achieving sector objectives and the EDPRS in general and that their funding is aligned with government priorities.

To improve efficiency, the Government is planning to develop a sector-wide funding mechanism whereby donors will fund the sector instead of a specific programme. It will also ensure that funding is used in alignment with government priorities.

This will help to improve coordination, harmonization and synergy across the different ministries and institutions that implement social protection. This will be done through joint action plans, division of labour and accountability mechanisms.

To improve coordination and the monitoring and evaluation, the building of a management information system will be a key asset to provide information for analysis and decision-making. The management information system will enable decentral-

ized entities to provide updated data to the central government about the number and status of the different vulnerable groups.

A summary of the social protection system in Rwanda is presented in table 2.

Table 2 | Summary of the social protection system in Rwanda.

Health care	Formal sector	Specific system to cover formal-sector employees (Rwandan Health Insurance Scheme (RAMA), Military Medical Insurance (MMI), private insurance). Existing system to cover occupational hazards (Social Security Fund of Rwanda, SSFR).
	Informal sector	Health care is affordable for all via community-based health insurance (CBHI) scheme (poor and indigents included thanks to programmes such as Genocide Survivor Assistance Fund (FARG), Global Fund (GF)).
Education	Basic education	Nine years of education free of charge.
	Secondary and university	Existing programmes to facilitate access for vulnerable groups (FARG, Ministry of Gender and Family Promotion (MIGEPROF)).
Housing	Shelter	Support is provided to vulnerable groups to enable them to have a shelter (FARG).
Social transfers	Pension	Formal sector: contributory pension.
	Cash transfer to extremely poor people	<i>Public works</i> for the extremely poor: providing work on community infrastructure projects (<i>Vision 2020 Umurenge Programme, VUP</i>). <i>Direct support</i> for the extremely poor unable to work (<i>VUP</i>).
	Financial services/support	Support is provided to increase access to financial services infrastructure for vulnerable groups and to develop income-generating activities (<i>VUP, FARG, MIGEPROF</i>). Via financial support to local initiatives, a community process creates social capital, development of citizenship and building of a strong civil society (<i>Ubudehe</i>).
	Transfer in kind	Programme to support the demobilization, reinsertion and reintegration of ex-combatants (<i>Rwanda Demobilization and Reintegration Programme</i>). Through ownership and management of a cow, the goal is to improve the livelihood, nutrition and soil fertility of the household (<i>One Cow per Poor Family</i>).

Note: Specific vulnerable groups (orphans and vulnerable children, elderly, etc.) are also reached by more general social protection interventions, especially the ones mentioned above.

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- ⁱ National Institute of Statistics, 2009.
- ⁱⁱ World Bank, *World Development Indicators* 2008.
- ⁱⁱⁱ WHO, Global Health Observatory, 2008.
- ^{iv} WHO, UNICEF, UNFPA and World Bank, Global Health Observatory, 2005.
- ^v World Bank, *World Development Indicators* 2008 and *Global Development Finance* 2008.
- ^{vi} Ibid.
- ^{vii} UNDP, *Human Development Report* 2009.
- ^{viii} Economic Development and Poverty Reduction Strategy [EDPRS], 2008-2012, September 2007. The text of the Strategy is available at: http://planipolis.iiep.unesco.org/upload/Rwanda/Rwanda_EDPRS_2008-2012.pdf.
- ^{ix} EDPRS, 2007.
- ^x Ibid.
- ^{xi} Ibid.
- ^{xii} Ibid., p. 5.
- ^{xiii} Ibid., p. 13.
- ^{xiv} Ibid., p. 36.
- ^{xv} National Social Protection Policy, 2005.
- ^{xvi} National Social Protection Policy, 2005, p. 10 (available at: http://minaloc.gov.rw/IMG/pdf_SP_Policy_English.pdf).
- ^{xvii} Ibid., p. 4.
- ^{xviii} Ibid., p. 5.
- ^{xix} Poverty Reduction Strategy Paper Evaluation Report, 2006, p. 26.
- ^{xx} EDPRS, 2007, p. 1.
- ^{xxi} Ibid., p. 104.
- ^{xxii} Additional information on RAMA is available at: <http://www.rama.gov.rw/spip.php?article44>.
- ^{xxiii} Further details on MMI are available at: http://www.amategeko.net/display_rubrique.php?ActDo=ShowArt&Information_ID=1297&Parent_ID=30693147&type=public&Langue_ID=An&rubID=30693154#30693154
- ^{xxiv} Social Security Fund of Rwanda (SSFR) website: <http://www.csr.gov.rw>.
- ^{xxv} Common Development Fund (CDF) website: <http://www.cdf.gov.rw/>
- ^{xxvi} Rwanda Demobilisation and Reintegration Commission, Rwanda Demobilization and Reintegration Programme, *Annual Activity Report, 2009*, Foreword, p. 2 (available at: <http://rdrc.org.rw/Documentation/RDRC%20REPORT%202009.pdf>).
- ^{xxvii} Draft National Social Protection Strategy, 2010-2015, p. 3.



South Africa

Population ⁱ	48,687,000
Age structure	
• 0-14 years	30.8
• 15-64 years	64.9
• 65 years and over	4.4
Infant mortality rate (per 1,000 live births) both sexes ⁱⁱ	48
Life expectancy at birth (years) female	53.1
Life expectancy at birth (years) male	50.0
Maternal mortality ratio (per 100,000 live births) ⁱⁱⁱ	400
GDP per capita	
• Current USD ^{iv}	5,678
• PPP (current international \$) ^v	10,116
• Constant local currency	26,120
Unemployment rate ^{vi}	25.3
Human development index (HDI) rank ^{vii}	129
HDI poverty indicators – Human poverty index rank	85

South Africa is a constitutional democracy established in 1994 after three centuries of colonialism and apartheid. It has a large young population. It is classified as a middle-income country. Economic growth rates have declined in recent years as a result of negative impact of the global economic crisis. Approximately half of the population may be classified as poor, with high rates of poverty among children, youths, women and people in rural areas. High HIV and AIDS prevalence rates have increased the burden of care, which has impacted negatively on the country's human development profile.

Child Support Grants

Leila Patel

16

South Africa

Summary

- The Child Support Grant is a means-tested non-contributory cash transfer targeted at children 0 to 18 years of age. It was established in 1998 by an Act of Parliament.
- The Child Support Grants are publicly funded through taxation and account for 3.5 per cent of GDP.
- A flat-rate benefit is paid to the caregiver who is responsible for the care of the child. The caregiver may be a biological parent, grandparent, relative or non-relative of the child.
- The benefit amount is \$34.50 and reaches 10 million children.
- The Child Support Grant is one of the Government's most effective poverty reduction programmes.
- The Child Support Grant forms part of a wider social protection strategy complemented by the provision of publicly funded compulsory basic education, health care, housing, basic services, public works, and support for micro and small enterprises.

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INTRODUCTION

Since the inception of democracy in South Africa in 1994, the social protection system has been refashioned to meet the country's constitutional mandate to promote social and economic justice and to address the legacy of its apartheid past. The social assistance programme in 2009

reached about 26.2 per cent of the population and is now widely acknowledged to be the Government's most successful poverty reduction programme, with far-reaching developmental impact (Neves et al., 2009; Delany et al., 2008; Patel and Triegaardt, 2008; van der Berg et al., 2005; Samson et al., 2004; Woolard, 2003; van der Berg and Bredenkamp, 2002; and Ardington and Lund, 1995).

South Africa's social protection strategy includes social assistance complemented by the provision of other publicly funded services and social programmes such as compulsory primary education, health care, housing, basic services, public works, support for micro and small enterprises and a progressive taxation system that has an important redistributive function. Various in-kind programmes such as school feeding schemes, price subsidies for basic foods, housing, energy and transport subsidies, and value added tax (VAT) exemptions on basic foods are also covered. In practice, however, the public provision of basic and social services is constrained by administrative inefficiencies caused by institutional and capacity problems, including corruption, which results in delivery failures that have fueled public discontent in recent years.

"Social assistance", also referred to as "social grants", is a means-tested non-contributory cash transfer that is tax-funded and targeted at specific categories of people. The right to social assistance and the rights of children are guaranteed by South Africa's Bill of Rights. Beneficiary numbers have expanded from 3 million in 1995 to 14 million in 2010, and benefits constitute 3.5 per cent of GDP and are a generous contribution for a middle-income country (National Treasury, 2010).

The focus of this case study is on the Child Support Grant, which is an innovative programme that was introduced in 1998. It exists alongside old-age pensions

that have been in existence since the 1920s and disability grants. The grant is paid to the caregiver who is responsible for the care of the child. A flat-rate "benefit" is paid to the caregiver of the child based on a means test. The grant has the largest number of beneficiaries of the three main social grants (68 per cent), reaching 10 million poor children in 2010 (National Treasury, 2010).

This case study is organized as follows. In the first section after the introduction, key concepts such as "social protection" and "social grants" are clarified and a brief overview of the South African social, economic and political context is provided. The next two sections focus on a description of the policy development process and an outline of the design features, financing and implementation challenges of the Child Support Grant. The social and economic impact of the Child Support Grant is the subject of the final section, which concludes with some success factors relevant to the replication of similar programmes in other developing countries.

CONCEPTS AND APPROACH

"Social protection" refers to private and public measures to ensure effective access to a range of basic goods and services by all people, particularly the most disadvantaged in society. These goods and services may be cash or in-kind services and benefits to reduce poverty, promote equality, build human capabilities and assets, and thus achieve empowerment

and human well-being. In South Africa, the term "social security" is often used in policy and legislation that include public (social assistance), private (insurance), social insurance (national health and pension system) and informal measures (savings) to protect the population against risk and vulnerability. While "social protection" is a broader concept, "social security" and "social assistance" (also known as "social grants") refer to specific measures to achieve income protection, alleviate and prevent poverty, achieve income distribution and provide a means of social compensation for loss of earnings due to extraneous factors (Republic of South Africa, 1997, p. 48).

Commonly used approaches to poverty rely on indices of income, consumption or social position and do not consider wider social factors that impact on poverty. The view put forth in this case study is that poverty is an interlocking, multidimensional phenomenon caused by a lack of multiple resources such as employment, food, assets (housing, land), basic infrastructure (water, energy and sanitation), health care and literacy. Psychological dimensions of poverty and the lack of a political voice are also important in defining and addressing poverty (Narayan, 2000).

Increasingly, emphasis is placed on understanding the nature and scope of the adaptive responses of poor households, which is associated with the livelihoods approach (Beall, 1997; Chambers, 1995). Poor households also tend to rely on informal social protection, systems of

social mutuality and reciprocity (Neves et al., 2009; De Wet et al., 2008), which may include the exchange of goods, resources and social support from individuals and organizations in the communities. From a gender perspective, how care burdens are distributed in the private domain in ensuring household survival is critical. Furthermore, account needs to be taken of how poor people themselves mediate risks and vulnerabilities arising from the impact of external economic and political, social and environmental factors, particularly in response to the impact of the global economic crisis. Most importantly, an understanding of poverty needs to factor in human agency and active citizenship, which encompass a combination of rights and obligations that connect them with the State. How citizens exercise and claim these rights through formal and informal social and political processes to improve the quality of their lives is also critical to an understanding of poverty (Green, 2008).

SOUTH AFRICAN CONTEXT

South Africa achieved its independence in 1994 after more than three hundred years of colonialism and apartheid. The new democratically elected government inherited a racially divided society with over half of the black population defined as poor. Poverty was most prevalent in rural areas (60 per cent) and among women and children, with more than half of female-headed households being poor (May, 1998; UNDP, 1999). High rates of child poverty are associated with malnutrition, with 38 per cent of children in

the poorest quintile and 27 per cent in the second-poorest quintile suffering from stunting (Reconstruction and Development Programme, 1995).

These trends reflect the race-based geography of apartheid and race-based policies of the past. The new government also inherited a racially segregated welfare system that favoured a white welfare elite through the provision of expansive social services and benefits to whites and a residual system for blacks (Patel, 1992). Resistance to white minority rule and racial capitalism was marked by consistent demands for political, economic and social inclusion and for the human rights of all South Africans in a common society. These demands shaped the nature and the content of the new Constitution that was adopted in 1997 following the first democratic elections. The Constitution recognizes a common citizenship, universal adult suffrage, a multi-party democracy, a free press and judicial review of government. The Constitution of South Africa may be described as liberal egalitarian in its orientation in that it attempts to reconcile individual rights with the achievement of social and economic transformation of the society, with benefits and opportunities accruing to the most disadvantaged.

A distinguishing feature of the Constitution and the Bill of Rights is that they uphold social and economic rights. Section 27 of the Constitution protects the rights of citizens to health care, water and social security, which include the right to social assistance. These rights are subject to available resources and are

intended to be realized progressively. Section 26 makes provision for the right to access to housing. Section 28 upholds the right of children to basic services and social support and to family/parental care while Section 29 provides for the right to basic and further education.

The newly elected democratic government under the leadership of former President Nelson Mandela adopted the Reconstruction and Development Programme in 1995; it sought to democratize the State and society, promote economic growth after years of economic decline and indebtedness, and heal the divisions of the past. The Programme also provided for the meeting of people's basic needs and the development of human resources.

The welfare system was redesigned in line with the Reconstruction and Development Programme and a new developmental welfare policy set out in the White Paper for Social Welfare (Republic of South Africa, 1997) was adopted and implemented. Two key programmes were identified: first, social welfare services for specific target groups such as children, youths, women and families, older persons, people with disabilities and those affected by chronic illnesses and, in particular, those infected and affected by HIV and AIDS. The second key programme was social security, which included social assistance, private savings and social insurance.

Developmental welfare is informed by the social development approach (Patel, 2005) to social welfare. Its distin-

guishing features include a commitment to a rights-based approach to social development; the employment of pro-poor policies and strategies; and the promotion of citizen participation in development and a reliance on pluralist social arrangements involving the State, civil society, the private sector, individuals, families and communities as collaborative partners in development. The policy, however, identifies a leading role for the State in development. Lastly, it views social and economic development as interrelated and acknowledges that economic growth must be accompanied by the redistribution of the benefits of growth to the least advantaged, thus emphasizing equitable growth and development.

South Africa had a population of 47.9 million people in 2005 and is classified as a middle-income country. Economic growth was slow following the creation of the new democracy but increased after 2000, reaching a high of 5 per cent by 2006. The post-apartheid poverty headcount increased marginally after 1994, followed by small decreases in poverty levels between 2001 and 2005 largely due to the expansion of social assistance, which resulted in improvements in social welfare after 2000 (van der Berg et al., 2005). Growth rates have slowed down to just over 2 per cent as a result of the impact of the global economic crisis on the local economy, which has negatively impacted employment and poverty levels since 2008. Unemployment rates continue to be unacceptably high at 25.5 per cent, based on a narrow definition, with youth unemployment reaching 70 per

cent. The HIV and AIDS prevalence rate is around 21.5 per cent (IndexMundi, 2008), with far-reaching implications for the care of children, adults who are AIDS ill, older persons and people with disabilities. High HIV prevalence rates have also lowered the country's human development performance, with the human development index falling to levels attained in 1980 (UNDP, 2007/2008).

This cursory overview points to the enormous human development challenges facing the country 15 years after the creation of a democracy. While significant gains have been made in social and political transformation in key social sectors, the past legacy of race, class, gender and spatial inequality and poverty persists and remains one of the country's greatest social policy challenges. It is against this background that the contribution of social protection needs to be assessed.

THE POLICY PROCESS

The background and policy context within which the policy was developed are outlined briefly in this section, including the creation of a ministerial committee – the Lund Committee on Child and Family Support – that played a key role in the policy formulation process.

In December 1994, the Minister for Welfare and Population Development, with the Members of the Executive Councils responsible for social welfare in the nine provinces, mandated a consulta-

tive and participatory policy development process that culminated in the adoption by Parliament of the White Paper for Social Welfare in April 1997. The White Paper provided a set of developmental welfare policies, principles, guidelines and proposals to be implemented by all spheres of government. Social security and social assistance constituted a key pillar of the developmental approach. While old-age pensions and disability grants were to be continued, the White Paper recommended that sustainable and affordable options of social security provision for children and families be developed and that the private maintenance system be revised. Furthermore, it also called for the development of a comprehensive system of social security to give effect to the right to social security. Thus, social security needs and gaps were identified after 1994 through a range of policy review and development processes such as the Child Support Grant.

Later, the Taylor Committee (2002) appointed by the Minister for Social Development reviewed the country's social security system; it reaffirmed its contribution to poverty reduction and identified gaps in coverage for the unemployed and informal-sector workers. The Committee also made further recommendations for a basic income grant and for reforms to create a comprehensive social security system.

Policy formulation for the Child Support Grant was informed by research evidence that demonstrated the positive poverty-reduction effects of old-age pen-

sions and social assistance in general and its concomitant developmental impacts (Ardington and Lund, 1995; van der Berg and Kruger, 1995; Le Roux 1995, Lund 1993). Gaps in social-security provision and in achieving equitable access were also identified by researchers and formed part of the body of knowledge that informed the White Paper and subsequent work on the reform of the system of child and family support.

Of particular concern was the racial inequity in access to State Maintenance Grants, which were introduced in the 1930s to protect poor white families. Later these grants were extended and accessed mainly by coloureds, Indians and a small percentage of white single parents. Although some of the self-governing territories and provinces made provision for child and family support, in reality very few Africans received the grant. The following figures indicate the level of inequity in access to the State Maintenance Grant among the race groups: 50 and 40 per 1,000 coloured and Indian beneficiaries, respectively, received the grant; 14 per 1,000 whites and only 2 per 1,000 Africans were grant beneficiaries (Lund, 2008). The extension of the grant to all women and children who qualified at existing levels would have cost around R12 billion, depending on the assumptions made. This was almost the total cost of social assistance in the early 1990s as the former Government attempted to achieve parity in spending on grants prior to the first democratic elections in 1994. The fiscal problems associated with the equalization of the

State Maintenance Grant constituted another factor that was critical to the policy reform. The programme therefore needed to be redesigned or abolished. The Government appointed the Lund Committee on Child and Family Support in 1996 to make recommendations on the redesign of the system, taking into account the Government's concerns about affordability and sustainability (see Lund, 2008, for a detailed documentation of the policy process and context; Republic of South Africa, 1996).

South Africa was not unaffected by the global diffusion of neo-liberal ideas that shaped social policy profoundly during the 1990s. The fiscal environment for policy reform became more constrained after the Government adopted a conservative macroeconomic policy – the Growth, Employment and Redistribution (GEAR) policy in 1996. The intention of the GEAR policy was to promote economic growth of 6 per cent, reduce inflation and the budget deficit, and contain fiscal expenditure. The GEAR strategy intended to promote foreign direct investment and to integrate the economy into the global economic system after years of isolation, economic crisis and indebtedness. The strategy was widely criticized for being a neo-liberal policy that represented a shift away from the Government's commitment to the Reconstruction and Development Programme and to its social goals in response to the pressures arising from big business and foreign capital (Mhone and Edigheji, 2003; Bond, 2000).

The mandate of the Lund Committee also included a consideration of State support across all government departments for children and families and an investigation into the possibilities of extending parental financial support through the private maintenance system. The terms of reference also requested the Committee to develop approaches to effectively target social programmes for children and families. This limited the Committee's options to employing a selective approach in its policy proposals. The consideration of policy options was constrained by the changing macro-economic policy of the time. It also limited the policy options of the Lund Committee.

The Lund Committee was led by Frances Lund, a respected leader and researcher in social security, social welfare and development who was based at the University of Natal. The Committee had two other academic researchers who were economists. Five civil society organizations placed representatives on the Committee who were drawn from child welfare organizations, rural development groups, children's rights organizations, the National Welfare and Social Services and Development Forum, Schools of Social Work and the Maintenance Action Group. Additional members were government representatives involved with social security administration and management and people co-opted for their particular expertise in household data analysis, gender issues and knowledge of the way in which social assistance programmes work in practice. The

Committee also had the benefit of contributions from international advisers and experts who were knowledgeable about social protection.

Tight time frames were set for the work of the Lund Committee. A report was required to be delivered in six months. There was therefore a very short time in which to conduct the work and to build consensus with all partners in government and in civil society. The main work was conducted between February and August of 1996. This involved commissioning research, a systematic review of existing research, a study of international evidence, and a three-day retreat with international advisers to consider the research and policy options. In addition, a workshop was held on the reform of the private maintenance system, and limited consultations were conducted with governmental and non-governmental stakeholders.

The following three sections focus on a discussion of the policy options, the proposal for a new cash transfer and the political process.

POLICY OPTIONS

The Lund Committee debated a range of policy options, which included the following: (a) the reform of the private maintenance system; (b) an increase in financing social welfare services; (c) support for the developmental social welfare model; (d) support for nutrition programmes for young children; (e) support for early childhood development (ECD) programmes; and (f) support for social funds.

While each of these options had merit and required intervention by the State, by itself, the Committee was of the view that it would not address income poverty directly and on the scale required if the State Maintenance Grant were to be abolished. Extensive proposals for the reform of the flawed private maintenance system to increase parental support for children were generated by a workshop organized by the Lund Committee. The workshop reiterated how the failure in the private maintenance system resulted in increased reliance on the State by mainly poor women who lacked support from the fathers of their children. The proposals were later implemented in part by the Department of Justice, but the system continues to be dysfunctional and poorly resourced (Khunou, 2006). The second option of boosting social support through the child and family welfare system, already severely underfunded, was considered, especially in light of the impact of the HIV and AIDS pandemic. Large numbers of children at risk ended up in alternative care owing to poverty and other social problems. The option existed to support non-governmental organizations (NGOs) delivering welfare services for children. Current child and family models was expensive and had a limited reach. To address the need for more appropriate models, the Department of Welfare was piloting community-based developmental models but it would be some time before these models could be taken to scale.

Regarding nutritional interventions, the Lund Committee noted the vital role that nutrition plays in the early years of children's lives and the negative consequences on their intellectual, cognitive and physical development if they are nutritionally deprived. A review of current nutrition programmes and international best practice was conducted. Much more research was needed to inform policy and programmatic nutritional interventions and to assess State and non-governmental capacity to deliver effective nutrition programmes. However, the concern about child nutrition was highly influential in the Committee's thinking about the Child Support Grant. Lund (2008) further points out that almost 90 per cent of children did not have access to early childhood development education and care. At the time, the Department of Education was in the process of developing an early reception year and the Department of Social Development was also funding NGOs delivering early childhood development programmes. There was a need for expansion of community-based early childhood development. Similar considerations to those referred to above trumped this option. Social funds to boost child and family support activities were also considered but concerns about the efficacy of social funds in reaching the very poor (and in particular women), among other factors, resulted in the Lund Committee deciding on a cash transfer as being the most viable option.

PROPOSAL FOR A CHILD SUPPORT GRANT

The State Maintenance Grant and the child-allowance component of the grant were to be phased out over a three-year period. This affected about 200,000 women and a similar number of children and made up 12 per cent of total fiscal expenditure on social assistance in 1995/1996 (Lund, 2008). The current system was unsustainable and inappropriate. It was fashioned on British social-policy models based on the nuclear family model. The notion that there was a male breadwinner in the family and that State support would be provided in the event of interruption of the earning capacity of the breadwinner did not quite fit changing family forms in South Africa. The disruption of family life due to the migrant labour system and apartheid policies that began in the early twentieth century fundamentally altered family composition and structure. Large numbers of children were also being cared for apart from their biological parents as a consequence of past policies (Republic of South Africa, 1996). Single parenthood and three-generation families were more widespread than nuclear families and a diversity of family forms existed, including customary marriages and couples not married but living together.

The new system was designed to "follow the child"; thus a cash transfer was devised to be paid to the primary caregiver of the child, which was a local innovation. The Lund Committee also developed costing models with different scenarios based

on three possible age cohorts. Eligibility was to be determined by a means test and a flat rate was to be paid to the caregiver of the child. The level of the benefit was set low and was motivated by basing it on an objective measure of need: the food costs of a child. The Committee set this cost at US\$10.35 per month at the time. After considerable deliberation, the Committee limited the age cohort to six years, covering 3 million children; it was the least costly option.

In order to target the children who were the most in need and to concentrate investment in the early years of life, a differentiated means test for urban and rural areas and people living in informal settlements was devised. A threshold was set for eligibility for children from rural and informal settlements to compensate for the disadvantages that they faced in accessing health and education services and for the lack of employment opportunities for their caregivers. The means test was initially based on household income. No behavioural conditions were applied since these would have penalized children who lived in areas where there were no clinics or schools. The only requirement was that a child's birth should be registered and the applicant should have the relevant identity documents.

The Lund Committee was also clear that should the implementation of the Child Support Grant prove to be successful, it could be expanded by raising the age limit of eligible children. This indeed occurred, and the qualifying age was

gradually increased; today children up to 18 years of age qualify for the grant.

POLITICAL PROCESS AND ROLE OF CIVIL SOCIETY

The Lund Committee Report was submitted to the Ministers Committee for Social Welfare in September 1996. Political and legislative processes took another 14 months and the first applications for the grants were received in April 1998. Some of the key issues in the management of the adoption of the policy and the role of civil society are discussed below.

Once the Cabinet had approved the recommendations, the proposal was released for public comment. The report was then debated and considered by the Portfolio Committee for Social Welfare, which is a parliamentary committee. Extensive public hearings were held and large numbers of civil society organizations made representations to the Portfolio Committee. The phasing out of the State Maintenance Grant was widely condemned by advocacy groups. They argued that this action would only increase the hardship of poor women – that it ended the only financial support provided for parents themselves and that there was no recognition of or compensation for their caring work (Goldblatt, 2005, p. 239). The low amount of the grant, set at US\$10.35¹ per month, was very controversial since advocacy groups argued that the amount was set far too low given the cost of living. Political engagement with civil society groups

¹US\$1 = 7.2479 rand as at 18 August 2010.

resulted in an increase in the amount of the grant to US\$13.80 and the qualifying age was also extended to seven years of age. This also resulted in a revision of the means test from basing the income threshold on household income to individual or joint income (if the applicant was married), which cast the net wider. The participation of civil society groups led to key compromises in the design of the grant.

Lund (2008) in her personal reflections on the process identified the trade-off between developing a proposal quickly based on political imperatives and pressures to deliver to the poor and a long consultative process to build national consensus on the grant. The reality was that, on the one hand, there was a need to capitalize on the political space that existed even though the fiscal environment was constrained; on the other hand, engaging in a long consultative process might not have yielded a concrete and tight proposal that was doable and acceptable to the Government. While civil society groups engaged in participatory processes, they also reserved the right not to be associated with government decisions that took benefits away from some groups. The political and parliamentary processes to get the proposal accepted were managed by the Minister, the Director-General and senior public servants in the national and provincial Department of Social Development while the National Treasury played a critical role in enforcing strict fiscal parameters. Other government departments such as the Department of Home Affairs,

which is responsible for identity documents, were critical to successful implementation. This is discussed below.

IMPLEMENTATION

EARLY PROCESSES

An implementation task team led by an experienced project manager was established to facilitate the process. The overriding idea was that the grant should be simple and accessible, but the procedures and systems required were complex. First, legislation had to be drafted and enacted to abolish the old grant and to create a new cash transfer. The legislation had to be adopted by Parliament, which is usually a lengthy process. Second, administrative and computer systems had to be redesigned. The new cash transfer was to be delivered through the existing computer systems, which were outmoded, and there were fears that the current computer system would be unable to handle the growth in beneficiary numbers. Third, transformation fatigue among public officials at a time of great change and transition in the new Government may have resulted in increasing bureaucratic obstacles and challenges that needed to be managed by the implementation task team. The speed with which the implementation progressed did not allow much space for organizational learning.

In the early years after the grant was launched, uptake was slow. The Government launched major awareness-

raising campaigns, especially on public and community radio stations, while NGOs played a key role in promoting the new grant by actively supporting claimants to access the grant. NGOs also lobbied government to address some of the shortcomings in the administration of grants. A number of high-profile Supreme Court rulings protecting the rights of claimants also contributed to public awareness and stimulated debate.

The agent for the delivery of the grant was the Department of Social Welfare's social security division, which employed approximately 2,256 staff nationally in 1995. The delivery of cash transfers up to the 1980s was done by government at pay points that were established throughout the country. These pay points reached deep into rural areas and included shops, government offices, institutions for the elderly and post offices, and grants were paid through the bank accounts of beneficiaries who had such accounts. The system was inefficient and resulted in long queues and it was not accessible.

After 1980, the Government privatized the delivery of cash transfers. Private companies with heavy involvement of private security firms began delivering the grants via mobile delivery vans equipped with the electronic fingerprinting identification and built-in-automatic teller machines. The new technology increased the number of pay points, reduced the queues and allowed for reconciliation of accounts but it also increased transaction costs. Currently 80 per cent of beneficiaries receive their

grants by a cash payment method (National Treasury, 2010) although increasing numbers of Child Support Grant beneficiaries are beginning to receive the grant through bank accounts. The linking of poor people with financial institutions was identified as a major problem and this continues to be a challenge even though banks are now required to create opportunities for low-income people to open their own bank accounts at lower transaction costs.

Social assistance is now delivered by the South African Social Security Agency, which was created by statute to administer and deliver social grants. Social security was previously delivered by provincial governments. It became a national governmental function in 2005 to address some of the service delivery challenges especially in the delay of approvals, payments, possible fraud and corruption in the system and to curtail delivery costs of grants. This has been a positive development that paved the way for a more professional service delivery system.

FINANCE AND SOCIAL SPENDING

At the inception of the Child Support Grant, alternative ways of funding it were considered, such as raising income through a value added tax, achieving efficiency gains through the better management of existing social assistance budgets, and reprioritization within budgets. However, this would not yield the income needed to finance the estimated US\$689.9 million that the programme would cost. This was four times the size of the initial budget allocation of

US\$165.6 million, which was the cost of the State Maintenance Grant at the time. The Government agreed to fund the programme in full from public revenue. This was in line with increased government spending on social welfare of 120 per cent between 1991 and 1997, 30 per cent on health spending, 26 per cent on education, and decreased spending on defence of 48 per cent (Republic of South Africa, 1996, and van der Berg cited in Lund, 2008, p. 6).

Since then, there have been massive increases in spending on social grants and in the Child Support Grant. The average growth of Child Support Grants has been 14 per cent since 2006, from US\$2.4 billion to an expected expenditure of US\$5.3 billion in 2012/2013. In 2009/2010, close to 14 million beneficiaries are estimated to receive social grants, of which 9.4 million or 68 per cent are Child Support Grant beneficiaries. This brings the fiscal allocation for social welfare (now renamed "social development") to US\$11.9 billion in 2009/2010. Real growth in social spending is expected to increase by only 2 per cent in view of the volatile economic situation prevailing nationally and globally (see National Treasury, 2010; Minister of Finance Budget Speech, 2010). The extension of the Child Support Grant to include children up to 18 years of age was announced by the Minister of Finance in his budget speech in 2010. This will bring an additional 2 million children into the safety net. The current level of the grant is US\$34.49 per month, which is an increase slightly below inflation owing to

the financial implications of the Child Support Grant age extension. Social grants account for 3.3 per cent of GDP and are expected to increase to 3.5 per cent in 2010/2011 owing to the impact of the global economic crisis (Minister of Finance Budget Speech, 2010).

The transaction cost of a cash payment is between US\$3.31 and US\$4.83 per grant payment (National Treasury, 2010). The Government is exploring ways of reducing these costs, particularly through promoting payments through banks, which could bring more recipients into the formal banking sector.

The question of fiscal sustainability remains high on the public agenda and in parliamentary debates. Over the past decade, there has been a strong lobby for extending the age limit to the grant to 18 years, which is now being implemented. A national coalition of civil society groups and trade unions has consistently advocated a basic income grant. This latter proposal has not been accepted by government because of affordability considerations at this stage. As the uptake in social grants has increased, the National Treasury has raised concerns about the impact of social assistance on other social spending such as health and education. The expansion of social assistance resulted in the latter part of the 1990s in the crowding out of spending on welfare services. Despite the doubling of spending on social welfare services between 2006 and 2009, welfare services remain underfunded. There were also increases in education spending amounting to 17.7 per cent between 2006 and 2009 and an

8 per cent increase in health spending over the next three years is expected (National Treasury, 2010). It is therefore important to take cognizance of the impact of the expansion of social protection programmes on other social services, particularly health and education.

IMPLEMENTATION CHALLENGES

Numerous implementation challenges have been identified since the introduction of the grants and have been well documented by researchers (see Goldblatt, Rosa and Hall, 2006). Briefly, these were related, first, to human resource and infrastructural problems such as a lack of privacy in the processing of applications, inaccessible office hours of services, a lack of computers, long queues and waiting periods, and a lack of adequately trained staff.

Second, a lack of coordination among government departments resulted in bureaucratic delays in, for instance, the processing of documents. Documentary requirements are considered to be a major barrier in ensuring access to the grants and in increasing uptake, particularly in the early years. Significant barriers in gaining access to the grant included proof of income to assess eligibility of the applicant, proof of birth registration of the child, and having the necessary identity documents of the caregiver. At the time of the Child Support Grant roll-out in 1998, only a quarter of the children in the qualifying age cohort were in possession of a birth certificate (UNICEF, 2005). However, concerted efforts by the Department of Home Affairs to process birth registrations through community

mobilization campaigns, mobile units to reach rural areas, accessible service hours and registrations at hospitals resulted in registrations reaching 78 per cent of children under five years of age in 2008 (UNICEF, 2008). This demonstrates how access to public services could impact positively on increased birth registrations. However, advocacy groups continue to point out that conditionalities of this kind end up penalizing children who live in communities where these services do not exist. A lack of adequate birth registration documents continues to be a barrier to Child Support Grant access (National Income Dynamics Study, 2009). Children whose mothers are deceased or absent are also less likely to be in receipt of a Child Support Grant (McEwen, Kannemeyer and Woolard, 2009; Case, Hosegood and Lund, 2005); they also were among the poorest and the most vulnerable children. There have been recent amendments to the Regulations removing the requirement that those children whose birth is not registered should not be denied access to the Child Support Grant. However, they will be strongly encouraged to apply for the necessary documents.

Another key obstacle was that the threshold of the means test has not been adjusted to keep abreast with inflation since the grant was established. Civil society advocacy groups consistently argued for these changes, and, in 2008, a more expansive and inflation-related means test was introduced where the income threshold is calculated at 10 times the amount of the Child Support

Grant. This significantly increases the number of children who will now qualify for the grant.

A third implementation challenge pertains to a lack of awareness of the Child Support Grant as well as a lack of knowledge of where and how to apply. Government campaigns, however, have contributed significantly to addressing this issue.

A fourth challenge remains the ongoing need to combat fraud and corruption in the system.

Finally, the cost of the applications for those who needed to travel from afar, language and communication barriers, and the lack of consistent application of the regulations among different government offices and by officials are other issues that hampered uptake.

Some of the challenges that were identified earlier in the roll-out resulted in timely amendments to Regulations, such as the requirements that children be in possession of a clinic card and that there be an assessment of income. Civil society organizations and researchers working with applicants identified a range of administrative requirements that were barriers to access. There is constant interaction between these groups and the South African Social Security Agency.

While the Child Support Grant was introduced without any behavioural conditions attached to accessing it, the Government introduced conditions for the grant from January 2010. The grant will in future be conditional on school

attendance and enrolment of children. The new Regulations apply to all children including older children who will now have access. Although a punitive approach is not envisaged, social workers will be required to investigate and put measures in place to address non-attendance. Conditionalities of this kind do not make sense since South Africa already has a high primary school enrolment rate of 86 per cent (UNICEF, 2008). Problems with non-attendance and poor school performance are related to the poor quality of schooling, especially those schools serving the poor. Budlender, Rosa and Hall (2008) argue that unless these problems are addressed, there may be little gain from incurring additional costs of compliance. The provision that social workers will monitor school attendance is not implementable as there are simply insufficient social workers to do so, especially in rural areas. The effect of these new provisions will be to limit children's right of access to the grant and exclude poorer children. Lund et al. (2009) argue that better administration and provision of grants would be more rational and fairer than the imposition of conditionalities.

IMPACT OF THE CHILD SUPPORT GRANT

The beneficiary profile of the Child Support Grant indicates that the grant is well targeted at poor households and children. It penetrates rural areas significantly, with beneficiary numbers being the highest in three of the poorest

provinces in the country: the Eastern Cape, Kwazulu-Natal and Limpopo. Vorster and de Waal's national survey of grant beneficiaries (2008, p. 239) found that over half of the households receiving at least one Child Support Grant are in rural areas, with more than one third living in informal houses with limited access to basic services. The majority of beneficiaries of the Child Support Grant are women (96 per cent) and 90 per cent are black (de Koker, de Waal and Vorster, 2006). The feminization of grants is a new trend and the gender impact and dynamics of the grant require further research. Just over half of the beneficiaries are single and have never been married while 34 per cent are married or living with a partner (de Koker, de Waal and Vorster, 2006). With regard to the age of the beneficiaries, 50 per cent were between 21 and 33 years of age, with only 5 per cent being under 21 years and over 57 years, respectively. Grant beneficiaries are fairly evenly split between males and females (McEwen, Kannemeyer and Woolard, 2009).

Although the Child Support Grant was intended to be paid to the caregiver of the child, who could be a parent, relative or non-relative guardian of the child, 91 per cent of biological mothers claim the grant on behalf of their children, with a small percentage claiming the grant on behalf of other children as their guardians (Vorster and de Waal, 2008). Most of the children lived with their biological mothers (Vorster, 2006), with most women receiving either one (58 per cent) or two grants (30 per cent) (Department of

Social Development, 2006). The question may be asked as to whether grants in fact provide positive incentives for mothers to care for their children. To date, no research has been done on this topic. With regard to employment, 83 per cent of Child Support Grant beneficiaries were not employed or doing paid work. The take-up rate of the grant ranged between 78 and 80 per cent of the children who were eligible (Leatt, 2006; Budlender, Rosa and Hall, 2005).

Without the Child Support Grant, Woolard (2003) estimates that 48 per cent of children would be living in poverty and 23.9 per cent would be classified as ultra-poor. While all three types of social grants reduced the total rand poverty gap by 45 per cent, the greatest poverty-reducing potential was considered to lie with the extension of the Child Support Grant to age 18, which would reduce the poverty gap by 28.3 per cent (Samson et al., 2004). The extension of the qualifying age to 18 years over the next three years will have positive poverty-reduction benefits for children and their families.

Although the measurement of poverty after 1994 is the subject of debate among researchers, there is agreement that social grants reduce poverty significantly, especially among the extremely poor, regardless of the methodology or poverty lines employed (van der Berg et al., 2005; Samson et al., 2004; Meth and Dias, 2004). Various researchers have also posited the positive effects of social grants in the reduction of income

inequality. Samson and his colleagues (2004), using a micro-simulation model with household data from the year 2000, estimated that the full take-up of all three social grants could lower the Gini coefficient by 3 percentage points (Samson et al., 2004). It may be concluded that social grants therefore contribute to a more equal distribution of income as well as to economic growth (see Neves et al., 2009; Samson et al., 2004).

DEVELOPMENTAL IMPACT

Successive research studies have found that social grants have positive developmental impact in that they facilitate human capital development through improved access to health, nutrition and education. They also aid job searches, are positively associated with higher success rates in finding employment and improve the productivity of workers in households in receipt of a grant as well as support household livelihood activities (Neves et al., 2009; Delany et al., 2008; Samson et al., 2008; Vorster and de Waal, 2008; Case, Hosegood and Lund, 2005). Thus social grants empower and improve the welfare of recipients and their households as a whole, particularly where resources and income are pooled.

Research findings that demonstrate the developmental impact of the Child Support Grant are summarized here. In a national study on how the grant is used, Delany et al. (2008) found that just over half of Child Support Grant beneficiaries indicated the pooling of their income, with 49 per cent stating that they spent

the money exclusively on the child. Overall, the grant made up 40 per cent of household income and closer to half of household income in some of the poorer provinces such as Limpopo and the Northern Cape. The majority of beneficiaries (79 per cent) spent the money on food, school fees (26 per cent), school uniforms (25 per cent) and electricity (22 per cent) (Delany et al., 2006). Child Support Grant households also spent more than half of their income on food, and one in five reported experiencing hunger because there was no food. A propensity matching study conducted on the Child Support Grant points to a positive relationship between the receipt of the grant and decreased child hunger (Samson et al., 2008). Researchers are also beginning to demonstrate the positive nutritional impact of the grant measured in terms of height-for-age gains in children receiving the grant, with positive spinoffs for increases in future earnings of 60 to 130 per cent (Agüero et al., 2006). The latter researchers argue that these positive effects have been achieved without conditions being imposed that children should attend a clinic. They attribute this positive effect to the fact that the grant is received mainly by women who are more likely to spend money on basic essentials for their children. A KwaZulu-Natal study in poor rural areas (Case, Hosegood and Lund, 2005, p. 467) found evidence supporting the claim that receipt of a Child Support Grant increases the likelihood of children being enrolled in school after the receipt of the grant compared with equally poor

children of the same age. The grant therefore helps to overcome the impact of poverty on school enrolment. Positive impacts on school attendance were also confirmed by Samson et al. (2008).

However, negative effects of social assistance are identified by some researchers who point to perverse incentives to work, increasing fertility rates (especially among teenagers), disruption of private remittances, displacement of private savings and the inappropriate spending of grant income in general. Based on a range of research studies, various researchers conclude that there does not appear to be evidence to support these claims (see Makiwane, 2010; Neves et al., 2009; Steele, 2006; Samson et al., 2004).

The public perception that the Child Support Grant is associated with increased teenage childbearing is often cited. Drawing on national administrative statistics on the Child Support Grant and secondary data on estimates of teenage fertility, Makiwane (2010, p. 193) argues that teenage fertility began to decline in the first half of the 1990s and that this trend was already under way when the grant was introduced. The findings of her analysis do not show a positive association between the introduction of the Child Support Grant and increased teenage childbearing.

CONCLUSIONS

The South African experience of laying the foundation for a national social protection floor and in building a social protec-

tion system progressively could provide valuable insights for other countries in the Global South as they search for solutions to the intractable problems of mass poverty, inequality and underdevelopment.

Some of the critical success factors of the process of policy development pertain, first, to the credibility and quality of the leadership of the Committee and the expertise, range of practice experience and knowledge of social assistance among Committee members. Second, the evidence-based approach that informed the decision-making was open to contestation but it was nevertheless robust and persuasive, and it is a good example of evidence-based policymaking. Third, the Committee also enjoyed the confidence of politicians, who were therefore able to build consensus in their political constituencies despite the outcry about the phasing out of the State Maintenance Grants. Fourth, the process was backed up with strong administrative capacity, which was built up over 80 years in the delivery of social assistance. Despite problems with service delivery, there was the necessary capacity to drive the adoption and implementation at national and provincial government levels. Finally, there was a window of opportunity in the transition period immediately after the ruling party, the African National Congress, came to power. In addition, this political and administrative space allowed for an environment in which innovation and new ideas could flourish in a public sector that was reinventing itself. The Child Support Grant was adopted and implemented in a short

space of time in a contracting fiscal milieu amid skepticism from civil society. Looking back, the Child Support Grant demonstrates what can be done when knowledge is combined with imagination, commitment to equity, and a belief that effective governments can be made to serve the common good.

In conclusion, ongoing governmental, political and electoral support for a national social protection floor or a minimum standard below which no one should fall is one of South Africa's success stories. It has been made possible by consistent investments in administrative capability, infrastructure, generous fiscal allocations and growing although sometimes ambivalent public support for cash transfers. The building of human capabilities, employment creation (especially for youth), and the search to find ways to include working-age adults who fall outside the social protection net remain key challenges.

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Thailand

Area	513,115 km ²
Population ⁱ	67,312,624
Age structure	
• 0-14 years	22.0%
• 15-64 years	70.6%
• 65 years and over	7.4%
Infant mortality rate (per 1,000 live births) both sexes ⁱⁱ	13
Life expectancy at birth (years) female	72.1
Life expectancy at birth (years) male	65.8
Maternal mortality ratio (per 100,000 live births) ⁱⁱⁱ	110
GDP per capita	
• Current USD ^{iv}	4,043
• PPP (current international \$) ^v	8,086
• Constant local currency	64,722
Total expenditure on health (in millions of baht)	363,770.8
Private expenditure on health as percentage of total expenditure on health	25%
Unemployment rate ^{vi}	0.7%
Labour force ^{vii}	38.7 million
Percentage of workforce in informal economy ^{viii}	62.3%
Human development index (HDI) rank ^{ix}	87
HDI poverty indicators – Human poverty index rank	41
Adult literacy rate (ages 15 years and above)	94%

The Universal Coverage Scheme

Thaworn Sakunphanit
Worawet Suwanrada

17 Thailand

Summary

Target group: Every Thai citizen not covered under other public schemes.

Target population: 47 million (80% of total population).

Benefits: Comprehensive package (in kind) that includes:

- prevention services covering immunizations, annual physical check-ups, premarital counselling, antenatal care and family planning services as well as other preventive and promotive care;
- ambulatory care and in-patient care (high-cost treatments such as cancer treatments, open heart surgery, antiretroviral drugs and renal replacement therapy are all included);
- only a few conditions are excluded, i.e., infertility, cosmetic surgery.

Delivery process:

- A national centralized, online registration database links providers to public health insurance schemes. Beneficiaries must register with a primary-care contracting unit near their home area (within 30 minutes' travel time from home). Primary care unit acts as a gate-keeper for access to care. Treatment outside this area is limited to accident and emergency care. For complicated cases, there is a referral system to hospitals or special institutes;
- Benefits are provided free of charge;
- Hospital submits electronic claims to the Universal Coverage Scheme for inpatient services.

Total expenditure (fiscal year 2008):

Expenditure	Nominal Price (in millions of constant 2005 PPP \$)	% of GDP
Benefit expenditure	5,522.2	0.97
Administrative expenditure	50.6	0.01
Total	5,572.8	0.98

Source of funding: General tax revenue.

Impact:

- 88,000 households in 2008 were prevented from falling below the poverty line;
- Well-controlled diabetic patients increased from 12.2 per cent of total diabetic patients (2003-2004) to 30.6 per cent (2008-2009);
- Well-controlled hypertensive patients increased from 8.6 per cent of total hypertensive patients (2003-2004) to 20.9 per cent (2008-2009).

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SOCIO-ECONOMIC CONTEXT

Thailand is located in Southeast Asia. The official national language, spoken and written by almost 100 per cent of the population, is Thai. Buddhism is the professed faith of 94.6 per cent of the population and Islam is embraced by 4.6 per cent of the Thai people; the rest of the population practices Christianity, Hinduism and other religions.

DEMOGRAPHIC CHANGE

Thailand is rapidly becoming an ageing society. The “demographic dividend”, the phenomenon of having a low dependen-

cy ratio, will end soon. The total fertility rate of Thailand is now far below the replacement level. The overall dependency ratio, which kept falling until 2010 (table 1), will rise owing to an increased proportion of the elderly. The population 60 years of age and over will increase to more than 7 per cent in 2010. Around 2005, Thailand became an “ageing society”. By the year 2030, the proportion of the elderly in the Thai population is expected to increase to 15 per cent. A 2005 survey of population change and an analysis from the Bureau of Registration Administration of the Ministry of Interior showed the same pattern: a decrease in total fertility, belying previous estimates.

Table 1 | Population projection (in millions).

Age	2005	2010	2015	2020	2025	2030	2035	2040	2045	2050
0-14 years	16.2	15.2	13.4	12.3	11.7	11.4	10.8	10.0	9.3	8.7
15-59 years	43.8	46.0	47.8	48.4	47.7	46.1	44.3	42.4	40.3	38.2
60+ years	6.0	7.1	8.7	10.8	13.3	15.8	18.1	20.1	21.5	22.3
Total	66.0	68.3	69.9	71.5	72.7	73.3	73.2	72.5	71.1	69.2

Source: World Population Prospects, United Nations, Department of Economic and Social Affairs, Population Division, 2000.

The average family size will continue to decrease: from more than 5 persons per household to 3.9 in 2000 to 3.4 in 2010 and 3.1 in 2020. Also, data from the Urban

Development Cooperation Division of the National Economic and Social Development Board (NESDB) show that there is increased migration from rural

areas to urban areas, which will decrease the rural population from 65.28 per cent in 2000 to 60.01 per cent in 2010.

ECONOMIC PERFORMANCE

Since 1961, the base of the Thai economy has rapidly changed from agriculture to services and manufacturing. When Thailand started the first five-year National Economic and Social Development Plan (1961-1966), the Thai economy relied mainly on the agricultural sector. The share of agriculture decreased from 40 per cent of gross domestic product (GDP) in 1960 to 10 per cent in 2002, however, and manufacturing increased from 13 per cent to 37 per cent of GDP. Economic growth has been impressive over more than three decades although an economic crisis during 1996-1997 brought negative growth for a few years. Thailand had to adopt a structural reform for a loan of US\$17.2 billion from the International Monetary Fund (IMF). In 1997, the Thai economy had generated a negative growth rate of 1.4 per cent and it experienced a greater decline to negative 10.5 per cent in 1998. Economic growth, which in Thailand is dependent on exports, resumed in 1999. Then in 2008, GDP growth dropped to 2.5 per cent, and, in 2009, the country faced another economic crisis, which manifested itself especially through problems in the sector of goods and services production.

THE STATUS OF POVERTY AND SOCIAL PROTECTION

As early as the drafting period of the second National Economic and Social Development Plan (1967-1971), there were concerns about income distribution and poverty reduction, but Thailand used mainly economic policy in tackling poverty through economic growth. The country's economic growth has contributed to a sharp drop in poverty levels. Between 1999 and 2000, poverty rates fell by 2 per cent. However, poverty decreased between 2004 and 2006 at a relatively slow pace. The poverty head-count ratio fell from 11.2 in 2004 to 9.6 in 2006. There are 6.1 million people living below the national poverty line of 1,386 baht or 87.0 constant 2005 PPP \$¹ per person per month.^x However, it should be noted that the Thai poverty measurement uses the absolute poverty line, which is not sensitive enough for the measurement of social exclusion (income distribution).

Economic development in Thailand has led to greater income disparity instead of narrowing the gap between rich and poor. Since the first National Economic and Social Development Plan in 1962, the Gini coefficient for income distribution increased from 0.41 in 1962 to 0.54 in 1992 and then fell slightly when the country faced an economic crisis in 1997 (table 2). The share of income of the poorest 20 per cent (quintile) was

¹PPP in this case study refers to the results of the 2005 International Comparison Program (ICP), which was led and coordinated by the World Bank (1 PPP \$ = 15.93 baht).

Table 2 | GDP growth and the Gini coefficient.

Year	1962	1969	1975	1981	1986	1988	1990	1992	1994	1996	1998	2000	2002	2004	2006
GDP Growth (%)	7.8	7.8	4.9	5.9	5.5	13.3	11.2	8.1	9.0	5.9	-10.5	4.8	5.3	6.3	5.1
Gini Coefficient (person)	0.41	0.43	0.45	0.47	0.49	0.49	0.51	0.54	0.53	0.52	0.51	0.53	0.50	0.50	

Source: GDP Growth from National Economic and Social Development Board (NESDB); coefficient for 1962-1988 from Panarunothai, S. and Patamasiriwat, D., *Macromomic Indices for Measuring Equity in Health Finance and Delivery 1986-1998*, Center for Health Inequity Monitoring, Faculty of Medicine, Naresuan University, 2001; Gini coefficient for 2000-2004 from NESDB and National Statistical Office.

7.9 per cent in 1962 and 4.8 per cent in 2004 while the share of the richest quintile was 49.8 per cent and 51.0 per cent in those same years.

According to a national survey of older people in Thailand, there are elderly who do not have a secure living arrangement and/or a secure financial situation. The elderly still must depend on family support. According to the surveys of 1994 and 2002, the proportion of the elderly population living alone increased from 3.6 per cent to 6.3 per cent. The most recent survey in 2007 showed that it had increased further to 7.7 per cent. Some of those living alone faced problems or obstacles such as financial difficulties (15.7 per cent). Among all elderly, 31.3 per cent did not have savings or any financial assets, and 34.1 per cent had an annual income of less than B20,000 (1,255.50 constant 2005 PPP \$). These situations led the current Government to introduce social protection measures aimed at the elderly.

NATIONAL RESPONSE

Thailand first recognized the imbalance of development with the fifth five-year National Economic and Social Development Plan (1982-1986).² The Government paid more attention to poverty reduction and developed and implemented various initiatives. Lessons learned led to redesigned programmes, which were implemented again. After decades of this learning-by-doing, the Government implemented basic social protection schemes, the Universal Coverage Scheme (UCS) and the 500 Baht Universal Pension Scheme, under the concept of universal coverage. The current government has a “pro-welfare-state” policy and has proposed implementing the plan, “Construction of Welfare Society within B.E. 2560 (2017)”.³ Social protection has been selected as a theme of the eleventh five-year National Economic and Social Development Plan (2012-2016). An ageing society has been perceived as one of Thai society’s new concerns for the next 20 years.

²The National Economic Development Board, which became the National Economic and Social Development Board in 1972, is a national agency that is responsible for formulating the National Economic and Social Development Plan and translating it into action within a five-year time frame. As noted earlier, Thailand launched the first five-year National Economic and Social Development Plan in 1961.

³The official calendar in Thailand is based on the Eastern version of the Buddhist Era, which is 543 years ahead of the Gregorian (Western) calendar.

PROCESS OF INTRODUCING THE UNIVERSAL COVERAGE SCHEME

CURRENT HEALTH-CARE SYSTEM

The health-care system in Thailand is an entrepreneurial market-driven system. It has a pluralistic public/private mix in both health-care providers and financing agencies. However, most health services are provided by public health-care providers. These public health-care facilities receive government monies mainly for salary and capital investment and are allowed to keep their revenue from services for running their business. In 2007, 65.9 per cent of hospitals and 63.3 per cent of beds belonged to the Ministry of Public Health (Wibulpolprasert, 2008). Currently, the Ministry owns 891 hospitals, which cover more than 90 per cent of the districts, and 9,758 health centres, which cover every subdistrict (tambon). Private hospitals have increased since the economic expansion during the period 1992-1997. Most of them are located in Bangkok and other urban areas. There were 318 private hospitals and 16,800 private clinics in 2007. Most of these clinics belong to doctors who are government civil servants. These doctors work in their own clinic after office hours.

These health services are financed mainly through third-party payers. Thailand reached universal health-care coverage in 2002. Government spending on health care gradually increased from 56 per cent in 2000 to 75 per cent in

2008, when it totalled B343 billion or 21.5 constant 2005 PPP \$ (US\$9.83 billion). Recurrent health-care expenditure as a percentage of GDP slightly increased from 3.2 per cent in 2001 to 3.8 per cent in 2008 (IHPP, 2010).

By law, Thai citizens belong to one of the country's social health protection schemes. The Civil Servant Medical Benefit Scheme (CSMBS) for central government employees and other small, public-employee benefit schemes cover 7 per cent of the population. The Social Security Scheme (SSS) for private employees covers 15 per cent of the population, and the rest (76 per cent) are covered by the Universal Coverage Scheme. The Universal Coverage Scheme covers everyone who is working in the informal sector, whether rich or poor. It should be noted that private health insurance companies play a very limited additional role in Thailand owing to their high premium rates and very strict underwriting policies.

THE PROCESS OF ESTABLISHING THE UNIVERSAL COVERAGE SCHEME

RAISING AWARENESS AT THE NATIONAL LEVEL

The history of Thai health-care policy includes the ideology of using health care to strengthen State power in the nineteenth century and treating health care as an important part of long-term invest-

Table 3 | Cause and effect of health policy in Thailand.

	Health Policy	Implementation
Before 1961	Health care was used to strengthen State power.	Expansion of public health facilities and health protection scheme for employees, e.g., Civil Servant Medical Benefit Scheme (CSMBS), Social Security Scheme (SSS).
Early National Socio-economic Plan	Health is an important part of long-term investment for economic growth.	
1973 Constitution	Health services for the poor should be provided free of charge.	Low-income scheme.
1977 Constitution	Health is considered as an entitlement of Thai citizens and equal access to basic health services should be guaranteed.	Universal coverage for health care.

Source: Sakunphanit (2008).

ment for economic growth. Health care is now considered to be an entitlement of Thai citizens. Every step pushed the Thai health system further into providing universal access to care and into the protection of people’s rights (table 3).

Expansion of public health facilities to cover every administrative area started during the first five-year National Economic and Social Development Plan (1961-1966). Health care was considered not only as an important part of long-term investment for economic growth but also as a strategy for promoting the Government during the Cold War period. Though the majority of the population was active in the agricultural sector

and lived in rural areas, it was difficult to encourage private health facilities to provide services in those areas. Therefore, the expansion of public health facilities to cover the entire population was crucial to overcoming physical barriers.

The Ministry of Public Health decided to establish a hierarchical health service system using administrative areas as the main approach for investment in the health-care infrastructure. In the third National Economic and Social Development Plan (1972-1976), the Government set targets to reach “one hospital for every district and one health centre⁴ for every sub-district” (tambon). The period from 1992 to 2001 was

⁴Health centres are health-care facilities that provide mainly preventive and basic outpatient services. Health-care professionals in these facilities comprise public health personnel, nurses and other paramedical personnel. There were no medical doctors in these health centres.

the decade of the Health Centres Development Project. In 1993, with public health centres in closer proximity to more people, everyone could access services within one hour's walking distance from home.

The government policy of charging for services in public health-care facilities was established in 1945. Later, these facilities were allowed to keep their own revenue for running their business. An informal exemption for the poor was implemented along with the user charge.

It took nearly four decades for Thailand to gradually move from out-of-pocket payment to many prepayment schemes. Regarding the informal sector, there were two public prepayment schemes, the Medical Welfare Scheme and the Health Card Scheme, which were implemented before the era of the Universal Coverage Scheme.

The Medical Welfare Scheme was called the Low Income Scheme when it was introduced in 1975. Coverage of this Scheme was maintained by several successive governments, which financed the Scheme with government revenue. The name of the scheme was changed to the Medical Welfare Scheme when it expanded coverage to people 60 years of age or older, children 12 years or younger, the disabled, veterans and monks.

The Health Card Scheme was initiated in 1983 to support primary health care in the community. Designed as a community financing fund in the beginning, it then expanded nationwide, but many

problems occurred owing to a lack of administrative skills and financial risks. Finally, the Health Card Scheme changed its financial model to voluntary health insurance and established the health insurance office at the Ministry of Public Health to manage the Scheme. The main target groups of the Health Card Scheme were households with an income level higher than the poverty line.

The policy of universal health-care coverage could be traced back to the idea behind the Health Card Scheme (Boonyuen and Singhkaew, 1986). After the successful implementation of the Social Security Scheme in 1992, Thai technocrats decided to expand coverage of the "occupational" schemes to both the formal and informal sectors. These pluralistic approaches had weaknesses in terms of efficiency, quality and equity. There was debate as to whether the Government should provide care to the poor or whether it should provide universal health care for the sake of upholding basic human rights. The Ministry of Public Health started to design policy options and estimated the cost of universal coverage.

There were three policy options: gradually reforming the existing schemes to cover all Thai citizens; undertaking a major reform to set up a central agency to manage health insurance; and coordinating every scheme. Advocacy efforts vis-à-vis politicians and related organizations included a series of discussions and a study visit to Australia and New Zealand (Office of Health Insurance, 1994).

International workshops were held among Thai experts and international experts between 1993 and 1996.

The Health Insurance and Standard Medical Service Bill was drafted during 1995-1996. The Bill proposed a compulsory health insurance model. However, the draft failed to receive full-hearted support from bureaucrats and politicians in the government (Sakunphanit 2004). Nevertheless, social movements pushed the universal coverage policy into the 1997 Constitution and the eighth National Health Plan (1997-2001).

Non-governmental organizations (NGOs) and civil societies played a significant role in providing legitimacy for universal health-care coverage. A group of NGOs also drafted their National Health Security Bill and campaigned for universal coverage in 2000. In addition, the press played an influential role in keeping the general public informed of the universal coverage policy. A public opinion survey confirmed that the universal care policy was popular. Political parties added this universal coverage for health care to their policies. After the general election in early 2001, the Government started the implementation of the Universal Coverage Scheme. Finally, the National Health Security Act was enacted on 19 November 2002.

IMPLEMENTATION

SCHEME DESIGN

The Universal Coverage Scheme provides

health-care coverage to all Thai citizens who are not covered by any other public health protection scheme. It is a result of the reform of the Medical Welfare Scheme and the Health Card Scheme and is administered by the National Health Security Office.

The Scheme is designed for efficiency by using primary care as a gate-keeper and set-up referral system for complicated cases that need inpatient service. It also emphasizes managed care.

The Universal Coverage Scheme provides a comprehensive benefit package. Benefits include curative services, health-promotion and disease-prevention services, rehabilitation services, and services based on traditional Thai or other alternative medical school practices. The Scheme also provides personal preventive services and health-promotion services to all Thai citizens.

The co-payment of B30 (1.9 constant 2005 PPP \$) per visit was abolished at the end of 2006. Data analyses indicated that abolition of the co-payment had no effect on the overall use.

For greater efficiency and effectiveness, fragmented medical services have been streamlined into a new integrated continuum-of-care design. The Universal Coverage Scheme introduced a new periodic health examination as a risk-stratification tool. The goal of the screening is to prevent the onset of disease or warn of an existing disease. Many chronic diseases are treated using an actively managed approach.

Health facilities must register for the Universal Coverage Scheme. The primary medical-care unit is the first contact point for beneficiaries, who are not allowed to go directly to secondary or tertiary care facilities without referral from the primary medical-care unit except in cases of bad accidents or other health emergencies.

Although health-information technology is fragmented, there are two applications that providers and social health-protection schemes now share at the nationwide level. The national beneficiary registration system is based on a national personal identification number. A centralized registration database has been developed since 2002. It covers the entire Thai population, including information from the Civil Service Medical Benefit Scheme, the Social Security Scheme and the Universal Coverage Scheme and is updated twice a month.

COSTING FOR UNIVERSAL COVERAGE

The Universal Coverage Scheme prepared an actuarial model to estimate the annual budget. This estimate is used for negotiations with the Bureau of Budget on a yearly basis.

Fiscal space is estimated from a long-term financial projection. The earliest model was developed in 2004 by experts from the International Labour Organization (ILO) and their Thai counterparts. Currently, models for the Civil Service

Medical Benefit Scheme, the Social Security Scheme and the Universal Coverage Scheme have been developed by experts from ILO and the Thai counterparts using the ILO social-budgeting models. Preliminary projections show that Thailand will spend around 4.5 per cent of GDP on health in 2020.

The Universal Coverage Scheme uses different payment mechanisms to control the behaviour of hospitals.

The Social Security System, with supervision by the ILO and Thai experts, has introduced a payment methodology of capitation⁵ since 1992. However, a small budget amount is kept to pay the high cost of prosthetics and fee-based medical devices.

Between 1998 and 2001, the Ministry of Public Health modified the methodology of capitation in six provinces under a social investment project. This model used capitation for outpatient care only and case-mixed payment (diagnosis-related group) for inpatient care. This initiative can solve the problem of the high cost of inpatient care. These six provinces were selected to be the first batch of provinces for the Universal Coverage Scheme in 2001, before it expanded nationwide.

Currently, the Universal Coverage Scheme uses different payment mechanisms for specific types of services in order to have health-care providers contain costs. Capitation is used for most

⁵Capitation: A payment methodology in which the physician is paid an amount determined by a per-member-per-month calculation to deliver medical services to a specified group of people.

preventive services and ambulatory care. In-patient services are reimbursed using the case-mixed system, the diagnosis-related group (DRG). However, the Universal Coverage Scheme approach is different from the "original" DRG payment system of calculating the inpatient budget, and the total relative weight of DRG is used to allocate the amount of money paid to hospitals. A small fraction of the budget is allocated to pay for specific services or equipment (i.e., prosthetic heart valves) under the fee-for-service method.

Contracted health-care facilities must send clinical and financial data to the National Health Security Office (NHSO), the organization responsible for managing the Universal Coverage Scheme. Every year, representatives of health facilities and the NHSO negotiate the capitation rate and other payment mechanisms.

The Voluntary Quality Improvement Programme is operated in parallel to the cost-containment mechanism. The Healthcare Accreditation Institute, a public organization, provides voluntary hospital accreditation for both public and private providers. This accreditation is popular with hospitals because it boosts their public reputation. The Universal Coverage Scheme also provides grants to this institute for its facility accreditation services.

Every year, an external evaluator analyses the performance of the Universal Coverage Scheme. As a financing agency, the Scheme is subjected to close financial monitoring by the Office of the Auditor General of Thailand. Finally, performance reports and audited financial statements are reported to the Cabinet and the Parliament and published in the *Royal Gazette*.

IMPACT ANALYSIS⁶

INCREASED ACCESS TO CARE

After implementation of the universal health-care scheme, the proportion of insured people accessing health facilities rose from 65 per cent in 1996 to 71 per cent and 71.6 per cent in 2003 and 2004, respectively. Further analyses showed that the outpatient utilization rate slightly increased (table 4). The utilization rate of both periods should be analysed separately owing to the different methodology of the survey in 2003-2005 and in 2006-2007.

At the inception of the Universal Coverage Scheme in 2001, its beneficiaries were not entitled to receive antiretroviral drugs for AIDS treatment and renal replacement therapy. However, the triple-drug antiretroviral therapy (ART) as a standard of care for people living with HIV and AIDS has been integrated

⁶Further discussion of the impact of the Universal Coverage Scheme on the establishment of a social protection floor is contained in case study 18 under "Joint Impact of the Universal Coverage Scheme and the 500 Baht Universal Pension on the Establishment of a Social Protection Floor".

Table 4 | Use of health services, by number of visits per member, 2003-2007.

	2003	2004	2005	2006	2007
Outpatient utilization (visit/members)					
Civil Service Medical Benefit Scheme	3.48	3.41	3.50	3.12	4.02
Social Security Scheme	1.92	1.96	1.53	1.29	1.87
Universal Coverage Scheme	3.48	3.66	3.50	2.34	3.40
Inpatient utilization (visit/members)					
Civil Service Medical Benefit Scheme	0.10	0.14	0.13	0.09	0.11
Social Security Scheme	0.06	0.07	0.05	0.07	0.07
Universal Coverage Scheme	0.09	0.09	0.08	0.09	0.09

Source: National Statistical Office, Health and welfare survey 2003-2007.

into the benefit package of the Scheme since 2006. In addition, since 2007, beneficiaries of the Universal Coverage Scheme have had access to chronic hemodialysis, continuous ambulatory peritoneal dialysis and renal transplantation.

INCREASED QUALITY OF CARE

The Universal Coverage Scheme supports the "real" concept of primary health care according to which people themselves become the key actors and become actively involved in improving their own health, with the close support of health personnel. Community committees have been established that are financed by the Scheme and local governments. These funds are used for disease prevention, health promotion and management of other social determinants of health according to health problems in each

community. An annual health examination is included in the Universal Coverage Scheme benefit package to screen for health risks and to provide intervention. These activities are operated by health staff and health volunteers in the communities. Community and individual involvement is currently encouraged to supplement the previous top-down approach.

Analysis of the National Health Examination Survey (Aekplakorn, 2010) results revealed that after the introduction of the Universal Coverage Policy in 2002, the percentage of well-controlled hypertension and diabetic patients more than doubled from 2003 to 2008 (table 5). These two diseases are included in the annual screening programme, which follows up with chronic disease management.

Table 5 | Better performance of hypertension patients and diabetic control (as a percentage).

	2003-2004	2008-2009
Hypertension among those age 15 years and above		
Prevalence of hypertension (systolic blood pressure ≥ 140 or diastolic blood pressure ≥ 90 mm)	22.1	21.4
• Never been diagnosed	71.4	50.3
• Being diagnosed but not treated	4.9	8.7
• Getting treatment but uncontrolled	15.0	20.1
• Getting treatment and well controlled	8.6	20.9
Diabetes among those age 15 and above		
Prevalence of diabetes (fasting blood sugar > 126 mg/dl)	6.9	6.9
• Never been diagnosed	56.6	31.2
• Being diagnosed but not treated	1.8	3.3
• Getting treatment but uncontrolled	29.4	34.9
• Getting treatment and well controlled	12.2	30.6

Source: National Health Examination Survey 2003-2004 and 2008-2009.

CHALLENGES AHEAD⁷

EXPANSION OF COVERAGE TO OTHER PEOPLE LIVING IN THAILAND

Minorities who live in border areas of Thailand and are unidentified nationals were excluded from universal health-care coverage although the Cabinet has just approved a budget to provide medical care for this group. There are also other foreigners living in Thailand who are still not covered. This group is more complicated since some are illegal migrants.

ESTABLISHMENT OF A SYSTEM OF GOVERNANCE AT THE NATIONAL LEVEL AND ALIGNMENT OF THE PLURALISTIC SYSTEM

Thailand must establish a governance body to provide policy direction to the health-care system. Health-care financing also must be harmonized. A single-payer system is not possible. Many countries with universal health-care coverage have many insurance schemes, which are harmonized under the same revenue collection and their payment mechanism is overseen by the appropriate system of governance.

⁷Further discussion on challenges for the Universal Coverage Scheme and the 500 Baht Universal Pension Scheme as well as lessons learned applicable to other countries are available in case study 18 under “Common Challenges for the Universal Coverage Scheme and the 500 Baht Universal Pension Scheme” and “Key Factors for Replication (South-South Cooperation)”.

INEQUITY FROM THE SUPPLY SIDE

Unequal distribution of health-care facilities among rural and urban areas or among

regions still exists (table 6), and it affects people’s access to care. Distribution of health personnel is also different between Bangkok and rural regions.

Table 6 | Health facilities, by region.

Region	Number of Health Centres	Public hospitals		Private Hospitals		Total		Population-to-bed Ratio
		Number	Beds	Number	Beds	Number	Beds	
Northern	2,228	216	20,314	50	3,944	266	24,258	1:498
Northeastern	3,464	318	26,752	42	2,801	360	29,553	1:740
Central, excluding Bangkok	2,556	266	47,050	105	9,066	371	39,735	1:388
Bangkok		43	47,051	89	12,711	132	29,092	1:223
Southern	1,510	177	15,327	32	2,042	209	17,369	1:498
Total	9,758	1,020	156,494	318	30,564	1,338	140,007	1:468

Source: Health Resources Survey Report, Bureau of Policy and Strategy, Ministry of Public Health, 2007.

INADEQUATE MEDICAL PERSONNEL

Owing to increasing work demands, lack of incentives and more opportunities in the private sector, health-care personnel, particularly physicians, have left rural care facilities. This situation has an adverse effect on social health-protection schemes, which depend mainly on public health-care facilities.

- ii WHO, Global Health Observatory, 2008.
- iii WHO, UNICEF, UNFPA and World Bank, Global Health Observatory, 2005.
- iv World Bank, *World Development Indicators 2008* and *Global Development Finance 2008*.
- v Ibid.
- vi Labour Force Survey, National Statistical Office, December 2010.
- vii Informal Sector Labour Force Survey, National Statistical Office, 2010.
- viii Ibid.
- ix UNDP, *Human Development Report 2009*.
- x World Bank, *World Development Indicators 2008*.

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For information on the references, see the bibliography for case study 18, “The 500 Baht Universal Pension Scheme”.

ⁱ Estimate by National Economic and Social Development Board (NESDB), 2010.

500 Baht Universal Pension Scheme

Thaworn Sakunphanit
Worawet Suwanrada

18

Thailand

Summary¹

Target group:	Every elderly Thai person (60 years of age or older) who is not in elderly public facilities or does not currently receive income permanently (i.e., government pension recipients, government employed persons).
Target population:	6.87 million (approximately 95% of the elderly); Number of registered elderly: 5.65 million (82.2% of target population).
Benefits:	In-cash benefits, 500 baht (31.4 constant 2005 PPP \$) per month.
Delivery process:	In principle, the elderly or the authorized representative must register with the local authorities where he or she has inhabitancy registration. The qualified recipients can choose among four methods: <ul style="list-style-type: none"> • to receive cash directly from the local authority office; • to designate an authorized representative to receive cash directly from the local authority office; • to have the pension transferred to the elderly person's bank account; • to have the pension transferred to a bank account of an authorized representative. However, the elderly must bear the fee for the bank-account transfer if they do not have a Krungthai Bank account.
Total expenditure (fiscal year 2010):	33,917 million baht or 2,129.1 constant 2005 PPP \$ (approximately 0.37% of GDP).
Source of funding:	General tax revenue.

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¹More detailed information on the socio-economic context of Thailand is available in case study 17 under "Socio-economic Context".

THE NEED FOR THE NEW PUBLIC PENSION SYSTEM

It is no exaggeration to say that various factors are forcing the Government of Thailand to consider designing a new public pension scheme. As mentioned in the case study on the Universal Coverage Scheme, Thailand is currently in the process of demographic change towards an ageing society. The National Economic and Social Development Board (NESDB) projected that the elderly population (those 60 years of age or older) will increase gradually and exceed 20 per cent in 2023 and that in 2030 the potential support ratio will drop to 2.52 (NESDB, 2007). The 2007 Survey of the Older Persons in Thailand by the National Statistical Office found that the main source of income for the elderly is financial support from their children. Nevertheless, the reduction of fertility rates may change this trend in the near future.

Among Thai people, the changes have started to raise public awareness about financial preparation for old-age livelihood. In the opinion poll, "Knowledge and Attitude toward the Elderly", conducted among 18-to-59-year-olds nationwide through the cooperation of the National Statistical Office, the Ministry of Social Development and Human Security, and the College of Population Studies of Chulalongkorn University in 2007, approximately 95 per cent of respondents said that financial preparation was crucial to prepare for old age. Unfortunately, this poll found that

42.4 per cent of respondents had not started to prepare financially or had not yet thought about their old-age years.

Theoretically, a public pension could – if well equipped – make up for the elderly's lack of private resources. Thailand had various types of formal income-maintenance systems that provided financial support to the elderly; regrettably, such systems were not available to all elderly people before the introduction of the 500 Baht Universal Pension Scheme. There were compulsory and contributory public pension systems only for private and public employees. Those systems were the Social Security Fund (private employees; contributory system), the Government Pension Scheme (for central and regional government officers financed by the national budget and by contributions), the Local Government Officers Pension Scheme (local authorities; non-contributory system), Private School Teachers and Headmasters Mutual Fund (private school teachers and headmasters; contributory system) and Public Enterprise Employees Pension Scheme (public enterprise employees; a mostly contributory system in the form of a provident fund, with employees required to save a certain portion of monthly wages and employers contributing on top of that) (Chandoevit, 2006 and Suwanrada, 2009). For the rest of the working population, there was no pension scheme. If necessary, they could access a means-tested old-age allowance system, which preceded the 500 Baht Universal Pension Scheme.

The lack of coverage and accessibility in the public-pension system caused

widespread requests for the reform of the current public pension system or the introduction of a new system. In addition, Part 9 of the Constitution of the Kingdom of Thailand B.E. 2550 (2007), is entitled "Rights to Public Health Services and Welfare from the State", thereby recognizing the State's role in upholding social rights. Furthermore, the Constitution contains "Directive Principles of Fundamental State Policies". Both parts concern the grand design of a future public pension system and have been clearly written, respectively, as shown by the following excerpts:

Constitution of 2007, Part 9, Section 53. A Person who is over sixty years of age and has insufficient income shall have the right to receive dignifiedly public welfare, public facilities and proper aids from the State.

Directive Principles, Section 84(4). The State shall pursue directive principles of State policies in relation to economy to provide savings for the people and State officials for their living in old age".

SOCIAL DEBATE PRIOR TO THE INTRODUCTION OF THE 500 BAHT PENSION SCHEME

In order to extend the coverage of old-age support to the rest of the population, there are three policy options. The first is to change the existing means-tested old-age allowance scheme to a universal-pension scheme, financed through taxes. The second policy option is to establish a new

contributory public pension scheme. The third policy option is the promotion of the so-called Community-based Social Welfare Fund. This option can theoretically be regarded as a privately provided (or initiated) pension system. This section will cover the main points pertaining to the second and third options.

ESTABLISHMENT OF A NEW CONTRIBUTORY PUBLIC PENSION SYSTEM

To date, the establishment of a new contributory public pension system has been proposed in many forms. Until the proposal of the so-called National Pension Fund, the Ministry of Finance used to promote a defined contribution scheme called the National Provident Fund, which would force employees to save more. This scheme also expected high-income groups in informal sectors to voluntarily participate. Nevertheless, this proposal has been criticized and is still pending because it does not focus on medium- or low-income groups, which constitute the majority of the population without formal old-age income-maintenance tools.

Recently, Thai academics conducted many studies, which were supported by the Thailand Research Fund, the Thai Health Promotion Fund or the Foundation of Thai Gerontology Research and Development Institute (see Pananiramai, 2003; Chandoewit, 2006; Khamnuansilpa et al., 2006; Patamasiriwat, 2007; Suwanrada, 2008b; Chandoewit et al., 2008; and Suwanrada, 2009). The studies looked at maintaining the means-tested

old-age allowance system for the initial elderly cohort (especially for the truly underprivileged elderly) during the transition period and establishing a contributory pension scheme for the rest of the working population. Moreover, in these studies, the central government and/or local authorities give financial support to the poor. In addition, local authorities are proposed as the node of contribution collection. Among the reasons why many academic researchers prefer a contributory pension to a universal pension are the following: pensioners can be self-reliant and maintain their dignity as opposed to begging from the government; resources are allocated to the truly unprivileged elderly rather than being allocated equally; there are concerns about increasing the financial burden on future generations affected by the drop in fertility; and there is the matter of the budget capacity of the Government.

From 2006 to 2008, these studies were presented many times not only in academic forums but also in broad public forums in which many stakeholders participated, including academics, central and local government officers, practitioners, NGOs, politicians, community representatives and general participants. In addition, in the Elderly Council Congress 2008 in April 2008, participants agreed to the policy option of establishing a contributory pension scheme for the rest of the population. The National Elderly Committee also approved, in principle, the introduction

of this policy option. The Fiscal Policy Office of the Ministry of Finance relinquished the idea of a National Provident Fund and proposed a National Saving Fund option, which focuses on establishing a contributory pension scheme for the rest of the population. The National Saving Scheme for Old-Age Promotion Sub-committee, which was assigned by the National Elderly Committee, became the platform for brainstorming and revising the Ministry of Finance option.

Finally, after the introduction of the 500 Baht Universal Pension Scheme, in December 2009, the Cabinet of Prime Minister Abhisit Vejjajiva approved the National Pension Fund Act B.E. 25XX,² which aims to establish the additional pension scheme for the working population in the informal sector in addition to the universal noncontributory 500 baht pension. This Act is waiting for parliamentary approval at the Council of the State. This option represents a voluntary, contributory and defined contribution-type pension scheme. The target group of this scheme is the 20-to-59-year-old working population that is not affiliated to any compulsory public pension scheme. The basic contribution is 100 baht (6.3 constant 2005 PPP \$) per month, which is paid at a government Savings Bank or a Bank for Agriculture and Agricultural Cooperatives. The Government adds to the worker's contribution at the level of B50, B80 or B100 per month, depending on the contributor's age. Low-income workers or mem-

²At the time of publication, it had not yet been approved by the Parliament.

bers who cannot afford to pay temporarily can skip the contribution without any penalties. The benefits, in the form of life annuities, will be allocated to the contributors when they turn 60 years old. The level of the pension depends on their contributions. For people with low economic capacity (such as the disabled) who cannot fully contribute, the Government will contribute 50 per cent of the normal rate into their individual account.

PROMOTION OF THE COMMUNITY-BASED SOCIAL WELFARE FUND

In many areas of Thailand – for example, the Songkhla, Lamphang, Trat or Khonkaen provinces or Metropolitan Bangkok – a large number of communities have initiated the so-called community-based social welfare fund. The objective is to solve the lack or inadequacy of publicly provided social welfare services, particularly pension coverage. These schemes provide various types of welfare throughout the life cycle of community members. The benefits often include family support (maternity fee), an education loan, a community business loan, a subsidy for medical expenses and a subsidy for funeral expenses. In some groups, a pension is also one of the special-feature benefits (Suwanrada, 2009). Some Thai practitioners and academic researchers emphasized this scheme as the core for old-age benefit expansion.

Table 1 shows the benefits package of the type found in the community-based social welfare fund in Songkhla (a province in the south of Thailand), which

is known as the Contractual One-Baht Expenses Reduction Group. In principle, members of the scheme will strictly decrease their unnecessary expenditures by 1 baht (0.06 constant 2005 PPP \$) in order to contribute with 1 baht per day. After paying the contribution continuously for 180 days, the member will be eligible for all types of benefits except a pension, which requires a long-term contribution over 15 years. The level of the pension depends on the duration of contribution (table 1). Chob Yodkaew, the founder of this scheme, thinks that everyone can contribute 1 baht per day by cutting unnecessary expenses. Thus, the scheme is friendly even to the poor because of its low contribution rate and its accessibility.

However, Suwanrada (2009) has pointed out limitations to the community-based social welfare fund and particularly its pension benefits. There exists no interregional insurance function because each group is administered under a unified rule but is financially independent without any cross-subsidization across communities. In addition, the financial sustainability of the scheme depends on the internal situation of the communities, such as the number of members, the balance between contributions and benefits, the returns of the fund, and the age structure of the members. There are some community funds that have a large proportion of elderly members due to the attractiveness of the funeral expense subsidy and pensions. Meanwhile, there is no guarantee that younger generations

Table 1 | Benefit package of the community-based social welfare fund in Songkhla Province.

Type	Details	
Maternity pay	<ul style="list-style-type: none"> • For newborn baby: 500 baht per birth (limited to 1,000 baht/year); • For mother: medical expense subsidy of 100 baht/night (limited to 5 nights/birth). 	
Medical expense subsidy	100 baht/night (limited to 10 nights per year).	
Education loan	30% of educational expenses.	
Funeral expense subsidy	2,500 baht-30,000 baht (according to contribution periods)	
	180 days - 2,500 baht	1,460 days - 15,000 baht
	365 days - 5,000 baht	2,920 days - 20,000 baht
	730 days - 10,000 baht	5,840 days - 30,000 baht
Debt clearing for the deceased	Maximum 30,000 baht (limited to debt to local/community savings organization and continuously and punctually repaid debt).	
Savings reward for the deceased	Reward of 50% of the deceased's savings (limited to 15,000 baht and local/community savings organization account; 100 baht monthly paid to the surviving family).	
The needy	Fund will pay contribution as his/her representative.	
Contribution-collector compensation	130 baht/collection time (30 baht will be used as daily contributions of the collector to the fund).	
Pension	300 baht-1,200 baht/month (depending on contribution period)	
	15 years - 300 baht/month	40 years - 800 baht/month
	20 years - 400 baht/month	45 years - 900 baht/month
	25 years - 500 baht/month	50 years - 1,000 baht/month
	30 years - 600 baht/month	55 years - 1,100 baht/month
	35 years - 700 baht/month	60 years - 1,200 baht/month

Note: US\$1 = 32.324 baht (as of first quarter of 2010) and 1 constant 2005 PPP \$ = 15.93 baht.

Source: Table 3, Suwanrada (2009), p. 57.

will participate voluntarily in such areas, potentially harming the long-run financial sustainability of the fund (Suwanrada, 2007). At this stage, Prime Minister Abhisit Vejjajiva's Cabinet made the decision to allocate subsidies for well-

organized groups in order to empower the community-based social welfare funds. Nevertheless, this Government has not clearly emphasized the use of the community-based social welfare fund for pension coverage.

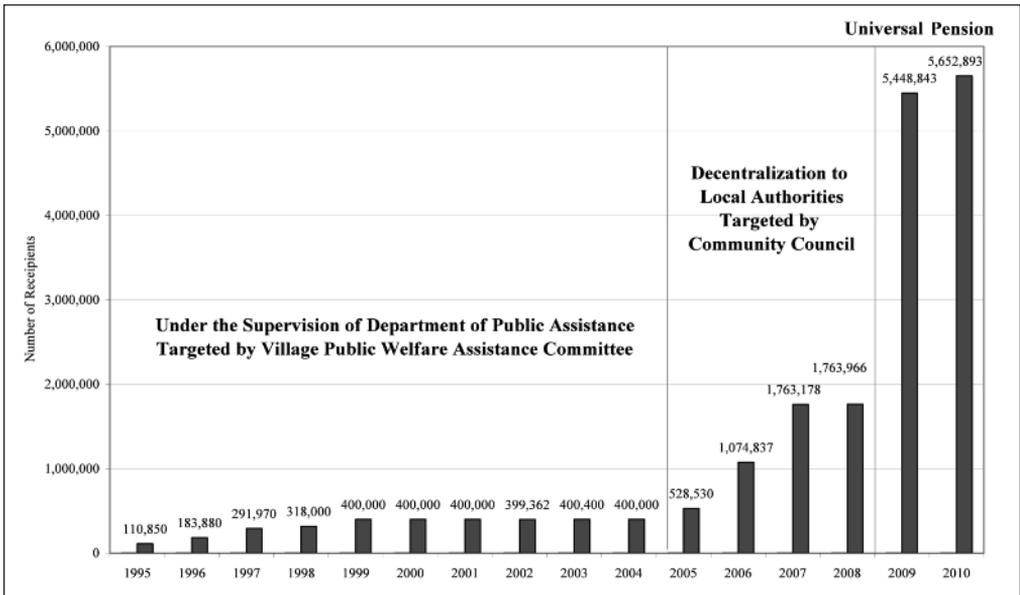
THE PROCESS OF INTRODUCING THE 500 BAHT UNIVERSAL PENSION SCHEME

HISTORICAL BACKGROUND: BEFORE THE UNIVERSAL PENSION SCHEME

The old-age allowance system was established in 1993 in the form of a means-tested system under the aegis of the Department of Public Welfare. The system provided financial assistance to the underprivileged elderly, defined as a person at least 60 years of age with inadequate income to meet expenses, lacking a sup-

porter, or who is abandoned or unable to work. The allowance per person per month was 200 baht or 12.6 constant 2005 PPP \$ (US\$7.90 in 1993). In the beginning, the process of selection was as follows. First, the village public welfare assistance committee had to identify eligible elderly. After that, the selection committee for the provincial underprivileged elderly would recheck the eligibility of the targeted elderly and pass the lists of their names to the provincial governor for official approval. In the first year after the introduction of this scheme, the number of recipients was merely 20,000. In 1995, recipients had increased to 110,850 (see graph).

Number of recipients of old-age allowances after 1995.



Source: Figure 2-1 in Suwanrada and Kamwachirapithak (2007) and Ministry of Social Development and Human Security.

In 2000, the allowance amount increased to 300 baht or 18.8 constant 2005 PPP \$ (US\$7.47) per person per month. In 2002, the rule for targeting the

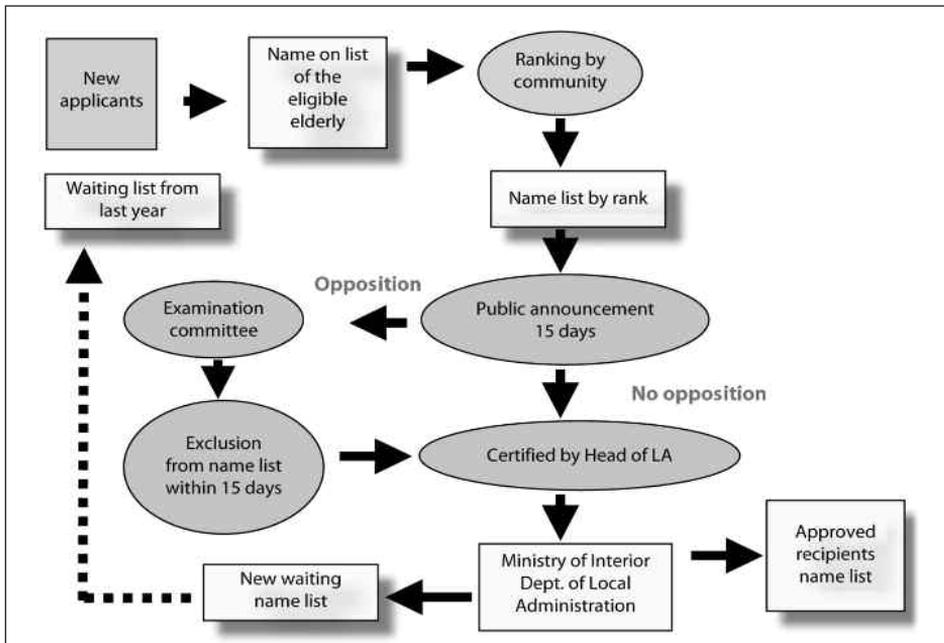
appropriate recipients was revised and priority was given to the elderly in several underprivileged situations or those living in remote areas with minimal public serv-

ices. In addition, the selection committee was diversified in order to include representatives from local authorities, from elderly-related local organizations or from the community.

In 2005, there were significant reforms of the means-tested old-age allowance system. Because of Thailand's decentralization process, the tasks of identifying clients and defining allowance payments were delegated to local authorities through grants from the central government, namely, the Department of Local Administration in the Ministry of Interior (Internal Affairs). The definition of "underprivileged elderly" was maintained. The targeting process (see figure) occurs cooperatively between local authorities and the *prachakom* (community

council). The community ranks the elderly on the new applicant list and the waiting list (from the previous fiscal year). The community councils use a range of methods for ranking, such as ranking the elderly by age, using the majority-voting mechanism, adopting the community committee system, ranking by various characteristics of the elderly, and allocating the allowance to all elderly (Suwanrada, 2009). In addition, local authorities with adequately strong fiscal resources can use their own funding to increase allowances (the total must not exceed 1,000 baht or 62.8 constant 2005 PPP \$ per month) or increase the number of qualified recipients. In 2006, benefits were increased to 500 baht or 31.4 constant 2005 PPP \$ (US\$13.88) per person per month.

Targeting process of the old-age allowance system.



Source: Figure 1 in Suwanrada (2009).

LIMITATIONS OF THE MEANS-TESTED OLD-AGE ALLOWANCE SYSTEM

In practice, there were many limitations to the implementation of a means-tested old-age allowance system. All local authorities had to follow the process that was made clear by the Ministry of Interior Order on Old-Age Allowance Payment of Local Authorities B.E.2548 (2005). However, according to Suwanrada (2009), the local authorities' understanding of the process was extremely diversified. Some allocated the transfer to all elderly without applying any means-tested eligibility criteria while others followed the process strictly. The definition of *prachakom* was also treated differently. Some authorities created a two-tier committee system or cross-check or overview system in order to maintain the transparency and good governance of the selection process. Nevertheless, this did not prevent inefficiency problems from occurring. More than 50 per cent of underprivileged elderly did not receive the old-age allowance, according to the Monitoring and Evaluation Project of the National Elderly Plan by the College of Population Studies, Chulalongkorn University.

The implementation failure forced the Government to go from a means-tested to a universal scheme. The ILO (2004a and 2004b) and Mujahid, Pannirselvam and Doge (2008) also recommended the introduction of such a scheme. The change in government ideology was also a critical factor in the transformation. It was reflected in the

policy speech that Prime Minister Abhisit Vejjajiva delivered to the Parliament at the start of his Cabinet in December 2008 as well as in his opening speech at the Elderly Council Congress 2009 in April 2009, in which he showed concern that the old-age allowance be a right for the elderly and a reward representing gratitude from society.

IMPLEMENTATION OF THE 500 BAHT UNIVERSAL PENSION SCHEME

The 500 Baht Universal Pension Scheme officially started in April 2009, following the decision taken during the meeting of the National Elderly Committee. In the period April-September 2009 (mid-fiscal year 2009), the Government of Thailand allocated additional monies to implement the scheme as one item of an economic stimulus package, using its authority under the Order of National Elderly Committee on Old-Age Allowance Payment B.E. 2550 (2009). For fiscal year 2010 (October 2009-September 2010), the Order of the Ministry of Interior on Old-Age Allowance Payment B.E. 2550 (2009) was launched in October 2009. The source of funding switched to coverage in the annual government budget.

All elderly (60 years of age and older) who are not in elderly public facilities or do not receive permanent income (i.e., recipients of a government pension, government-employed persons) are eligible for the Scheme. In principle, the elderly or their authorized representatives must

register with the local authorities, where they are registered as Residential Inhabitants. The qualified recipients can choose among four methods: (a) to receive cash themselves directly from the local authority office; (b) to designate an authorized representative to receive cash directly from the local authority office; (c) to have the pension transferred to their bank account; or (d) to have the pension transferred to the bank account of the authorized representative. However, the elderly must bear the fee of the bank-account transfer if they do not have a Krungthai Bank account. To dis-

seminate the information on the universal pension, announcements were made by local authorities and a commercial film on free television or an advertising board was used to convince the elderly to register. At the same time, a booklet on the basic rights of the elderly (produced by the Ministry of Social Development and Human Security) was distributed.

As of fiscal year 2010, recipients of the 500 baht pension represent approximately 77.5 per cent of the elderly population. There are still 1.22 million elderly who have not yet registered for the Scheme (table 2).

Table 2 | The elderly and the 500 Baht Universal Pension Scheme.

	Number of Elderly
No. of elderly (as of 30 September 2009)	7,239,755
No. of recipients (means-tested system) (A)	1,872,182
After introduction of universal pension	
- 1st round registration (April-Sept. 2009) (B)	3,576,661
- 2nd round registration (Oct. 2009-Sept. 2010) (C)	204,050
No. of registered elderly (A+B+C)	5,652,893
Government officers	360,679
Unregistered elderly	1,226,183

CHALLENGES AHEAD

As mentioned earlier, the three competing schemes are a concern for the Cabinet of Prime Minister Abhisit Vejjajiva. The Prime Minister has not disregarded any of the proposed options. One big challenge ahead for Thailand is

to clarify the grand plan for the design of the public pension system. Based on the speeches of the Prime Minister, it is possible to sketch the blueprint of his grand design for a future public pension system. The government officers benefit from their own pension system. While the 500 Baht Universal Pension Scheme is going

to become the basic pension and constitute a social protection floor for the elderly, old-age benefits under the Social Security Fund or life annuities from the National Pension Fund will become the first tier for private employees and the rest of the population (excluding government officers).

Currently, there are a few movements that can be expected to promote adjustments among various previously fragmented pension systems. For example, owing to the targeting process, the 500 Baht Universal Pension Scheme is going to be transferred from local authorities to the authority of the central government. In addition, the so-called National Welfare Provision Promotion Committee has been formally established to sketch the grand design of Thailand's social protection scheme.

TOWARDS THE IMPLEMENTATION OF A SOCIAL PROTECTION FLOOR IN THAILAND

JOINT IMPACT OF THE UNIVERSAL COVERAGE SCHEME AND THE 500 BAHT UNIVERSAL PENSION ON THE ESTABLISHMENT OF A SOCIAL PROTECTION FLOOR

Poverty Reduction

An income-security scheme such as the 500 Baht Universal Pension Scheme and the Universal Coverage Scheme contribute to poverty reduction. A study showed the impact of the Universal Coverage Scheme on poverty reduction during the period 2001-2004 (Siamwala & Jitsuchon, 2007). Recent analysis revealed that around 88,000 households

Table 3 | Poverty impact of out-of-pocket payments (as a percentage).

	1996	2000	2004	2008
Pre-payment poverty headcount (A)	14.4	18.6	10.9	8.6
Post-payment headcount (B)	15.8	20.3	11.5	9.0
Poverty impact (difference between post- and pre-payment poverty headcount) (C)	1.4	1.7	0.6	0.5
Poverty impact, increase in % ((C)/(A))	9.9	9.1	5.5	5.4

Source: Limwattananon (2010), Analysis of Health and Welfare Survey (various years).

in 2008 were prevented from falling below the poverty line. Out-of-pocket payment for health care had increased the number of poor Thai households by 9.9 per cent (= 1.4/14.4) in 1996 (table 3).

This figure dropped to 5.4 per cent (=0.5/8.6) in 2008.

Universalism Rather Than Targeting

Thailand is gradually moving from a tar-

getting approach to universalism. For both health and elderly-income allowances, the country previously used a targeting approach because of fiscal constraints. However, there was concrete evidence that the poor were not protected properly and some non-poor received this benefit from both inclusion and exclusion errors.³

An egalitarian approach to providing equal access to necessary health and social services was debated in the 1970s. Two decades later, after the economic crisis, social movements successfully managed to have the concept included in the 1997 Constitution, which led to a universal health-coverage policy in 2002. The efforts of other social movements and further advocacy by the organizations of the elderly pushed the idea of universal elderly income security into the 2007 Constitution. Finally, the current Government announced the 500 Baht Universal Pension Scheme and amended the Elderly Act. Although the allowance amount is not enough to live on in decent conditions, it provides more living security over the old-age time span.

Although mainstream social protection in Thailand is moving towards more egalitarian policies, the balance of social-risk management between individuals and institutions is still a topic of hot debate, especially regarding the pension system. Many affluent groups advocate libertarian or laissez-faire views.

COMMON CHALLENGES FOR THE UNIVERSAL COVERAGE SCHEME AND THE 500 BAHT UNIVERSAL PENSION SCHEME

Infrastructure (Supply Side)

Building health-care infrastructure should be the first step prior to the arrangement of health-care financing for universal coverage. Well-functioning local governments are also needed in order for the universal pension to be successful in an informal economy.

Administrative Capacity

The capacity to design, implement and monitor the system in the specific context must be established and maintained. This is a long-term investment.

Ageing Society

Strategies to ensure healthy and productive older people are needed. Social health protection schemes will help to guarantee access by everyone and actively improve health service benefits in a way that encourages people to change their behaviour towards a healthier lifestyle.

Another issue is long-term care for the elderly who lose their physical capacities and the need for health care and long-term care. Home care should come before institutional care, and the traditional pattern of care within the family must be encouraged as much as possible.

³An inclusion error is one in which benefits reach individuals who were not intended to be beneficiaries. An exclusion error occurs when intended beneficiaries did not receive the benefit.

Financial Sustainability

The Universal Coverage Scheme and the 500 Baht Universal Pension Scheme now depend on general revenue financing through an annual budgeting process. Because of budgetary competition among ministries, the Schemes remain vulnerable to receiving budgets below the actual cost of services. Current taxes are not enough. New taxes are needed.

KEY FACTORS FOR REPLICATION (SOUTH-SOUTH COOPERATION)

Political and System Ideology

Experiences in Thailand have shown that having a political ideology with an appropriate emphasis on social justice is a prerequisite for social policy formulation. Economic development that emphasizes growth and ignores redistribution leads to inequities and social unrest.

Participation of Stakeholders

The interrelationship between civil society, academics and politicians regarding policy is the key to success. Prof. Dr. Prawase Wasi proposed the concept of a "triangle that moves the mountain". The triangle consists of (a) creating relevant knowledge through research, (b) social movement or social learning, and (c) political involvement (Wasi, 2000). This triangular approach was applied successfully during the agenda-setting, policy formulation and policy implementation of the Universal Coverage Scheme and the 500 Baht Universal Pension scheme.

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UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP)

The United Nations Development Programme (UNDP) is the UN's global development network, an organization advocating for change and connecting countries to knowledge, experience and resources to help people build a better life. It is on the ground in 166 countries, working with them on their own solutions to global and national development challenges. As they develop local capacity, they draw on the people of UNDP and its wide range of partners.

World leaders have pledged to achieve the Millennium Development Goals, including the overarching goal of cutting poverty in half by 2015. UNDP's network links and coordinates global and national efforts to reach these Goals. Its focus is helping countries build and share solutions to the challenges of:

- democratic governance;
- poverty reduction;
- crisis prevention and recovery;
- environment and energy; and
- HIV/AIDS.

UNDP helps developing countries attract and use aid effectively. In all its activities, it encourages the protection of human rights and the empowerment of women.

SPECIAL UNIT FOR SOUTH-SOUTH COOPERATION (SU/SSC)

The Special Unit for South-South Cooperation, formerly known as the Special Unit for Technical Cooperation among Developing Countries (TCDC), was established by the United Nations General Assembly within UNDP in 1978. It carries out its United Nations mandate to mobilize international support for sustained South-South cooperation for development.

The Special Unit for South-South Cooperation:

- encourages developing countries to become important providers of multilateral cooperation;
- fosters broad-based partnerships for supporting South-South initiatives;
- supports the efforts of the South to pool the vast resources of Southern countries as a way of achieving common development goals; and
- facilitates South-South policy dialogues.

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THE INTERNATIONAL LABOUR ORGANIZATION (ILO)

The International Labour Organization (ILO) is the international organization responsible for drawing up and overseeing international labour standards. It is the only "tripartite" United Nations agency that brings together representatives of governments, employers and workers to jointly shape policies and programmes promoting Decent Work for all.

The ILO is devoted to promoting social justice and internationally recognized human and labour rights, pursuing its founding mission that labour peace is essential to prosperity. Today, the ILO helps advance the creation of Decent Work and the economic and working conditions that give working people a stake in lasting peace, prosperity and progress. Its tripartite structure provides a unique platform for promoting Decent Work for all women and men. Its main aims are to promote rights at work, encourage decent employment opportunities, enhance social protection and strengthen dialogue on work-related issues.

Since its creation in 1919, the ILO has actively promoted policies and provided assistance to countries to supply adequate levels of social protection to all members of society. The mandate to work for universal access to an adequate level of social protection was re-affirmed in the Declaration of Philadelphia on the aims and purposes of the ILO. The ILO Social Security Department, with its long experience in the field of technical cooperation activities, research and policy development in the area of social security, provides ILO constituents with tools and assistance to achieve and maintain the human right to social security anchored in various ILO conventions and international labour standards. In April 2009, the ILO and WHO were jointly entrusted to lead the United Nations Chief Executives Board Social Protection Floor Initiative. The Social Security Department carries out the ILO work in relation to this initiative.

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THE GLOBAL SOUTH-SOUTH DEVELOPMENT ACADEMY

The Special Unit for South-South Cooperation has committed to transforming, consolidating and institutionalizing its current programme activities into integrated, mutually reinforcing components of an architecture that supports multilateral South-South cooperation. It is doing so by introducing an innovative approach aimed at strengthening social and economic cooperation among developing countries and the sharing of knowledge and best practices with the goal of actual transfers. The Special Unit is building this 3-in-1 architecture as a key contribution to the implementation of its fourth cooperation framework for South-South cooperation (2009-2011), guided by the vision of its director, Mr. Yiping Zhou. This architecture has the following three interlinked components:

1. The Global South-South Development Academy (GSSDA): to enable development partners to systematically identify, document and catalogue Southern development solutions for subsequent validation and mutual learning;
2. The Global South-South Development Expo (GSSD Expo): to enable development partners to showcase successful, scalable development solutions for visibility to the broader international development community in order to obtain feedback and build partnerships; and
3. The South-South Global Assets and Technology Exchange (SS-GATE): to enable development partners to list the most scalable solutions and technologies for partnership-building, resource mobilization and actual transfer.

The GSSDA is a platform for knowledge production, management and sharing for human development solutions. It offers knowledge products and tools to enable partners to research, document, publish and learn about effective practices. Among its many elements, the GSSDA includes a network of focal points; how-to training materials such as manuals, e-courses and workshops; rosters of experts; and publications. The knowledge produced, refined and catalogued through this platform will serve as the stepping stone to the other components of the architecture.

(continued from previous page)

The GSSD Expo is a marketing platform for showcasing Southern solutions to facilitate and promote their dissemination and replication. It focuses on presenting proven development solutions through poster and booth presentations at an annual exhibition. In addition, the GSSD Expo includes forums, round tables and an award competition for innovative development solutions in order to promote best practices and encourage and facilitate their transfer and replication.

SS-GATE is a transactional platform that enables the listing of Southern technologies and development solutions as proposals for social investment. It operates as an open, market-driven mechanism to attract social investment via coordinated but independent tracks to capitalize on different market segments with their distinctive dynamics and players. Current transactional tracks in the design, pilot or operational stage include:

- Track 1 – Technology Exchange: to increase trade of assets and technology among Southern countries and global markets. Phase: operational;
- Track 2 – Human Development Investment Exchange (HDSX): to focus on social investment that will scale up successful development practices in Southern countries. Phase: design;
- Track 3 – Creative Economy Exchange: to increase trade of creative products and services among Southern countries and global markets. Phase: design; and
- Track 4 – New Energy and Energy-saving Technology Exchange: to facilitate the exchange of new energy and energy-saving technology among Southern countries and global markets. Phase: pilot.

With this novel architecture, the Special Unit is offering a service platform that can strengthen social and economic ties among developing countries and capitalize on best practices with the goal of their actual transfer.



Participants in the international workshop on the social protection floor organized by the UNDP Special Unit for South-South Cooperation and ILO at the ILO International Training Centre in Turin, Italy, in July 2010.



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