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Health care privatization processes in Europe: Theoretical justifications and empirical classification

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Abstract  This article analyses the health care system reform process in Europe based on the concept of privatization. This notion is understood from two perspectives. First, privatization may concern the health care financing or the provision of health services. Second, privatization can be “imposed” on individuals or be “internalized” and then introduced by individuals (patients and doctors). So we emphasize the diversity that privatization can assume. We classify privatization mechanisms used by different countries and identify which of the perspectives presented are more common in 14 European Union countries since the 1980s. The article shows that even if privatization processes are widespread, they assume different patterns in each country.

Keywords  health policy, privatization, social security administration, Europe

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Preliminary versions of this article were presented at the seminar on the political economy of health care in June 2014, at the Fourth Congress of the French Association for Political Economy (Association française d’économie politique) in Paris in July 2014, at the colloquium on research and regulation in Paris in June 2015 and at the Social Economics Association Days at Bobigny in September 2015. Our thanks to the participants at the various sessions and, in particular, to Philippe Abecassis, Nathalie Coutinet, Jean Paul Domin, Maryse Gadreau and Christian Léonard as well as to the anonymous referees.
Health systems in Europe are characterized by a growing and complex collection of arrangements that seek to address a variety of problems. It is difficult to reduce these arrangements to a common objective. While a central motivation of health policies is managing the public budgets allocated to health care, this is also accompanied by the desire to reduce health care inequalities and to improve the organization and operation of health care systems. The means employed can also vary according to the features of the health systems. The indirect promotion of private insurance that is observable in all countries should be seen as being different from the hospital reforms that have also been implemented widely. While it is common to emphasize the national specificity of health care reforms and the role of “path dependency”, similar tendencies can be identified concerning the introduction of market mechanisms in social policies that support solidarity through the promotion of entrepreneurial behaviour with regard to both supply and demand (Saltman, 2002). Developments such as the withdrawal of statutory public insurance schemes, the introduction of incentive systems for both patients and doctors and the strong presence of “New Public Management” are often synthesized into concepts such as “commodification”, “marketization” or “neoliberalism”. While these terms are of great political significance, they are frequently polysemic and sometimes poorly defined (commodification in the Marxist sense is not at all the same as that put forward by Esping-Andersen (1990), for example).

In this article we propose to develop the concept of privatization to describe the new situation. This concept, which will be refined and clarified here, appears to us to be capable of analysing the changes taking place in two different directions:

- **Intra-country comparison.** If, as we highlight, the reform taking place in health insurance in various countries is by nature different from that in the hospital sector, it must be possible to identify a common cognitive framework for analysing the various processes. The notion of privatization, as we define it, seeks to meet this objective.

- **Inter-country comparison.** National approaches and the identity of health systems lead to change that is, at one and the same time, specific and local. Nevertheless, this change has to be able to submit to analysis with common driving elements in the various European countries. What we are seeking to define, therefore, is the diversity in privatization approaches as local versions of a generic form of privatization. Health care privatization French style is different from that observed in Germany or the United Kingdom, but these privatizations share common characteristics that we seek to bring out.

In what follows, the first section presents our concept of privatization which designates the dynamics of a reform where that which was previously public has
become private. What is highlighted is diversity in privatization that meets this generic definition, both in terms of financing health care and its delivery. Our health care privatization mapping is underpinned by an analysis of schemes, in the first instance mainly of France. The second section uses this mapping to position health care reforms in 14 countries of the European Union (EU). These countries are classified according to the use they make of various privatization processes. The material used for this classification consists of a historical overview of the development of health care systems and the use of legal texts and data series over 30 years, sourced from the Organisation for Economic Co-operation and Development (OECD), World Health Organization (WHO) and Eurostat.

Privatization diversity

Privatization mapping

In the widest possible sense, the concept of privatization reflects a legal status designating a type of property, often associated with the pursuit of profit. Privatization therefore designates the transfer of legal property from the public to the private domain as observed for certain public enterprises. This strict definition is unsuitable for the health care sector. First, because such privatizations are rare (they can be seen in Germany and, to a lesser degree, in Sweden and Austria). Furthermore, the notion of the private sector in health care is ambiguous, since there are profit-making and non-profit-making private organizations. Most often, non-profit-making organizations are subject to the same legislation or regulations as the public sector. In the health care sector, differences between what is public and what is private cannot thus be reduced to legal property entities or real estate entities or facilities. Privatization also covers modes of governance and types of financing.

We also propose to designate by the term privatization, the organization of any transfer from the public to the private sector under the various forms envisaged above.

In France as in Europe, health care is an increasingly privatized sector (Maarse, 2006; André and Hermann, 2009; Angeli and Maarse, 2012; André, 2015). This trend is not in contradiction to the role of the State in health care systems and the reinforcement of this role in numerous countries, particularly in France. On the contrary, it is public authorities that drive privatization processes.

Furthermore, the concept of “private” applies not only to private institutions in the health care sector such as private insurance schemes or private clinics which have won new prerogatives in health care financing and delivery. Privatization is also defined by a certain way of conceiving how actors behave. When doctors and patients are encouraged to think about health in terms of a private good, privatization becomes a frame of mind. “New Public Management” is, by example, also moving in this direction.
We propose to present an overview of this diversity in privatization using two aspects:

- The goal of privatization which may concern the financing or delivery of health care.
- The process of a privatization which may be imposed on those individuals affected by it or which can be driven by the individuals themselves and be presented as a form of governance. We will designate the first type of privatization as “imposed privatization”. Individuals must therefore submit to new rules of the game which privatize health care. The second type of privatization acts like an induced rationality that may be considered as normal behaviour or a way of thinking. We will therefore use the term “incorporated privatization”.

Figure 1 presents a synthesis of this plurality of privatization and the subsequent sections will underpin them using the case of France (Batifoulier, 2014).

The development of private health insurance and the increase in direct payments for households

The development of private health insurance (Figure 1, north-west quadrant) is a general phenomenon in Europe. This trend is part of the view of social protection as a cost for public finances and aims at reducing public health care expenditure,

1. It aims at “actively playing on the space for liberty left to individuals so that they come to conform to certain norms by themselves” (Dardot and Laval, 2009, p. 15).
but not necessarily reducing health care expenditure overall if this can be financed using a private operator or directly through households themselves. Shifting costs onto households is also supposed to make the patient aware of the cost of health care (Léonard, 2012).

The aim here is to transform obligatory public contributions into obligatory private contributions to the extent that health care costs are costs that fall on households. The fact of having a *mutuelle* available (i.e. being affiliated to a complementary mutual health fund) is not seen as a luxury, but a necessity if individuals have the means to pay contributions.

Such privatization also rests on the increase in the direct financial contributions patients are required to make. Patients are called on to meet a rising part of health care costs in the form of co-payments, flat-rate fees or deductibles. These mechanisms referred to as “cost-sharing”, which are imposed on patients, are not specific to any particular social protection model or given era. Making the patient pay has become a regulatory model in all countries even if it is more accentuated in certain countries such as France.

In France specifically, the regulatory model is that of transferring the public insurance burden (social security) onto supplementary health care insurance operators (*mutuelles*, insurance companies and insurance institutes) rather than a move towards direct payments from households not refundable from health insurance schemes or supplementary insurance schemes. The direct costs or “balance payable” is 9 per cent in France against 11 per cent in the United Kingdom, 13 per cent in Germany, of the order of 20 per cent in Belgium, Italy and Spain or even more than 30 per cent in Switzerland according to the basic figures from OECD Health Data (2010). These figures mask a more negative reality for French patients, however. While direct patient payments are low on average, they have risen since 2004 and are particularly high for non-hospital and general practitioner medical services. This movement also camouflages a move towards increased public

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2. The co-payment (or co-insurance arrangement) represents a percentage of health care costs and is widely used for consultations with general practitioners and specialists as well as for medicines in France, Belgium or Switzerland. It is widely used in Germany for medicines (there is also co-insurance cover for hospital stays, ambulance transportation and the first local consultation (Busse and Blümel, 2014). Flat-rate fees correspond to fixed initial costs, which are frequently used for hospital stays. Deductibles represent an annual threshold before reimbursement starts to operate; this is particularly widespread in Switzerland and the Netherlands and also in Sweden for reimbursable medicines. They have recently started to appear in France in connection with flat rates for medicines and medical transportation costs; full reimbursement becomes operational once an annual threshold of EUR 50 has been reached. Deductibles are very widely used in the United States both for private insurance schemes and the public Medicare programme.

3. On international comparisons, see Reibling (2010), Montanari and Nelson (2013), and Quesnel-Vallée et al. (2012).

4. “Co-payment” refers to that which is not covered by the public insurance scheme and “balance payable” that which is covered neither by the public insurance scheme nor a private insurance scheme.

payments for patients with chronic health problems but reduced payments for the “average patient”. Reimbursement for routine health care (excluding hospital and long-term illnesses) sits at about 55 per cent in France. For this type of health care, complementary insurance schemes are no longer really complementary and widely form the dominant type of cover in sectors such as ophthalmic care, where the public share is 4 per cent. If the relative insurance role of social security is shrinking overall, what we are currently witnessing is a health insurance meltdown with regard to routine care. Given that this is the type of care most demanded by the majority of the population, the scale of privatization is, in fact, extremely large. Furthermore it is routine care that the poorest decide to forgo given the associated financial barriers to access (Batifoulier, 2013).

The abandonment of public service

Privatization also concerns health care delivery. Here, public authorities have delegated a certain number of tasks incumbent upon them to private actors. This privatization by transfer of competence (north-west quadrant) is imposed on patients and is rarely the subject of democratic debate. An emblematic example of this type of strategy is the transfer of the public service mission to private hospitals. The legislation governing “Hospitals, Patients, Health and Territory” (Hôpital, Patient, Santé, Territoire – HPST) in 2009 removed the public hospital service and replaced it by the idea of public service missions, which could be variously attributed to public hospitals, private not-for-profit establishments or for-profit clinics which would then contract with Regional Health Agencies (Agences régionales de la santé). The very notion of public service becomes a means of developing competition given that the public hospital no longer has a monopoly and operators compete for public service missions. While the notion of public service was re-established in 2012, in the case of hospitals, the HPST legislation of 2009 opened health centre management up to private operators. The traditional model of the municipal health centre is now gradually giving way to the “low cost” health centre focused on profitability,6 in a context where the budgetary difficulties of local authorities force them to delegate to the private sector.

The private sector takeover of activities entrusted to the public sector has come as a result of budgetary constraints expressly sought by the public operator. This organized penury obliges recourse to private operators through the outsourcing of work or invitations to tender. These privatizations can be termed implicit when they are induced by the reduction in sources of public financing.

6. The former model has salaried medical practitioners, while the latter has re-established “fees for service”, which is more in keeping with the principles of liberal medicine, a stance which is deemed unacceptable by salaried medical practitioners.
Another strategy consists of allowing private medicine to organize access to health care which was originally a prerogative of public authorities. In France local access to primary health care has been completely abandoned to private medicine. Young medical practitioners enter into practice in the same areas where there are already more senior doctors thus increasing the density of medical provision in these areas. Furthermore the shortage of doctors in other areas will increase since doctors seeking to retire cannot find replacements to take on very large lists of poor patients. This process will continue by virtue of the fact that young doctors aspire to a new medical model based on quality of life not on longer working hours, on the wish to enter a group practice rather than work alone, or even the progressive refusal to go into private medical practice, which would require lengthy negotiation with banks for those without sufficient private wealth. While these demands may be legitimate they nevertheless contribute further to the dearth of doctors in certain regions.

Inequalities in access to health care add to many other inequalities: the most socio-economically disadvantaged areas also have less access to doctors. Unemployment and poverty, lack of public transport, loss of the local school or post office go hand in glove with the absence of a doctor. Given that the health divide widens the social divide, the fight against “medical deserts” is a priority that goes far beyond health care.

Patients adopt entrepreneurial behaviour

Privatization can also act in a more diffuse way by changing from the inside the doctor-patient interaction that is at the heart of the medical relationship. Thus, in order to finance their health care, patients may develop strategies that lead them to modify how they view the health care system. Voluntarily, as private agents, they may act as self-motivated entrepreneurs promoting their own interests (south-west quadrant). Viewed as informed consumers (and not as anxious patients), patients are solicited so as to ensure competition, a process which not only reflects social inequalities but reinforces them.

Thus the development of fees in excess of tariffs has led patients to look for information about prices. Phoning a doctor’s practice to ask about fees or looking for information on a health insurance company’s web site is a new sort of behaviour based on consumer logic. Wherever prices have risen as a result of disengagement on the part of public insurance schemes (ophthalmic, dental and auditory services), patients are encouraged to compare prices or shop on the Internet (as they do for spectacles). The development of fees in excess of tariffs in hospitals leads to patients having to choose between a less expensive medical consultation, at the social security tariff – but in six months’ time – or a rapid consultation with the same doctor.
but at a higher price. Strategies introduced in hospitals to charge for certain services (single room, television, etc.) leave patients with “free choice”. On a different note, the mainstream media very regularly publishes hospital league tables which have a large readership (thus ensuring advertising revenue for publishing groups). Comparing hospitals encourages competition among establishments.

Privatization by the private sector colonizing the public sector

Integrated privatization in health care delivery (south-east quadrant) involves care providers, particularly in public hospitals. Hospitals are experiencing only a moderate level of privatization in health care financing, since public reimbursement rates remain high. In France public hospitals have not changed their legal status, whereas in Germany public hospitals have been bought up by private clinic chains. The privatization is different. It rests on the ability of the public sector to absorb private sector rules.

This type of privatization is driven by a constructivist project that calls for a particular way of thinking. It is based on New Public Management (NPM) tools. NPM is presented as a sort of universally-transferable neo-Taylorism. This is why there is little difference between its application in universities or hospitals. It attempts to reformulate all problems as organizational problems. Re-organization of medical work is done in the name of achieving gains in productivity. The fundamental hypothesis is that room for improvement exists at actor level to achieve the best possible results with the same budgetary resources.

Political arguments give way to technical presentations aimed at automating public decision-making. The notion of performance is extremely important in this regard, to the extent that it is associated with making a judgement about effectiveness based on statistical indicators. Thereafter, qualities are transformed into quantities, thus making it possible to count and present the work of a care-giver as a set of indicators. Under this approach hospitals then fall prey to organizational consultancy firms and public agencies which will then implement the performance approach using techniques taken from industry (Mas et al., 2011). “Lean management”, taken from Japanese industry, seeks to put a stop to wastefulness and enjoys great popularity with management advisors who are proud of knowing nothing about hospitals because “good management” knows neither limit nor place: it being universal. The race for productivity takes the form of the optimization of places (i.e. beds) or of periods and usage times for operating theatres. Staff are invited to be trained in this “performance-based” management – the definition and

7. In France, some of these procedures are driven by the Public Agency for Performance Improvement and Support (Agence nationale d’appui à la performance des établissements de santé et médico-sociaux – ANAP).
evaluation of which in the health care sector is particularly problematic (Da Silva and Gadreau, 2015) – as a requirement to take advantage of results-based bonuses that are awarded (this is particularly the case for hospital directors).

A results’ culture is set against a culture of public service where the obligation to commitment and resources is pitted against the obligation to achieve results. This is the sought-after aim; namely, to run hospitals under the same terms of reference as private enterprises. This rampant privatization impacts staff who often resist. There is, however, a pronounced aberration in the face of these calls for reform, the latter also being accompanied by staff who pass themselves off as actors for change. Some health care providers are able to benefit from this situation, either in the literal sense (creating space for lucrative activities in hospital is an attractive option for some), or in the figurative sense (creating rifts among various staff categories, such as doctors and nurses, or various medical specializations).

European privatization dynamics

In this section a number of European countries are classified according to various privatization processes. What we are comparing here are privatization changes, not levels of privatization in 14 countries of the EU–15. These countries have relatively similar economic development levels and social, political and cultural characteristics based on their membership of the EU. The study covered the period from 1980 until recent years.

Table 1 shows the main measures associated with the various privatization forms for each of the two dimensions, finance and health care delivery.

With regard to health care financing, country classification is mainly based on trends in direct household payments and private insurance payments (variations on 1980–2010) as well as on new measures adopted between 1980 and 2014, corresponding to quadrants 1 and 3. Regarding health care delivery the focus is more on the trend in the percentage of public expenditure overall (variation on 1980–2010) and new measures adopted between 1980 and 2014, for quadrants 2 and 4. It is important to point out that only changes judged to be the most important by virtue of their newness, the effectiveness of their application and the extent of their effect have been taken into account.

8. EU–15: Austria (AT), Belgium (BE), Denmark (DK), Finland (FI), France (FR), Germany (DE), Greece (GR), Ireland (IE), Italy (IT), Luxembourg (LU), the Netherlands (NL), Portugal (PT), Spain (ES), Sweden (SE) and the United Kingdom (UK). Here, Luxembourg has been excluded since it has, given the size of its revenues, established health and social services which receive significantly higher financing than other European countries. Luxembourg occupies a position far removed from these other countries.
Table 1. *The various forms of privatization*

<table>
<thead>
<tr>
<th>Health care financing</th>
<th>Health care delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Imposed privatization</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Quadrant 1</strong></td>
<td><strong>Quadrant 2</strong></td>
</tr>
<tr>
<td><em>• Transfers from public insurance to private insurance, increase in direct patient payment.</em></td>
<td><em>• Creation of new private services.</em></td>
</tr>
<tr>
<td><em>• Growth of private insurance brought about by growth of private health care services as a result of deficiencies in public services (&quot;privatization&quot; through (voluntary) State deficiency).</em></td>
<td><em>• Transformation of &quot;not-for-profit&quot; into &quot;for-profit&quot; (commercialization).</em></td>
</tr>
<tr>
<td><em>• Public-Private Partnership (PPP) for financing public hospitals with private funds.</em></td>
<td><em>• Purchase of public hospitals by private funds.</em></td>
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<tr>
<td><strong>Incorporated privatization</strong></td>
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<tr>
<td><strong>Quadrant 3</strong></td>
<td><strong>Quadrant 4</strong></td>
</tr>
<tr>
<td><em>• Empowerment for public insurance funds (hence: conclusion of contracts with health care providers, creation of health care networks run by mutual funds).</em></td>
<td><em>• &quot;New Public Management&quot;. Management autonomy for hospitals.</em></td>
</tr>
<tr>
<td><em>• Separation of health care purchasers and suppliers: competition between health care purchasers.</em></td>
<td><em>• New forms of hospital financing (global envelope, Diagnosis Related Groups (DRG), Price per Activity (T2A)).</em></td>
</tr>
<tr>
<td><em>• Development of free choice for the patient-consumer of the insurance fund (Germany, Netherlands), hence competition between insurance funds.</em></td>
<td><em>• Growth of the search for contracts (hence competition).</em></td>
</tr>
<tr>
<td><em>• Alignment of the status of mutual funds with that of insurance companies (European Directives).</em></td>
<td><em>• Evaluation of results, of quality.</em></td>
</tr>
<tr>
<td><em>• Emphasis on competition:</em></td>
<td><em>• Performance payments for (private) general practitioners from public insurance funds.</em></td>
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<tr>
<td>– internal market;</td>
<td></td>
</tr>
<tr>
<td>– separation of health care purchasers and providers: competition between health care providers. Local authority, regional or insurance fund contracts with public health care services. Health care purchasing by primary health care networks for their patients;</td>
<td></td>
</tr>
<tr>
<td>– development of free choice for the patient-consumer between public services.</td>
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</tbody>
</table>

Source: Authors.
Additionally, if privatization is the primary major reform trend in the countries in the study, increasing decentralization comes a close second and a link between privatization and decentralization does exist (André, 2015), with the second serving to reinforce the first in some cases. One of the difficulties in classifying the countries derives from the wide degree of autonomy granted to regions and local authorities concerning health care in certain countries (particularly: Austria, Denmark, Finland, Germany, Italy, Spain, and Sweden, and the United Kingdom post-1999), an autonomy that sometimes goes as far as the possibility of raising resources. In such cases, regions can conduct their own health care policies and, in particular, develop their own privatization policies or even oppose this trend. It is therefore particularly difficult to arrive at a solid overall evaluation of any given country, with that difficulty being further exacerbated by changes that have occurred in the degree of decentralization.

Table 2 presents a summary of the main features in privatization since 1980. In general, each country has employed most of the forms of privatization presented in Table 1. Table 2 shows only those measures that are used more in a given country than across all countries.

While one should interpret with an element of caution the results obtained from the available statistical series, the volume of data used, the uncertainties regarding the degree of implementation and the application time scales for new measures, it is nevertheless possible to show a structuring of privatization processes (Figure 2).

**Privatization processes in a hierarchy between countries**

Figure 2 shows what is happening in all countries with regard to the major components of health care systems. A general privatization movement can be observed given that imposed (or external) privatization processes can be found in all countries whether for financing or for health care delivery. Incorporated (or internal) privatization for health care delivery also appears in all countries. However, incorporated privatization for financing – other than general financing arising out of the application of European Directives on insurance – is only being developed in five countries.

With regard to financing, the Netherlands has pioneered privatization (imposed as well as incorporated) by giving private insurance companies the possibility to manage basic health coverage (imposed privatization, north-west quadrant) generally since 2006. Over many years, it has also strongly developed competition mechanisms between public insurance funds and those inviting patients to use competition between insurers to their advantage (incorporated privatization, south-west quadrant). However, the State retains considerable regulatory powers over private insurance schemes; all insurance companies must provide a minimum basket of health care services. Beyond that, competition reigns supreme.
<table>
<thead>
<tr>
<th>Financing:</th>
<th>Health care provision:</th>
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<tbody>
<tr>
<td></td>
<td>Imposed privatization</td>
</tr>
<tr>
<td>Austria</td>
<td>Limited rise in household payments.</td>
</tr>
<tr>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Belgium</td>
<td>Delay on direct household payments and importance of not-for-profit private sector.</td>
</tr>
<tr>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Denmark</td>
<td>Rise in co-payment arrangements and development of private insurance.</td>
</tr>
<tr>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Finland</td>
<td>Regulated co-payment arrangements.</td>
</tr>
<tr>
<td></td>
<td>*</td>
</tr>
<tr>
<td>France</td>
<td>Growth in supplementary private insurance schemes.</td>
</tr>
<tr>
<td></td>
<td>* Adaptation of the Mutual Societies Code made necessary by European Directives.</td>
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</tbody>
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*Note: The text continues on the next page.*
### Table 2. (Continued)

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</thead>
<tbody>
<tr>
<td>Germany</td>
<td>Private insurance progression since unification, upwards trend in household payments.</td>
<td>* Variable incentives for competition over time.</td>
<td>Privatization accelerated by unification; creation of private hospitals and transformation of public hospitals.</td>
<td>Internal privatization and a certain re-organization of the system.</td>
</tr>
<tr>
<td>Greece</td>
<td>Age of private insurance schemes, patient payments a major feature.</td>
<td>* Attempts to re-organize health insurance schemes to reduce heterogeneity rather than incentives for internal privatization.</td>
<td>Great traditional role of the private sector.</td>
<td>Measures still challenged.</td>
</tr>
<tr>
<td>Ireland</td>
<td>Major and long-standing importance of private insurance. Recent growth in direct household payments.</td>
<td>*</td>
<td>A long period of strong economic growth favourable to the public sector.</td>
<td>Search for greater integration of health care, some modifications to management.</td>
</tr>
<tr>
<td>Italy</td>
<td>Rise in household payments, variety of regional policies.</td>
<td>* Diversity of regional models.</td>
<td>Regional differences in privatization.</td>
<td>New hospital management measures applied differently according to region.</td>
</tr>
<tr>
<td>Portugal</td>
<td>Size and sustained growth in direct household payments.</td>
<td>*</td>
<td>Some incentives for the private sector.</td>
<td>Recent and limited internal privatization, Imposed reduction in spending.</td>
</tr>
<tr>
<td>Spain</td>
<td>Patient deferment, incentives for private insurance schemes.</td>
<td>*</td>
<td>Support for the private sector to compensate for persistent public sector deficiencies.</td>
<td>Differences in management style according to region.</td>
</tr>
</tbody>
</table>

* Variable incentives for competition over time.
Table 2. (Continued)

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<tbody>
<tr>
<td>Sweden</td>
<td>Rise in co-payment arrangements and recent development of supplementary insurance cover.</td>
<td>*</td>
<td>Role of the counties in privatizations.</td>
<td>Differences between counties, a certain re-organization of the system.</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>A certain measure of cost-sharing.</td>
<td>*</td>
<td>External privatization to mitigate public service deficiencies.</td>
<td>A pioneering role in Europe.</td>
</tr>
</tbody>
</table>

*All health care financing systems are subject to European Directives on insurance, which give rise to greater or lesser modifications particularly for mutual societies.

Source: Based on André, Batifoulier and Jansen (2014).
The extent in the growth of imposed (or external) privatization for financing in Ireland and Portugal is, above all, the result of the sustained catching up carried out by the health systems in these countries, which has been accompanied by a particular search for private financing (private insurance schemes and/or direct household payments).

At the opposite end of the spectrum, the United Kingdom, Austria and Finland have resorted least to imposed privatization for financing. In the United Kingdom, the National Health Service (NHS) covers all essential elements and its financing has been modified very little. In Austria, private health care is limited. As a consequence, possibilities for growth in the private health insurance sector are weak; furthermore, direct household payments have made little progress. In Finland, the rise of private insurance schemes has to some extent only been brought on by private health care; however, direct household payments have recently increased.

9. However, it should be noted that incentives by the Thatcher government in the 1980s and public sector deficiencies arising out of queues for treatment contributed to the percentage of the population covered by private insurance schemes rising from 6.4 per cent in 1980 to 11.7 per cent in 1990. Private insurance coverage has mainly involved persons in senior management positions in private industry. The population with private insurance coverage has since stabilized (Keen, Light and Mays, 2001).

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**Table:**

<table>
<thead>
<tr>
<th>Financing of health care</th>
<th>Delivery of health care</th>
</tr>
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<tr>
<td>• (NL)</td>
<td>• UK</td>
</tr>
<tr>
<td>• DE, (IT)</td>
<td>• AT, DE, DK, ES, FR, FI, IE, IT, SE</td>
</tr>
<tr>
<td>• FR, GR</td>
<td>• BE, GR, NL, PT</td>
</tr>
</tbody>
</table>

**Notes:** Figure 2 shows the relative importance of privatization processes since 1980. The relative importance of a given type of privatization is indicated by the size of the font: the more a country is developing a given privatization, the bigger the letters used for its name in the corresponding quadrant.

**Source:** Authors.
In the north-west quadrant the other countries are located between these two groups. The case of France is interesting since it serves to show the gap between the intention to introduce private insurance competition and the actual results. The increasing weight of private health insurance schemes is often accompanied by very high prices with regard to ophthalmic, dental and auditory care services, excessive fees or even hospital accommodation costs. To counter these pricing excesses without burdening public finances, one solution is to equip patients with market power. Supplementary insurance schemes offer a variety of contracts with different guarantees. This multiplicity of contracts goes hand in hand with their complexity. It is very difficult for patients to benefit from competition. Various proposals have been made recently to correct these aspects and develop competition.\(^{10}\)

In the incorporated privatization quadrant for financing (south-west quadrant), all countries are subject to the European Directives on insurance, which also apply to the way mutual societies operate. These have been invited to move closer to the private insurance model. The Netherlands has been developing competition among public insurance funds mainly since the 1980s and prior to 2006 (at which time there was a shift to the private sector); the setting aside of the Netherlands in this quadrant indicates the non-regularity, for the 1980–2004 period, of the importance of public insurance funds and, as a consequence, the importance of the policy applied to this sector. A small number of countries\(^{11}\) have developed this form of privatization beyond that which was imposed by these Directives.

For health care delivery, two groups of countries stand out with regard to imposed privatization (north-east quadrant). Since the 1980s, the presence of a significant private hospital sector has often contributed to limiting the sector’s expansion possibilities. But other forms of privatization are also to be taken into account (private practice in the public sector, agreements between public hospitals and private clinics, contracts between regions and the private sector, etc.). In certain cases, regional autonomy (Italy, Sweden) or the difficulty in appreciating the relative importance of trends (France, Ireland) gives rise to uncertainty regarding the classification of these countries, which in turn gives rise to the proposal given in brackets to attach them to another group. In certain southern European countries the relatively recent nature of the national health service and the difficulties encountered with its financing and introduction explain to a large extent the more sustained development of the private sector.

Finally, in the area dealing with incorporated privatization for health care delivery (south-east quadrant), the United Kingdom, as is well known, has become

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10. The definition of a standard contract based on a previously defined basket of health care services would aid comparison and develop price competition for a product that had been made homogeneous. This proposal can be found in Dormont, Geoffard and Tirole (2014).
11. In the south-west quadrant, Italy has been set aside, since its regions have had considerable autonomy in this area since the 1990s and it is difficult to evaluate the overall effects.
the pioneer in spreading New Public Management. For example, in England, general practitioners have recently been transformed into managers through the advent of Clinical Commissioning Groups (CCG)\(^{12}\) where they not only have to implement public health policies in their areas in their clinical specialization but also within their budget. The United Kingdom has started to replace hospital managers and certain administrative posts in the NHS with private sector managers with enterprise experience. This has increased administrative costs. They also increasingly set individual targets to be met in outpatient and hospital sectors following the development of the “quasi-market” (Hassenteufel et al., 2001).

The four countries with the least developed level of incorporated privatization are first of all Portugal and Greece, countries where the public sector is less important and where possibilities of resorting to a transformation in the way hospitals are managed, for example, are smaller and less used. Incorporated privatization is relatively recent in Portugal. Furthermore, in Greece, there are continuous challenges to the measures adopted as a result of the numerous changes in the direction of government policy. Two other countries have introduced rather moderate modifications: the Netherlands and Belgium, two countries where health care providers are mainly private and not-for-profit. Nevertheless certain incorporated privatization measures have been adopted (André, Batifoulier and Jansen, 2014).

All the other countries fall between this latter group and the United Kingdom. France, among others, has developed, mainly for hospitals, new management rules which consist of granting management autonomy freed from tight restrictions regarding balanced budgets in a context of competition.

**Differing strategies of countries for the same form of privatization**

Similar scope for a given privatization process does not mean that countries are resorting to the same instruments for this type of privatization. Some countries that are schematically classified on the same line in all four quadrants do not apply the same privatization policy, as we shall see.

Thus, in the north-west quadrant there is a generalized privatization strategy that mainly makes use of a hardening of the cost-sharing approach with the patient. Health care systems converge from the point of view of increased financing through private insurance schemes (Montanari and Nelson, 2013), which have become an unavoidable element of health care financing, and of increased direct household payments. The transfer of the burden from public financing to private financing for health care thus marks out new borders in health care coverage.

However, the link between public insurance and private insurance is variable. Given that the functions of private insurance schemes may vary with regard to

\(^{12}\) The CCG replace the previous primary care networks.
public insurance structures, this introduces differences in the extent of privatization of health care financing. Thus private insurance schemes can be substitutes, replacing compulsory medical insurance (CMI) schemes, as in Germany: over a gross monthly income of EUR 4,462.50 (2014), a person can subscribe to a private insurance scheme. This is the case for 11 per cent of insured individuals. By varying this threshold, public authorities can include or exclude households from the public health care insurance system. Private insurance schemes can also be duplicate, covering what is already covered under the CMI, but allowing wider access to private services or to services deemed to be of better quality than those of the CMI: private beds in the public sector; shorter waiting lists as for about 10 per cent of patients in Great Britain, Spain or Italy. Finally, private insurance schemes can be supplementary for services not covered by the CMI, for example, for dental and ophthalmic care, or even complementary completing CMI reimbursements. A private insurance scheme can also take on a variety of functions, such as the functions of complementary and supplementary insurance provider in France. Overall, it can be noted that there is no particular form of private insurance that determines whether the extent of any privatization is greater or lesser.

Similarly, imposed privatizations with regard to health care delivery (north-east quadrant) may be of a similar intensity, for example strong in Germany and Italy, yet the privatization processes are quite different. In Germany, certain public hospitals have been sold to private groups. In Italy, the public sector sub-contracts certain hospital activities to the private sector, as is also the case in France, albeit to a lesser degree, for public hospital service missions.

Overall, there are multiple policy instruments in each of the quadrants and their combination varies from country to country. Similar instruments may target different objectives and vice versa.

It is worth underlining one final point. It has been noticed that giving hierarchical priority to certain privatization processes serves to reveal a greater schematic proximity among certain countries: certain groups of countries are more frequently to be found along the same line in each quadrant. The typology of the dynamic for health system privatizations shows itself to be similar to the typology for overall reforms of health systems studied elsewhere (André, 2015). This latter typology is not only based on privatizations, but on reforms examined from all aspects and on trends in “results” for health care systems. In particular it reveals a greater coherence between continental European countries, Nordic countries, the special case that is the Netherlands, a separating out of the English-speaking countries (United Kingdom and Ireland), and a frequent distinction among the southern European countries between Italy and Spain on the one hand and Greece and Portugal on the other. Privatization processes thus reveal themselves to be interdependent across their respective contexts.

13. As can all civil servants.
Combinations specific to each country in their use of different privatization forms

Taking account of the measures that have actually been implemented, there is a hierarchical prioritization of the privatizations followed not just among countries but also within each country.

The most outstanding examples are the polar cases of the Netherlands and the United Kingdom. The Netherlands has implemented big reforms with regard to health care financing, but has made very little change to health care delivery (particularly with regard to internal privatization). At the other end of the spectrum, the United Kingdom has played a pioneering role with regard to internal privatization of health care delivery, but has made very little change in health care financing.

Conclusion

The reforms that have been carried out in the health sector can be traced back many years and are varied. Since the 1980s, they have affected and become a feature of all European countries. A tendency that is deep-rooted and common to the multiplicity of measures implemented has been to introduce market principles into a sector that had been relatively sheltered from these. We have proposed to refer to this trend as privatization, which should not be taken to have the restricted meaning of a transfer of legal property but a broader meaning taking in a multiplicity of forms. As we have discussed, there exists a diversity of privatizations.

Our proposal presents a mapping of privatization processes over the last thirty years to analyse changes in European health care systems. The analysis reveals a generalization in privatization strategies in Europe, but with each country differently prioritizing privatization forms.

In acknowledging a plurality of privatization modes present in all the reforms, the relative position and combination of these are specific to each country. This derives first and foremost from the institutional characteristics of health care systems (André, 2015). It is also linked to the second major trend in the general reform of systems: decentralization. In fact, the link between privatization and decentralization and the forms taken by decentralization, which also have an institutional dimension, have an important role to play in the developments observed. For example, greater financial autonomy for regions enables them to conduct their own privatization policies, even going as far as entering into conflict with the policy of the central State (Sweden, for example).

Furthermore, a whole range of reforms are aimed at mitigating the “defects” of the measures adopted, in particular the growth in inequalities of access to health care or the decline in health care quality associated with privatization measures.
Finally, both the timing and pace of development in privatization present common points and specific features. Political shocks and economic crises serve to explain the various phases of the slowing down or acceleration of privatization. Thus radical change in the political regimes in Spain, Portugal and Greece and major political inflexibility in Italy, all of which took place in the period 1970–1980, have led to a reform of health care systems that were judged to have “lagged behind”. During the same period, the first three countries became full members of the European Union. The emphasis was therefore placed on health care systems catching up before establishing national health care systems. Public funding shortfalls, however, linked to limited economic growth, motivated some of these countries to concentrate on the search for private funding. This was particularly the case in Portugal despite the receipt of significant European subsidies. The great political instability and economic difficulties in Greece have prevented any real implementation of a national health care system that had been planned in 1983 and reliance on private funding has increased, particularly as a result of austerity policies. In Germany, it was a political shock, that of unification, which accelerated privatization processes at the beginning of the 1990s to control public spending. Moreover, the beginning of the 1990s was also marked by the introduction of the Treaty of Maastricht, which provoked restrictive policy in many countries to satisfy budgetary deficit and associated public debt criteria. Lastly, the economic slowdown of 2001–2003 and above all the crisis that unfolded in 2008, and the austerity policies that were then adopted (Math, 2014), are at the root of a search for a reduction in public spending that is more or less severe according to the country. Austerity is now providing the impulse for privatization.

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Pension reforms in Chile and social security principles, 1981–2015

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Abstract Chile pioneered in Latin America not only the introduction of social security pensions, but the structural reform that privatized them and a process of “re-reform” implementing key improvements. A Presidential Commission in Chile, appointed in 2014 to evaluate reform progress and remaining problems in the pension system, released its report in September 2015. In light of the Commission’s findings, the article assesses Chile’s compliance with International Labour Organization social security guiding principles: social dialogue, universal coverage, equal treatment, social solidarity, gender equity, adequacy of benefits, efficiency and affordable administrative cost, social participation in management, state role and supervision, and financial sustainability. The exercise follows three stages: the structural reform (1981–2008), the re-reform (2008–2015), and the Presidential Commission proposals (2015).

Keywords pension scheme, social security reform, ILO Convention, Chile
Chile pioneered the introduction of social security pensions in Latin America. It also initiated the 1980 structural reform that privatized public pensions and influenced World Bank policies and the adoption of similar reforms in eleven countries in Latin America and others in Central and Eastern Europe. Such reforms endured design problems and made many promises that were unfulfilled. In 2008, Chile similarly pioneered a “re-reform” that achieved substantial improvements, but left key shortcomings. In 2014, a Presidential Commission, in which the authors were members, was appointed to elaborate on the reform progress attained as well as remaining problems and to develop proposals to address these. The Commission released its report in September 2015, and President Michelle Bachelet entrusted a Ministerial Committee to study the proposed changes for legislative action.

Building on the abundant literature on Chilean social security, this article aims to conduct a thorough and integrated evaluation of the three reforms and their effects: the structural reform (1981–2008), the re-reform (2008–2015), and the Presidential Commission diagnosis and proposals (2014–2015). To tackle this task, the article focuses on Chile’s compliance with ten social security guiding principles that have been shaped by the International Labour Organization (ILO) and supported by the International Social Security Association (ISSA) (ILO and ISSA, 1998). These guiding principles embody the good governance and design of a pension system (Mesa-Lago, 2012a): i) social dialogue, ii) universal coverage, iii) uniform treatment, iv) social solidarity, v) gender equity, vi) adequacy of benefits, vii) efficiency and affordable administrative cost, viii) social participation in management, ix) state role and supervision, and x) financial sustainability.

In the remainder of this article, we address each of the principles in turn, summarizing their content, assessing the impact of the structural reform and its flaws, appraising the improvements made by the re-reform and identifying extant drawbacks, and abridging the most relevant recommendations of the Presidential Commission to confront the remaining challenges by a future, second re-reform.1

**Social dialogue**

The ILO recommends social dialogue among workers, employers and government when debating a pension reform, to procure inputs, maximize consensus on proposed changes and legitimate the process (ILO, 2001).

Most of the structural reforms that privatized2 the former public pensions in eleven Latin America countries between 1980 and 2002 were approved without

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1. When no specific source is cited, readers are directed to Mesa-Lago (2012b).
2. Structural reforms transformed publicly-managed defined benefit pensions, PAYG or partially funded, into pensions that were privately-managed, defined contribution and fully-funded (Mesa-Lago, 2014).
prior social dialogue, provoking questions regarding system design issues and legitimacy. Chile’s dictatorial regime enacted its influential reform without a democratically-elected congress, and did so in a context of disbanded political parties, banned or controlled trade unions and no public discussion. Reformers claimed that the public system was bankrupt, inefficient and financially unsustainable, and that the private system would improve coverage, efficiency and benefits, reduce administrative costs and be financially sustainable in the long term.

In 2006, President Michelle Bachelet appointed an advisory commission with 15 representatives to collect views from social actors, study the system’s flaws and propose changes to correct them; 90 per cent of that commission’s recommendations were incorporated in the law enacted in 2008.

In her second term, President Bachelet appointed in 2014 a Presidential Commission comprising 24 members, national and international, with diverse views. A process of “citizen participation” saw over 2,500 people debating key pension issues at regional dialogues and public hearings, while an opinion survey was also undertaken (CAPSP, 2015a, 2015b). After 16 months of work, the Commission elaborated three re-reform global proposals and approved 58 recommendations.

Universal coverage

The 2001 ILO International Labour Conference (ILC) asserted: “The state has a priority role in the facilitation, promotion and extension of social security coverage … to those not covered by existing systems … including women, self-employed, employees of microenterprises, the elderly, and home workers”. “Support for vulnerable groups in the informal economy should be financed by society as a whole” (ILO, 2001).

Coverage of the labour force fell from 73 per cent in 1973 to 64 per cent in 1980 (year of the reform) and to 29 per cent in 1982. Coverage grew to 61.2 per cent in 2007 (the year before the re-reform), but still below the 1980 level. Affiliates who contributed declined from 73.6 per cent to 54.6 per cent in the period 1990–2008. Pension coverage of those aged 65+ shrank from 73.6 per cent to 63.9 per cent between 1990 and 2003, but has since risen (Table 1).

The re-reform mandated the coverage of all self-employed workers starting in 2012, with a contribution rising gradually from 10 per cent of 40 per cent taxable income to 10 per cent of 100 per cent of their taxable income by 2016. As an affiliation incentive, self-employed workers became eligible for family allowances, employment-risks protection, and pension benefits added by the re-reform. Previously-excluded unpaid family workers and housewives were allowed to join voluntarily. A state subsidy was granted to employers of low-income young workers. Coverage among the poor was extended by a non-contributory pension.

Labour force coverage grew from 61.2 per cent to 64.8 per cent across 2007–2013, the highest level since 1980, and the third highest in Latin America. Affiliates
to the system increased by 22 per cent across 2009–2013 (FIAP, 2014; Arroyo, 2015). Female coverage augmented by 10 per cent. The share of self-employed workers in total contributors climbed from 4 per cent to 20 per cent in the period 2008–2014, but only 22 per cent to 33 per cent of those with taxable income contributed in 2013 (Ministerio de Desarrollo Social, 2015). Elderly coverage by contributory and non-contributory pensions jumped to 84 per cent in 2009-2013, 6 percentage points higher than in 2006, placing Chile in the top five countries in the region, mostly due to the inclusion of women by the extension of the non-contributory pension. Without the latter, elderly poverty incidence would have been 2.1 percentage points higher.3

3. Chile’s population poverty incidence was 7.8 per cent in 2013, the third-lowest in the region (ECLAC, 2014; poverty is measured by the cost-of-basic-needs method).

### Table 1. Pension coverage of the labour force (based on contributors) and population aged 65+, 1973–2013

<table>
<thead>
<tr>
<th>Years</th>
<th>Labour force (%)</th>
<th>Population aged 65+ (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1973</td>
<td>73.0a</td>
<td></td>
</tr>
<tr>
<td>1980</td>
<td>64.0</td>
<td></td>
</tr>
<tr>
<td>1982</td>
<td>29.0</td>
<td></td>
</tr>
<tr>
<td>1990</td>
<td>46.8</td>
<td>73.6</td>
</tr>
<tr>
<td>1992</td>
<td>51.8</td>
<td>66.5</td>
</tr>
<tr>
<td>1994</td>
<td>51.8</td>
<td>68.2</td>
</tr>
<tr>
<td>1996</td>
<td>55.7</td>
<td>65.9</td>
</tr>
<tr>
<td>1998</td>
<td>53.4</td>
<td>62.2</td>
</tr>
<tr>
<td>2000</td>
<td>52.9</td>
<td>63.7</td>
</tr>
<tr>
<td>2003</td>
<td>55.8</td>
<td>63.9</td>
</tr>
<tr>
<td>2006</td>
<td>61.1</td>
<td>79.0</td>
</tr>
<tr>
<td>2007</td>
<td>61.2</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>62.8</td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>60.3</td>
<td>84.0</td>
</tr>
<tr>
<td>2010</td>
<td>60.3</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>63.6</td>
<td>84.0</td>
</tr>
<tr>
<td>2012</td>
<td>63.8</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>64.8</td>
<td>83.5</td>
</tr>
</tbody>
</table>

Despite the re-reform advances, a third of the labour force still lacks contributory coverage because of evasion or lack of affiliation (two-thirds are self-employed). Female coverage is much lower than male coverage; 9 per cent of all females are in household employment and half of these do not contribute. Elderly coverage stagnated from 2011 to 2013; voluntary affiliates are only 0.2 per cent of total affiliates; the youth employment subsidy covers only 3.6 per cent of those eligible; unpaid family workers, employees without a contract and small employers represent 12 per cent of the employed labour force and lack coverage (SP, 2014b; CAPSP, 2015b).

The Presidential Commission recommendations to address these flaws are to: expand access to the Basic Solidarity Pension (Pensión Básica Solidaria – PBS) to 80 per cent of the poorest households or universalize access with an income test; make adjustments to the gradual incorporation of the self-employed; increase fines imposed on employers that retain and fail to transfer contributions; create a more rapid judicial procedure for the execution of sanctions; and establish a special entity to coordinate all policies to promote affiliation and contributions (CAPSP, 2015b).

**Equal treatment**

According to the ILO, “equal treatment is a guiding principle of social security” (Greber, 1997), and should be enforced in pension programmes for powerful groups where entitlement conditions and/or benefits are more generous than in the general system (unless justified by factors such as physically-demanding or dangerous work). Such generosity is mostly state financed; in other words, it is subsidized by the general population, including insured persons with less generous entitlement conditions and benefits and also the uninsured.

The structural reform integrated a number of separate pension schemes into a unified agency with standardized entitlement conditions. The military government who implemented the structural reform proclaimed it would be superior to the public system – but the armed forces and police force were excluded and maintain their separate defined benefit schemes, with better entitlement conditions and pensions than those in the general system. These are 90 per cent subsidized by the state at a cost of 0.9 per cent of GDP per annum. This cost can be compared with the cost of the entire re-reform: 0.47 per cent of GDP (CAPSP, 2015b). Legislative attempts and social pressures so far have failed to correct such inequality.

The Presidential Commission asked that the armed forces and police force schemes have the same treatment and contributions as the rest of the labour force, which implies an elimination or reduction of the fiscal subsidy, and establishing adequate contributions from their members and the state as employer (CAPSP, 2015b).
Social solidarity

The 2001 ILC noted: “In pensions systems with defined benefits based on pay-as-you-go (PAYG), the risk is collectively assumed but in systems of individual saving accounts (fully funded), persons assume the risk. While this option exists, it should not weaken solidarity systems which spread risks throughout all members” (ILO, 2001).

Private systems normally lack endogenous social solidarity because the individual account belongs to the insured and there is no solidarity between generations, genders and income groups. The little social solidarity that Chile had was state provided: payment to complete the minimum pension, financing of non-contributory pensions (PASIS) – but restricted by quotas, waiting lists and available fiscal resources – and recognition of previous contributions to the public system.

The re-reform created two state-financed “solidarity pensions”:

· A “basic solidarity pension” (PBS) for old age and disability, for affiliates without the right to a minimum pension or to PASIS; the PBS was initially granted to 40 per cent and later to 60 per cent of the poorest homes, without any pension, aged 65+, and living in the country for 20 years4;

· A “solidarity contribution to pensions” (APS) replaces gradually the minimum pension and supplements low contributory pensions for those aged 65+. The APS decreases in tandem with increases in the contributory pension amount, and entitlement ends when the contributory pension exceeds a cap, with progressive effects. Entitlement conditions for the APS are similar to those for the PBS.

Attanasio, Meghir and Otero (2011) show that solidarity pensions have created a small disincentive to work formally, but conclude that the welfare benefits exceed such negative effect. The contributory private system continues to lack endogenous solidarity, whereas state-financed exogenous solidarity does not yet fill the subsisting gaps in employment coverage, gender equity and benefits adequacy.

Several Presidential Commission proposals have positive effects on social solidarity, such as extending the PBS’ coverage to all the poor or making access universal. Twelve countries in the region have non-contributory pensions, out of which eleven are targeted on the poor; only Bolivia has a universal pension, which is extended also to beneficiaries of contributory pensions, but the benefit level is low (USD 38 a month). Universal provision would cost more in Chile because the PBS amount is 3.5 times greater than the benefit in Bolivia. Filgueira and Espidnola (2015) estimate that universalization of the PBS would cost an additional 0.11 per cent of GDP, while the targeting on all the poor would cost an additional 0.04 per cent of GDP. Other proposals that improve social solidarity are discussed later.

4. Progress in elderly protection through PBS has been significant (Table 1; CAPSP, 2015b).

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Gender equity

The 2001 ILC asserted: “Social security should promote and be based on the principle of gender equality.” Women should be paid for their work in raising children and providing care for other relatives (ILO, 2001).

Gender inequalities are caused by: i) the labour market (e.g. women are paid lower wages than men for the same work and have more part-time, temporary or informal jobs); ii) the pension system (e.g. lower coverage rates for women than men, the retirement age for women is five years lower than that for men, and gender-differentiated mortality tables); iii) demographic factors (e.g. six years longer life expectancy for women); and iv) cultural aspects (men often do not undertake household chores, increasing women’s workload). Inequalities caused by the pension system were aggravated by the structural reform and the private system. While 69 per cent of elderly men were pension beneficiaries, only 54 per cent of women were (Rofman and Oliveri, 2012). Women’s pensions were lower than men’s due to: interrupted labour market histories to raise children or care for sick elderly relatives, lower contribution density than men (42 per cent and 61 per cent, respectively), and pensions calculated based on individual account funds and gender-differentiated mortality tables. Characteristically, with a lower individual fund value and greater life expectancy than men, the annuities of women are lower than for men, and female replacement rates were on average 38 per cent of the rates for males. Men lacked the right to a survivorship pension on the death of an insured wife.

The re-reform improved gender equity. Mothers affiliated to the private system, regardless of their income, receive a maternity voucher per child born alive; the voucher is deposited in the mother’s individual account, accruing an annual return, and is made effective at retirement. The disability and survivors insurance premium was equalized for both genders, but as women face lower risks and use this insurance less, the remaining amount of the premium paid by women is assigned to their individual accounts (0.15 per cent of the fee in 2013). In case of divorce, a judge can decide to divide funds, accumulated during marriage in the individual accounts, between the spouses, capped at 50 per cent. Housewives can affiliate voluntarily and receive contributions paid on their behalf by their partners. Husbands are now eligible for a survivor pension.

Female labour force participation rose from 40.9 per cent to 45.6 per cent across 2006–2013. Pension coverage for elderly women jumped from 74 per cent to 83 per cent, approaching the 84 per cent coverage rate for men (Ministerio de Desarrollo Social, 2015). The solidarity pension distribution favours women: concerning the PBS for old age, women’s share grew from 59 per cent to 72 per cent across 2009–2014 (the average PBS benefit for women was 4 per cent above that for men) and 91 per cent of APS beneficiaries were women. In 2014, 399,532 women had received the maternity voucher. The gender gap in the replacement rate
decreased 6 percentage points from 2008 to 2011. Regarding the splitting of individual accounts in case of divorce, 1,683 transfers of funds were completed by 2014, 95 per cent benefited wives and 5 per cent husbands (SP, 2015a).

Notwithstanding the progress achieved, women continue to be substantially discriminated against. The World Economic Forum’s Gender Inequality Index ranked Chile 125th (out of 136 countries) concerning equal payment for the same work (Montecinos, 2015). The gender gap in labour participation is 25 percentage points (Ministerio de Desarrollo Social, 2015). The replacement rate for women is 41 per cent of men’s; while the pension average for women is 43 per cent of men’s (SP, 2014a, 2014b). Sex-differentiated mortality tables remain in use.

The Presidential Commission proposed to: implement unisex mortality tables; assign half of the contributions to the individual accounts to the legal or common spouse; in case of divorce, equally divide the fund accumulated during marriage between the spouses; compensate unpaid work when caring for the elderly or incapacitated; increase the number of child day-care centres and improve access to these; and equalize retirement ages at age 65, starting with those born after 1970 (CAPSP, 2015b). Concerning the latter, women’s effective retirement age is 64.8 years, compared to the legal retirement age of 60.

**Adequacy of benefits**

The ILO Convention concerning Invalidity, Old-Age and Survivors’ Benefits, 1967 (No. 128), set the pension minimum replacement rate at 45 per cent for an average earner with 30 years of contributions. Pensions should be adjusted to the cost of living. State-financed non-contributory pensions for the needy should be granted according to available resources. The ILO’s Recommendation concerning National Floors of Social Protection, No. 202 (2012), set basic income security for the elderly at least equal to the national minimum (ILO, 2012).

A means-tested non-contributory pension (PASIS), which existed prior to the structural reform, has continued with a cap on the number of beneficiaries, with waiting lists for access, and is subordinated to available fiscal funds. The structural reform increased to 20 years the contributions needed in previous public schemes to grant a minimum pension and guaranteed it to those in the private system whose individual accounts were insufficient to finance it. The minimum pension averaged 62 per cent of the minimum wage in 2007 and projections suggested that 35 per cent of men and 60 per cent of women would eventually receive it. Some insured lacked both the right to a minimum pension (falling short of the required contribution years) and to a non-contributory pension (failing the means test, or due to a lack of public funds). Contributory pensions were automatically indexed to the UF.5

5. UF (Unidad de Fomento) is a monetary unit automatically adjusted to CPI.
The re-reform helped affiliates who did not qualify for a minimum or non-contributory pension. The monthly PBS in 2015 was USD 132, which is 79 per cent higher than the PASIS; it was increased by 50 per cent across the period 2008–2015, and is annually adjusted to the consumer price index (CPI). The average real contributory pension increased 83 per cent, an increase that has favoured most the lowest-income beneficiaries (Ministerio de Desarrollo Social, 2006, 2015). In 2015, on average, the value of the APS represented 79 per cent of total old-age pension income, and 92 per cent of disability benefit income (the cap was USD 428 a month); APS is adjusted to the CPI. The number of PBS and APS beneficiaries doubled in the period 2008–2014, reaching 1.24 million. Elderly poverty decreased by 2.7 percentage points. The PBS was paid to 96 per cent of the 60 per cent poorest families, but was incorrectly paid to 4 per cent among the 30 per cent with the highest income, leading to the suspension of benefits for 0.2 per cent of beneficiaries and the development of a new more efficient means-test method (CCP, 2011; CUSP, 2011; SP, 2014b, 2015a). A voluntary collective savings programme was created with contributions negotiated between employers and employees or paid by employers only, with deferred tax payment. However, few companies are taking part in this programme, and takeup is particularly low among middle-income insured.

The ILO and the Organisation for Economic Co-operation and Development (OECD) have set a minimum replacement rate (RR) of 45 per cent applied to the average salary during the insured active life. The Comisión Asesora Presidencial sobre el Sistema de Pensiones (CAPSP) originally estimated average RR that were, with few exceptions, above such a minimum, but found significant segmentation among pensioners and decided that using the median was more informative. CAPSP (2015b) estimated that the self-financed (individual savings) median replacement rate taking into account earnings from the last ten years before retirement was 34 per cent for all pensioners across 2007–2014 (Table 2). Pensioners with high contribution densities showed a median RR reaching 46 per cent; while those with low density achieved

| Table 2. Median replacement rates (RR), ten last salaries; 2007–2014 and projected 2025–2035 |
|-----------------------------------------------|-----------------|-----------------|
|                                | Total | Men | Women |
| RR (2007–2014)                  |       |     |       |
| Without APS (self-financed)     | 34    | 48  | 24    |
| With APS                       | 45    | 60  | 31    |
| Projected RR (2025–2035)       |       |     |       |
| Without APS (self-financed)    | 15    | 24  | 8     |
| With APS                       | 37    | 41  | 34    |

only 4 per cent. There were also significant differences by gender. The median RR for men was 48 per cent, while for women it was only 24 per cent. The APS significantly increased the median RR to 45 per cent for all pensioners; 60 per cent for men and 31 per cent for women; highlighting the important role of the state.

CAPSP (2015b) also projected the RR for workers whose entire working lives would be under the reformed system. For this purpose, simulated future profiles of earnings and labour force participation were used to estimate the accumulated pension savings balances and benefits obtained under the parameters of the system under the 2008 re-reform. The resulting median RR are lower than the ones discussed before: for self-financed pensions, 15 per cent (25 per cent for men; 8 per cent for women). Adding the APS, the median RR are higher: 37 per cent for all pensioners (41 per cent for men; 34 per cent for women).

The Presidential Commission recommended to: increase by 20 per cent the value of the PBS and APS; raise the contribution rate (and thus the amount deposited, i.e. the value of the monthly retirement savings placed in the individual account) from 10 per cent to 14 per cent, with 4 per cent charged to the employer; augment by 50 per cent the cap on taxable income; eliminate the programmed pension (which is selected by the vast majority of pensioners); and further improve the targeting mechanism and review it every three years (CAPSP, 2015b). Other improvements are listed in the sections on Gender equity and Efficiency and reasonable administrative costs.

Efficiency and reasonable administrative costs

The 2001 ILC affirmed that “schemes should be managed in a sound and transparent manner with administrative costs as low as practicable” (ILO, 2001).

In 1979, the government unified the separate pension schemes existing prior to the reform into the National Institute of Pensions (Instituto de Normalización Previsional – INP), except for the armed forces and the police force. The private system, starting in 1981, was (and is) managed by pension fund management companies (Administradoras de fondos de pensiones – AFPs) that charge fees as a percentage of the taxable income for administering the old-age pension, as well as a fixed fee with regressive effects. The premium to cover disability and survivor risks was collected by the AFP and transferred to commercial insurance companies. Market competition did not work out as expected: the number of AFPs dropped from 21 to 5 from 1994 to 2008, the concentration of contributors in the three major AFPs jumped from 67.1 per cent to 86.4 per cent, and freedom to select an AFP was restricted. Despite the structural reform’s assertion that administrative costs would decrease due to competition and private administration, the average fee increased from 2.44 per cent to 2.68 per cent across 1981–2008 (Table 3). Inefficiency and high managerial costs threaten to reduce future pensions: fees charged
in the private system take a quarter of affiliates’ deposits placed in individual accounts (OECD, 2013).

The re-reform produced measures to stimulate competition and reduce administrative costs: a) a biennial bidding process was introduced, where new entrants to the labour force are allocated to the AFP with the lowest fees; the new affiliates must remain with the allocated AFP for two years, but can then switch to another AFP charging lower net fees (the reduced fee is also charged to affiliates in the bid-winning AFP); b) the elimination of the fixed fee with regressive effects; and c) the replacement of the individual bidding process undertaken by each AFP to choose the commercial insurance company responsible for disability and survivor risks by a process of universal collective bidding.

The number of AFPs increased from 5 in 2008 to 6 in 2011. The concentration of affiliates in the top three funds decreased 19.8 per cent in the period 2001–2013 and by 2.9 per cent based on the value of the administered funds, but still 70 per cent are affiliated to the largest three AFPs. Due to the biennial bidding process, the net fee declined from 1.74 per cent in 2008 to 1.14 per cent in 2014. In January 2014, the bid was won by an AFP offering a net fee of 0.47 per cent. Conversely, the average premium rose from 2.68 per cent to 3.42 per cent in the years 2008 and 2009 because the abolished fixed commission was excluded from the previous averages, and it is now added as a variable cost; furthermore, coverage on disability and survivors

<table>
<thead>
<tr>
<th>Years</th>
<th>Old-age fee</th>
<th>Dis. &amp; surv. premium</th>
<th>Total</th>
<th>Total costs/ deposit (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1981</td>
<td></td>
<td></td>
<td>2.44</td>
<td>24.4</td>
</tr>
<tr>
<td>2007</td>
<td>1.71</td>
<td>0.73</td>
<td>2.40</td>
<td>24.4</td>
</tr>
<tr>
<td>2008</td>
<td>1.74</td>
<td>0.94</td>
<td>2.68</td>
<td>26.8</td>
</tr>
<tr>
<td>2009</td>
<td>1.55</td>
<td>1.87(^d)</td>
<td>3.42</td>
<td>33.8</td>
</tr>
<tr>
<td>2010</td>
<td>1.49</td>
<td>1.49</td>
<td>2.98</td>
<td>29.8</td>
</tr>
<tr>
<td>2011</td>
<td>1.48</td>
<td>1.49</td>
<td>2.97</td>
<td>29.7</td>
</tr>
<tr>
<td>2012</td>
<td>1.41</td>
<td>1.26</td>
<td>2.67</td>
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<tr>
<td>2013</td>
<td>1.39</td>
<td>1.26</td>
<td>2.65</td>
<td>26.5</td>
</tr>
<tr>
<td>2014</td>
<td>1.14</td>
<td>2.40</td>
<td>2.40</td>
<td>24.0</td>
</tr>
</tbody>
</table>

Notes:
\(^a\) Net fee paid to the AFP.
\(^b\) Disability and survival premium to the insurance company.
\(^c\) The deposit is 10% of taxable income.
\(^d\) In 2009, the same premium for men and women paid by the employers increased the rate, but it declined later.

Sources: Mesa-Lago (2012b) updated with CAPSP (2015b).
insurance was expanded. Due to bidding, the premium fell to 1.26 per cent in the period 2012–2014, but this is still higher than in 2008. The discount (net contribution plus premium) on the deposit descended from 27 per cent to 24 per cent across 2008–2014, but which is still deemed to be too high (Table 3; CAPSP, 2015b).

Despite progress, weak competition and high administrative costs persist. About 19 per cent of the affiliates had benefited from the net fee reduction in 2014, but the large majority have not switched to the lowest-fee AFP, and remain affiliated to the three most expensive – neither the fee nor the returns have a direct link to services provided by the costliest AFP – which may be explained by affiliates’ lack of knowledge or inertia, marketing and transfer costs. The only fee authorized is a fixed percentage on the taxable salary of each contributor to an AFP, which generates incentives to incorporate high-income affiliates. The average AFP profit rose from 26.5 per cent to 31.3 per cent in 2012–2013; the net fees for operational expenses represent between 60 per cent and 75 per cent of these profit earnings (CAPSP, 2015b; Sojo, 2014). In the 2014 opinion survey, 79 per cent of the interviewees supported a state-owned AFP, and 69 per cent would opt to affiliate to it (CAPSP, 2015a).

The Commission approved proposals to improve competition and cut costs, involving to: establish a public AFP with the same operating rules as the other AFPs; extend the current bidding process to win first-time affiliates also to a fraction of existing affiliates; allow entry of not-for-profit entities; transfer to the AFP the financial intermediary’s commission for investments currently charged to affiliates; and introduce collective bidding for annuities (CAPSP, 2015b).

Social participation in management

Social participation in management is a principle that complements democracy and helps systems to reflect the needs and aspirations of the insured and beneficiaries (ILO, 2000). The 2001 ILC recommended the effective participation of, and a key role for, social interlocutors in policy development, through bipartite or tripartite organs (ILO, 2001).

Before the structural reform, most pension funds had tripartite participation in their administration. The reform eliminated social participation in the AFPs and the Superintendence (the pension system’s supervisory body), although workers are the owners of their pension funds.

To alleviate the lack of social participation, the re-reform created a Commission of Users (CUSP), consisting of five different members, each one representing one of the following five groups: workers, pensioners, INP insured, scholars and AFPs. Representatives assess performance, monitor execution of re-reform goals, and publish annual evaluation reports. A state-financed Pension Education Fund was established to disclose information and educate the general public on pension matters, as do...
advisory centres that respond to questions from the public and help the insured to claim benefits and select AFPs, multifunds and pension options (CUSP, 2011).

The CUSP is a consultative body and its recommendations are not mandatory. Lack of knowledge about the pension system persists. The opinion survey of 2014 indicated that between 44 per cent and 51 per cent of those surveyed lack adequate knowledge of key elements of the system across all ages and educational and income levels – an obstacle to more active involvement. The least known elements are the fee charged and the APS (11 per cent and 12 per cent of those surveyed, respectively) (CAPSP, 2015a). The Pension Education Fund (PEF) has not lived up to expectations: the available information is too technical and not tailored for different educational levels; one of the Fund’s still unmet goals has been to promote school courses providing information on the pension system.

The Presidential Commission made a number of recommendations to: allow workers’ participation in the Board of Directors; expand the functions of CUSP and a Technical Consultation Council; introduce programmes in the Pension Education Fund to educate students, workers, trade union members and employers, and also to determine the population segment to be targeted, set specific goals and indicators to evaluate PEF performance; and fund pilot education programmes by a public institution. AFPs should develop pension educational activities to be approved by a government-appointed committee (CAPSP, 2015b).

State role and supervision

The ILO Social Security (Minimum Standards) Convention, No. 102 (1952) defines that, regardless of the type of administration chosen, the state must be responsible for the good management of institutions and services to ensure the protection guaranteed in ILO instruments.

Under privatization, the state was supposed to play a subsidiary role to the market but, actually, the state has had a key role in Chile, where 98 per cent of the insured are in the private system: affiliation and contributions are mandatory for salaried employees; the government regulates, supervises and guarantees the system; and finances the fiscal cost of the transition (see next section). Fragmentation resulted from multiple supervising entities: the AFP Superintendence, an autonomous technical agency supervised the private system, while the Social Security Superintendence and the INP oversaw the remaining public system. The armed forces and police force schemes are not under state supervision, except for general auditing.

The re-reform considerably widened the role of the state, which grants and finances solidarity pensions and the maternity voucher, improves social solidarity and gender equity, promotes competition, consolidates supervision and guarantees the financial strength of future benefits. A more systemic structure linked contributory and non-contributory pensions. The AFP Superintendence was replaced by a
unified Pension Superintendence, which oversees the private and public pension systems (excluding the armed forces and police force), the new solidarity pensions, and the advising centres. The INP became the Institute of Social Pensions (Instituto de Previsión Social – IPS) to administer the solidarity benefits (the AFP administration of minimum pensions ceased). The waiting time in the advising centres was reduced from one hour to 15 minutes. The general satisfaction index was 89 per cent and the adequate service index 96 per cent; a “single register” serves all types of pensions, making the service more agile (CUSP, 2011). Powers of the Pension Undersecretary were strengthened to better support the effective design of social security policies and to monitor the re-reform.

As already noted, Presidential Commission proposals strengthen the state’s role in the pension system: extending coverage of the labour force and the elderly through increasing coverage under the PBS; proposing the integration of the armed force and police force pension schemes; improving pension levels; closing the gender gap; further broadening social solidarity; creating a public AFP and promoting more competition between AFPs to reduce administrative costs; and guaranteeing financial sustainability of the pension system (CAPSP, 2015b).

Financial sustainability

According to ILO Convention No. 102 (1952): “the state must ensure that actuarial studies and estimates are periodically done to maintain financial equilibrium and … before any modifications in benefits, contributions and taxes … [b]enefits and administrative expenses must be financed collectively through contributions, taxes or both … Total contributions paid by the insured should not exceed 50 per cent of total resources devoted to protection”, the rest to be financed by employers and/or the state.

The structural reform abolished the employers’ contribution and shifted the responsibility to workers who pay 10 per cent of their taxable income (deposited in the individual accounts), as well as the commission and premium, thus infringing the ILO norm that the workers’ share should not exceed 50 per cent of the total contribution. The value of capital accumulated in individual accounts increased from 3.9 per cent to 64.4 per cent of GDP from 1982 to 2007, but decreased to 52.8 per cent in 2008 due to the global financial crisis. The average annual real rate of return since the inception of the system steadily declined from 20.6 per cent to 8.8 per cent. The portfolio composition by investment instrument gradually diversified from 1981 to 2008: investments shrank in public debt from 42 per cent to 14 per cent and in financial institutions from 55 per cent to 30 per cent, whereas they rose from 2 per cent to 27 per cent in stocks and from zero to 28 per cent in foreign instruments. In 2008, 55 per cent of the portfolio was concentrated in domestic

6. See also (in Spanish) <www.safp.cl/apps/boletinEstadistico/>.
enterprises and foreign instruments, whose return that year dropped sharply due to the global financial crisis (Table 4).

In 2002, multifunds were introduced permitting the insured to choose between five portfolios (A to E in terms of declining risk) with different risk exposure. (An

<table>
<thead>
<tr>
<th>Year</th>
<th>Accumulated capital (USD millions)</th>
<th>Real return (%)</th>
<th>Portfolio composition by instrument (%)</th>
<th>Fiscal cost (% GDP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1982</td>
<td>600</td>
<td>3.9</td>
<td>20.6 Public debt 28.5 Financial institutions 73.3 Enterprises 0.6 Foreign 0.0</td>
<td>6.4</td>
</tr>
<tr>
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<td>1,200</td>
<td>7.7</td>
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<tr>
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<td>5.9</td>
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<td>4,690</td>
<td>64.5</td>
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<td>6,799</td>
<td>59.1</td>
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<td>74,750</td>
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<td>61.0</td>
<td>10.2 Public debt 15.8 Financial institutions 26.3 Enterprises 17.0 Foreign 32.0</td>
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<td>111,037</td>
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<td>28.5</td>
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<td>118,053</td>
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<td>2010</td>
<td>124,726</td>
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<td>42.3</td>
</tr>
<tr>
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<td>69.5</td>
<td>8.6 Public debt 9.0 Financial institutions 21.4 Enterprises 17.6 Foreign 16.8</td>
<td>44.0</td>
</tr>
</tbody>
</table>

Notes:
- a All at 31 December.
- b Annual average since inception of the system until the end of every year.
- c Includes mortgage bonds, bank deposits, and financial bonds.
- d Includes shares, bonds, investment funds and commercial effects.
- e Total cost includes operational deficit, recognition bond, minimum pension, non-contributory pension, and armed forces deficit.

Sources: Annual real rate of return and GDP are taken from the website of the Banco Central de Chile; accumulated capital and portfolio distribution (SP, 2015a, 2015b); fiscal cost 1982–2004 (Arenas de Mesa and Mesa-Lago, 2006) and 2011 (CAPSP, 2015b).
insured person when close to retirement age (10 years before) should move retirement savings toward a less risky portfolio, to avoid potential losses to their accounts.) During the global crisis, the rate of return was negative, especially in the riskier funds: -45 per cent in A, -34 per cent in B, -23 per cent in C, -12 per cent in D and -1 per cent in E; in 2008, those who shifted from high to low risk instruments, lost a large part of their pension (CUSP, 2011). In 2013, the multifunds distribution of affiliates by portfolio risk was: 51 per cent in the riskiest funds (A and B), 35 per cent in the intermediate (C and D) and 14 per cent in the most conservative (E). Out of total affiliates that pursued an active strategy of changing funds in the period 2008–2013, 80 per cent had lower returns than those that were assigned by default to a more conservative fund; and 90 per cent had a worse return than those who stayed in fund C (intermediate risk). The active investment strategy, therefore, generates lower returns. These are additional indications of lack of knowledge and the need for financial education (CAPSP, 2015b).

The state finances all transition costs: the operational deficit resulting from closing the public system, the recognition bond for previous contributions to the former public scheme, the differential cost of the minimum pension, the non-contributory pension, and the armed forces and police force pension “deficit”. Contrary to original projections, transition costs were 5.5 per cent of GDP in 2004; excluding the last three elements in the previous list, it was 2.2 per cent. The state also guarantees pensions in case of AFP bankruptcy. Such costs are financed by the population through taxes (particularly the value added tax), which includes the poor and others who are not covered, provoking regressive effects. Contrary to other reforms in Latin America, Chile was able to finance its high transition costs because of substantial fiscal annual surpluses.

Table 4 shows significant improvement in the period 2008–2014 in the fund value, absolute and relative to GDP, setting new records in both. The average real annual capital return since the inception of the system grew from 8.8 per cent to 9.3 per cent in 2008–2010, but afterwards fell, and in 2014 was 8.6 per cent, lower than in 2008. The average return improved with the recovery, from -18.9 per cent in 2008 to 22.5 per cent in 2009, but turned negative in 2011 (-3.8 per cent) then recovered to 9 per cent in 2012–2014. The economic recovery, worldwide low interest rates, and volatile capital markets contributed to this performance. The portfolio composition in the period has been marked by an increase of 16 percentage points in foreign instruments, whereas investment in domestic financial institutions dropped 12 percentage points.

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7. The fiscal cost of the transition as percentage of GDP comes from a series constructed until 2003 that included all five components of transition costs. A new series since 2004 and going back to 1981 gives lower total costs because it excludes solidarity pensions, minimum pensions and the deficit of the armed forces and police force schemes.
Employers receive a fiscal stimulus to contribute voluntarily to their employees’ individual accounts, but in 2014 only 14,430 insured (0.04 per cent of the total) had such employer support. Employers fail to collect contributions from 6.6 per cent of their employees, and many employees reported contributions were not transferred to the AFPs. Although 80 per cent of the debt from declared-but-unpaid contributions is recovered within the first three months of being accrued, the stock of the debt relative to the total fund rose from 1.1 per cent to 1.6 per cent across 2011–2013. About 13.6 per cent of the debt was not recovered in the same year it was generated; the financial penalty imposed on employers who have evaded payment of contributions is only UF 0.75 per worker, which is very low (CAPSP, 2015b). Policies to cope with evasion problems were recommended by a Ministry of Finance study in 2014.

The total fiscal cost/GDP in 2012 came from: 1.9 per cent (operational deficit, recognition bond and minimum pension), 0.74 per cent (re-reform), and 0.90 per cent (armed forces and police force deficit); the total of 3.5 per cent was a reduction from 5 per cent in 2004 due to the decline of all cost components. The cost of the structural reform alone is projected to be 2.7 per cent of GDP in 2025 and should not disappear until 2050, thus taking 70 years to be fully paid off, longer than the original projections (CAPSP, 2015b). The new benefits/structures associated with the re-reform are financed through general taxes and savings deriving from the ending or reduction of obligations.

The long-term financial sustainability of the re-reform is ensured by: a) a solidarity PAYG pension fund with a reserve to finance new benefits; b) triennial actuarial studies of the fund and solidarity system that allocate fiscal funds according to the budget law, and elaborates annual reports on needed resources; c) quinquennial actuarial studies to assess the effects of demographic, financial and behavioural variables of affiliates upon RR and financial needs; d) an advisory board of experts monitors the solidarity pension, its fiscal impact, sustainability and the need for possible adjustment; and e) the Commission of Users annually evaluates the financial status (CCP, 2011, 2013; CUSP, 2011, 2012, 2014). The first actuarial study in 2010 showed that the system will fulfil its obligations until 2030 (CCP, 2011). The second in 2013 confirmed the fund’s sustainability in all scenarios (even in one of extreme crisis), as contributions (on average) exceed pension costs.

The re-reform shifted to the employer the 0.8 per cent premium to cover disability and survivor risks, but the worker still pays 11.4 per cent of monthly covered earnings (deposited in the individual account and net fee) or 93.4 per cent of the total contribution amount, well above the 50 per cent of the total contribution set by the ILO. Citizens’ dialogue strongly supported the tripartite contribution whereas the 2014 opinion survey had shown that 51 per cent of respondents favoured employers paying part of the old-age contribution (CAPSP, 2015a). The average real net rate of return of investment has declined over the lifetime of the
system. In 2014, 44 per cent of the portfolio was invested abroad, an unprecedented level that highlights a dangerous level of concentration abroad and the low dynamism of the domestic stock market (there are insufficient national instruments to absorb funds with a value equivalent to 69.5 per cent of Chilean GDP). Continuing world financial uncertainties suggest that more caution is needed as regards investments in foreign assets.

The Presidential Commission proposals deal with some of the above problems, to: develop new instruments of productive domestic investment, especially those that benefit small- and medium-sized enterprises; allow a greater share of investment in real assets (e.g. investment funds), and find new ways to contain the difficulties caused by the lack of market evaluation of such assets; raise the cap set on taxable income to increase revenue (with a progressive effect on distribution); impose on employers a contribution of 4 per cent (workers would still pay a 11.4 per cent contribution); increase the period before the legal retirement age (from ten to 20 years) after which investments should be shifted from higher-risk to lower-risk instruments; eliminate multifunds A and E to reduce excessive choice for insured persons without financial education; strengthen the attributes of the Technical Council on Investment; increase the currently low financial penalties for employers that withhold workers’ contributions and fail to transfer them; strengthen the Ministry of Labour and Social Security’s capacity in all matters related to the declaration of contribution payments, supervision and the delivery of pensions (CAPSP, 2015b).

Conclusions

Chile’s 2008 re-reform – proceeded by social dialogue – significantly improved the social security guiding principles that had been badly eroded by structural reform/privatization: in six years, labour force coverage rose from 62.8 per cent to 64.8 per cent, coverage of the self-employed rose from 4 per cent to 20 per cent, the coverage of women rose by 10 per cent, and coverage of the elderly population rose from 79 per cent to 83.5 per cent (Table 1; CAPSP, 2015b). Two new solidarity pensions (PBS and APS) reduced poverty, doubled the number of beneficiaries, improved pension levels and had progressive effects on distribution; employers now pay the disability and survivors premium; a maternity voucher is deposited in mothers’ individual accounts for each child born alive; in case of divorce, up to 50 per cent of the fund accumulated during marriage can be transferred from one spouse to the other; the PBS real amount has increased 50 per cent while the average pension has grown by 83 per cent, favouring lowest-income pensioners; the periodic bidding process has led to cuts in the average net commission from 1.74 per cent to 1.14 per cent of wages (0.47 per cent in the AFP with the lowest fees); and a Commission of Users with wide representation annually assesses
performance and the achievement of re-reform goals; the state’s role has been strengthened and supervision unified; the total fund value increased across 2008–2014, from 52.8 per cent to 69.5 per cent of GDP, 47 per cent above the pre-crisis level.

Despite the progress achieved, serious problems persist: 35 per cent of the labour force (particularly the self-employed) and 16 per cent of the elderly are uncovered; the privileged and heavily-subsidized (90 per cent) armed forces and police force schemes continue; the solidarity pillar has not yet filled lacunas in coverage, gender equity and inter-generational equity; 39 per cent of women are uncovered, their replacement rate is 41 per cent of that of men, their average pension amount is 43 per cent of that of men, and gender-differentiated mortality tables diminish female pensions; 68 per cent of pensions with a solidarity component are lower than the poverty line; 81 per cent of affiliates have not switched to the AFP with the lowest fees and remain affiliated to the most expensive three; 44–51 per cent of insured lack adequate knowledge of key system elements; tripartite participation in pension administration is still absent; despite a decline, employers’ evasion is still important and fines are very low; employers do not contribute to the old-age scheme (one of two countries in the region); the rate of return of investment shows a declining trend, 44 per cent of the portfolio is concentrated on domestic stocks and foreign instruments, and 80–90 per cent of affiliates that pursued an active strategy to move among multifunds have a lower rate of return than those who are either assigned by default to the least risky fund or are in one of intermediate risk.

In 2015, the Presidential Commission, after an unprecedented process of social and technical dialogue, approved 58 specific recommendations, with a majority of members’ votes, to cope with many of the identified flaws (most of them documented by a survey of affiliates); such proposals were summarized in each of the ten social security principles analysed in this study. In addition, the Commission voted on three global models to re-reform the current system: A) substantially strengthen the solidarity pillar and significantly modify the individual capitalization pillar to correct many of its flaws; B) create a mixed three-pillar system: the non-contributory basic pension, an intermediate social insurance pillar, and the individual capitalization pillar;8 and C) return to a pure PAYG system. Models A and B respectively received 12 and 11 votes, whereas Model C received one vote only and was considered financially unsustainable. The Minister of Finance calculated that the cost of implementing the 58 proposals will be 0.4 per cent of GDP, and is assessing the financial cost and sustainability of models A and B (CAPSP, 2015b). A Committee of Ministers has been entrusted with the study of the two

8. Current and future affiliates would be assigned to pillars 2 and 3, based on their income; those with lower income will be in pillar 2 only, and those with higher incomes will be in pillars 2 and 3.
models most voted for, as well as the 58 proposals, to decide which to submit to executive and legislative powers. Whatever the outcome, Chile will move forward in improving its pension system.

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Nepal’s Child Grant: A mixed-methods assessment of implementation bottlenecks

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Abstract This article evaluates the implementation of the Child Grant, one of the major social protection interventions in Nepal, and identifies bottlenecks that limit its ultimate effectiveness. On the whole, while delivery works for many beneficiaries, we found inconsistencies between the way the policy is laid out on paper, and the way it is actually implemented. Targeting efficiency is high, despite the wealth targeting criterion not being applied in practice. Owing to informal awareness-raising campaigns, beneficiaries’ knowledge on registration, eligibility and entitlement is patchy. Payment levels vary and tend to be infrequent. These implementation bottlenecks limit the Grant’s effectiveness and temper some of its impact potential.

Keywords benefit administration, cash benefit, claim procedure, registration procedure, eligibility, children, Nepal

Introduction

Social protection has become an increasingly prominent public policy tool in Nepal over the last two decades. Social protection, particularly in the institutional
forms of a social insurance work injury programme, a national provident fund and social assistance, has a long history in the country (SSA and ISSA, various years), with social transfers even provided throughout the Maoist insurgency between 1996 and 2000. Since the conflict’s end, the government of Nepal has ramped up its efforts, with social protection programming explicitly integrated into the broader post-conflict development and reconstruction agenda (Holmes and Uphadya, 2009; Köhler, 2011). For example, the National Planning Commission’s (NPC, 2007) three-year plan highlights the role social protection can play in reducing social inequalities and poverty. Social protection provision has a wide range of objectives, from increasing income and food security to overcoming social exclusion and assisting with the process of political healing (Köhler, 2011; Drucea, 2016).

One key intervention in Nepal’s National Framework for Social Protection is the Child Grant. It was launched by the government of Nepal in 2009 and covers about 20 per cent of the population of children younger than age five (CBS, 2011b). The Grant is domestically funded and delivered, and total expenditure in 2014/15 was 0.19 per cent of the national budget and 9.67 per cent of the national social protection budget. The Ministry of Federal Affairs and Local Development (MoFALD), District Development Committees and Village Development Committees are responsible for implementation.1

The objective of the Child Grant, access to which is subject to birth registration and targeting criteria (outlined below) but unconditional, is to improve the nutrition of children. Children are eligible from birth until their fifth birthday and the transfer covers up to two children per household, at a level of 200 Nepalese Rupees (NPR) (approx. USD 1.90 in early 2016) per child per month. Beneficiaries are supposed to receive three transfers of NPR 800 per year, paid at four-month intervals. The Grant is universal in the Karnali zone (one of the poorest of Nepal’s 14 administrative zones) and targeted at poor Dalit2 households in the rest of the country. In order to target poor Dalit households, a wealth criterion is defined. Households are eligible if they are landless, if they have less than a specified area of land (2 ropani3 in mountainous areas and 2 kattha4 in Nepal’s lowland plain, the Terai) or if the produce of their land is insufficient to feed the household for more than three months per year.

The transfer targets Dalit households outside the Karnali zone because these people have faced long-standing discrimination and poverty. Social exclusion and

1. This paragraph also makes use of 2015 data made available by the Ministry of Federal Affairs and Local Development in Nepal.
2. Dalits are those born into the lowest castes of the Hindu caste system and considered de facto “untouchable”. Although the caste system was legally abolished in 1963, it continues to influence and shape Nepali society, customs and opportunities.
3. Ropani is a unit of land area used in Nepal (approx. 8 ropani = 1 acre).
4. Kattha is a unit of land area used in Nepal equal to 338.63 m².
structural inequality can to a significant extent be explained by Nepal’s cultural and historical practices, which reinforce each other and stem mainly from traditions based on feudal, patriarchal and caste structures (World Bank and DFID, 2006). Caste discrimination has been outlawed since 1963, yet Dalit and other low-caste groups continue to face obstacles in terms of participating in the overall political system as well as in accessing government services, resources and opportunities (UNDP, 2009). Dalit, Hill Janajati and Muslim groups experienced the lowest decline in poverty between 1995/96 and 2003/04 (ADB, DFID and ILO, 2009). Meanwhile, there are intersecting inequalities between caste and gender, with Dalit women faring the worst, for example in terms of education. Among Dalit women in the Terai lowland belt, the literacy rate is 17 per cent, which is the lowest in the country compared with the national average for women of 55 per cent and the male average of 81 per cent (ADB, 2010). Finally, caste is still a strong influential factor in interpersonal relations in Nepali society. Among Dalit respondents in a survey on social inclusion, 20 per cent reported experiencing high levels of restriction or intimidation; all Dalit reported such experiences to some degree (Bennett, 2005). Caste-based discrimination occurs in most aspects of life; for example, in some cases, higher castes still refuse to use the same water sources as, or try to avoid direct contact and touching of, the “untouchables” (Bennett, 2005).

A number of other studies consider various aspects of the Child Grant. Some focus on implementation, sensitization campaigns and birth registration (e.g. Rana, 2012; UNICEF, 2010 and undated; CBS and UNICEF, 2012), as well as proposing funding options for the scale-up and enhancement of the Grant (Rabi et al., 2015). Two studies so far have analysed the impacts of the Grant, both with a focus on the Karnali zone. Adhikari et al. (2014) did not find any significant impacts of the Grant, while the qualitative research for the same study suggested it made a small contribution to household expenses. Okubo (2014) found that receiving the full transfer amount was associated with a lower prevalence of underweight children and severe acute malnourished children.

This article is the first to focus on how the Child Grant works for Dalit households, who are in fact the main target group. We analyse implementation of the Grant for Dalit households outside the Karnali zone in order to identify any barriers to effective programme delivery and impact. The analysis is based on mixed-methods research conducted in late 2014/early 2015. It draws on a survey of 2,000 Dalit households and more than 70 in-depth interviews (IDIs), focus group discussions (FGDs) and key informant interviews (KIIs). Two case study districts were selected that have a proportionally high share of Dalit households compared with the national average: Bajura in the Far-Western Mountains and Saptari in the Eastern Terai.

The remainder of this article is structured as follows. The next section presents data and methodology. We then consider all stages of programme implementation
in detail, including registration, targeting and delivery. Next, we discuss four implementation bottlenecks that were identified. We conclude by summarizing the main findings and presenting policy recommendations.

**Methods**

This research is based on mixed-methods research (i.e. using quantitative and qualitative findings) conducted in two case-study districts. The mixed methods approach allowed us to collect detailed data on implementation performance, as well as elicit detailed information on beneficiaries’ actual experiences and perceptions. Both districts have a high concentration of Dalit households, but somewhat different characteristics in terms of geography, livelihoods and food security. These selection criteria were chosen because geography (particularly remoteness) plays an important role in determining well-being outcomes in Nepal, and livelihoods and food security are of particular relevance, given that the objective of the Child Grant is to improve the nutrition of children.

For this study, the remote and difficult to reach Bajura district in the Far-Western Mountains was selected. Typical of the Far-Western region, more than 71 per cent of households participate in own agriculture (CBS, 2011b). This district experiences very high levels of chronic food insecurity (NFSMS, 2012) and 25 per cent of Bajura’s households are Dalit (CBS, 2011a). In the Eastern Terai, we sampled Saptari, a district with low levels of chronic food insecurity (NFSMS, 2012) and an above average share of households employed in non-agricultural self-employment, e.g. running a business (CBS, 2011b). The share of Dalit households is 23.1 per cent. Therefore, in both sampled districts, the share of Dalit households is much higher than the national average of around 12 per cent (CBS, 2011a).

The quantitative household survey was conducted in late 2014, covering 2,000 households in total: 1,200 in Saptari and 800 in Bardiya. Interviews were conducted in geographically remote as well as less remote Village Development Committees (VDC) – the lowest administrative unit. A total of 11 VDCs were covered in Bajura and 13 VDCs were covered in Saptari. Interviews were conducted only with Dalit respondents and 88 per cent of respondents were mothers of the youngest child in the household. We interviewed respondents from beneficiary and non-beneficiary households. The questionnaire covered experiences and perceptions of receipt of the Child Grant, as well as more general information on household demographics, livelihoods, food security and wealth.

We applied a sequencing approach, with the qualitative research being conducted after the quantitative survey. The qualitative study was conducted within the same population that had participated in the quantitative survey and with quantitative enumerators identifying relevant respondents for further interviews.
Three main tools were used in the qualitative fieldwork: (i) in-depth interviews (IDIs); (ii) focus-group-discussions (FGDs); (iii) key informant interviews (KIIs). An overview on the qualitative interviews conducted is presented in Table 1. The combination of tools aimed to collect detailed information on the experiences with and perceptions of the Child Grant of beneficiaries and non-beneficiaries, as well as considering the experiences of implementers and other officials in delivering the Grant.

The FGDs were conducted with beneficiary and non-beneficiary households to understand the targeting, application, registration and delivery processes. Within these groups, there were separate male and female discussions, to tease out gender and age perspectives. A small number of FGDs were conducted with eligible, non-beneficiary households in order to generate a better understanding of (possible) information gaps concerning the application and targeting process. A small number of FGDs were also conducted with non-beneficiary Dalit households. In total we conducted 34 FGDS: 11 in Saptari and 23 in Bajura, in two locations in each district; 23 with beneficiary households and 11 with non-recipient households.

Further, a number of in-depth interviews were also conducted with beneficiary and non-beneficiary households, in order to collect the detailed experiences of these households. In total, 22 IDIs were conducted (13 with beneficiaries and nine with non-beneficiaries).

Finally, 18 KIIs were conducted with knowledgeable local, district and central officials and other persons of authority at the local level in order to gain understanding of bottlenecks in the targeting, registration and delivery process that may limit effectiveness. The key informants included VDC secretaries, VDC assistants who help in the distribution of the Child Grant, local mobilizers, female community leaders, and district and central officials.

### Awareness of the child grant and the registration process

The quantitative data shows that there is a high level of general awareness of the Child Grant, with 98 per cent of respondents, including non-beneficiaries, having heard of it. The majority of respondents first heard of the Grant from the VDC

**Table 1. Number of qualitative interviews conducted**

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<tr>
<th></th>
<th>Bajura</th>
<th>Saptari</th>
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<tr>
<td><strong>IDIs</strong></td>
<td>7 (4 with beneficiaries, 3 with non-beneficiaries)</td>
<td>15 (9 with beneficiaries, 6 with non-beneficiaries)</td>
</tr>
<tr>
<td><strong>FGDs</strong></td>
<td>23 (14 with beneficiaries, 9 with non-beneficiaries)</td>
<td>11 (9 with beneficiaries, 2 with non-beneficiaries)</td>
</tr>
<tr>
<td><strong>KIIs</strong></td>
<td>6</td>
<td>12</td>
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</table>

**Notes:** IDIs = in-depth interviews, FGDs = focus group discussions, KIIs = key informant interviews. **Source:** Authors.
office (66 per cent of the sample on average), with some distinct differences between districts. In contrast to Bajura, in Saptari a much lower share first learnt of the Grant from the VDC/municipality office (54 per cent), with a third of respondents hearing of it first from relatives. Our qualitative research confirms the idea that awareness of the Grant is raised through multiple means. In Saptari, several interviewees reported learning about the Grant through conversations with neighbours, while participants in one FGD cited the local market as a good place to hear about such programmes. This word-of-mouth approach to awareness-raising has its limits: according to non-recipients in Bajura, it is difficult to find out about new programmes, because the large size of their village (and with Dalit households often physically isolated from the rest of the village) prevents an easy, rapid flow of information from person to person.

Commonly, many of the means through which people discover the Child Grant are of a fairly informal nature, and do not necessarily conform to the ways in which government officials might assume these to work. This is a double-edged sword: while it is probably the informality of the methods that enables people living in remote places to find out about the policy, when information is transmitted through these means it risks becoming diluted or distorted, in particular with language (i.e. translation) issues potentially coming into play. It is likely that this is what (partly) accounts for many beneficiaries’ incomplete knowledge of how the Grant should officially work according to its formal design (see below).

While there is a high level of general awareness of the Child Grant, specific knowledge around the registration process is not always strong. According to the quantitative survey, there seems to be a great deal of confusion regarding some of the rules and procedures of the registration process. Just under 50 per cent of all respondents, for example, believe one can apply for the Grant anytime – when in fact it is only once a year, in November. The qualitative data highlight a further problem regarding levels of awareness, with many eligible households confused about the difference between registration for the Grant and birth registration. Most respondents were under the impression that they automatically receive the Grant once they obtain a birth certificate for their child; hence, it is sometimes the case that parents do not register their children for the Grant after applying for a birth certificate. This confusion seems to stem from the fact that both Grant registration and birth registration are undertaken at the VDC office, and because the administrative processes for the Grant and birth certificates appear so closely intertwined: in both districts, many beneficiary households only started applying for birth certificates for their children once it became a condition for Grant registration.

Despite limited awareness concerning registration, the process works smoothly for many beneficiaries, but for some it takes time and money, with 20 per cent of respondents saying that they had encountered a problem. On average, it took...
respondents more than one trip to register. Registration involved a higher number of trips for respondents in Bajura (1.4 trips compared with 1.2 trips in Saptari). For 77 per cent of the sample, it took less than half a day for the round trip to register and return home; for more than 30 per cent of households in Bajura it took more than half a day, which is understandable given Bajura’s geography (Table 2).

Approximately half of all respondents in Bajura had to make a financial payment when applying for the Child Grant, compared with 32 per cent in Saptari. The average payment amounts to NPR 50. The fact that one in two respondents in Bajura made a payment when registering possibly signals “corruption” on the part of local government. However, more than 90 per cent of respondents in both districts said (or rather perceived that) this payment was for paperwork, and just 13 respondents in Saptari and one respondent in Bajura said this was for a “gift”. This again tells us something about people’s awareness of the official rules: owing to the close association between birth registration and Grant registration, and because of low levels of awareness concerning formal administrative procedures amongst most respondents, it is often difficult for recipients to distinguish between what constitutes an official registration fee or a payment for a birth certificate and what constitutes a bribe.

**Targeting effectiveness**

As discussed, outside the Karnali zone, the Child Grant is officially targeted at households exhibiting three characteristics: i) they are of Dalit caste; ii) they have at least one child younger than age five; and iii) they meet the wealth criterion (that is, owning no land/owning less than a stipulated amount of land/only being able to feed themselves from their own land for three months or less per year).

While the policy demands that service providers apply each of these three criteria evenly and consistently, it is clear from our qualitative research that, in practice, they do so with regard to only two of the three. Speaking to various government officials, it was apparent that the wealth criterion rarely formed part of the

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<th>Bajura</th>
<th>Saptari</th>
<th>Total</th>
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<tr>
<td>Less than half a day</td>
<td>69.5</td>
<td>82.5</td>
<td>77.3</td>
</tr>
<tr>
<td>Half to one day</td>
<td>23.3</td>
<td>16.3</td>
<td>19.1</td>
</tr>
<tr>
<td>Two days or more</td>
<td>7.3</td>
<td>1.1</td>
<td>3.6</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
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*Note: Differences between districts significant at the 1 per cent level.
Source: Authors.*
basis for determining eligibility. Although national guidelines stipulate a clear set of targeting criteria, in practice the wealth criterion would appear difficult to apply, one reason for which is limited state capacity to deliver the policy effectively at the local level. Consequently, a procedural norm seems to have become embedded into the operation of the Child Grant, whereby eligibility is de facto defined by two out of three criteria: Dalit caste status and the presence of a child or children younger than age five. As a result, in communities populated by a high number of Dalit households, even where some households are wealthier than others, it might appear that the Grant is almost universal. As one respondent in Saptari stated, “Everyone with a [child] under-five is getting money here”.

This unevenness in criteria application might be a threat to the programme’s ability to target the right families, which creates a need to determine the accuracy of targeting. It is for this reason that the survey’s sampling process deliberately included non-recipient households with children younger than age five, some of whom may be eligible. On this basis, it would be possible to calculate “targeting errors”.

Targeting errors measure the effectiveness of the implementation of targeting guidelines – that is, the extent to which official selection criteria are followed. The “exclusion error” measures the share of eligible households that are not receiving the Child Grant. The “inclusion error” measures the share of beneficiary households that are ineligible for the Grant but do receive it. Inclusion and exclusion errors, by district, are presented in Table 3.

International evidence suggests that exclusion errors in means-tested programme tend to be quite high, and it is common for over half of eligible beneficiaries to be excluded from programmes (Samson, van Niekerk and Mac Quene, 2010). For instance, based on the programme eligibility threshold, Brasil’s Bolsa Família in 2004 had an exclusion error of 59 per cent and Mexico’s Oportunidades had an exclusion error of 70 per cent in 2004 (Soares, Ribas and Osório, 2010). We find that both the exclusion error and the inclusion error for the Child Grant are

<table>
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<th>Bajura</th>
<th>Saptari</th>
<th>Total</th>
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<tbody>
<tr>
<td>Exclusion error</td>
<td>16</td>
<td>31</td>
<td>24</td>
</tr>
<tr>
<td>Inclusion error</td>
<td>17</td>
<td>37</td>
<td>29</td>
</tr>
</tbody>
</table>

Note: The mean for each district is statistically different from the sampled population as a whole at the 1 per cent level. Source: Authors.

5. It should be borne in mind that the sample is not representative of the entire Dalit populations of Bajura and Saptari.
fairly modest. For the sample, as a whole, 24 per cent of eligible households are excluded, whereas 29 per cent of beneficiary households are included despite not being eligible according to the targeting criteria. This is quite low for a means-tested transfer, particularly given that the wealth criterion has not been applied.

The exclusion and inclusion errors are both considerably lower in Bajura. There, because of the mountainous terrain, people tend to own less land, and this is generally less fertile than land in the Terai. Hence, households in Bajura are more likely to satisfy the wealth criterion for eligibility, and Bajura’s inclusion error is subsequently lower. The exclusion error is also significantly lower in Bajura. One possible (partial) explanation for this that emerged from the qualitative material is that dissemination campaigns in Bajura have been more effective. For instance, 85 per cent of respondents first heard of the Child Grant through the VDC office, which is the formal channel.

The next step is to identify the characteristics of “excluded yet eligible” households. For exclusion error, the study found that excluded households are more likely to be headed by women compared with the total population (15 per cent, compared with 11 per cent for the total sample) and the main livelihood activity of the excluded household is more likely to be paid employment and less likely to be in agriculture. It may be that, although these households may notionally qualify for the Child Grant because of low land asset holdings, the income earned through alternative, higher-return activities offsets their reliance on the Grant. This reduces the likelihood of these households registering to receive it. When we consider other evidence (discussed above and below) showing that both registration and the collection of payment attract an opportunity cost – in terms of lost labour time – and also take into account the low value of the transfer, there may be some value in this intuitive hypothesis. However, the qualitative interviews provided relatively little evidence on this issue, meaning that no firm conclusions can be drawn. This is a potential area for further research.

Awareness of the age and caste targeting criteria among beneficiary and eligible non-recipient households is very high. More than 92 per cent of respondents know that only Dalit households receive the Child Grant and close to 100 per cent of respondents know the age targeting criteria. However, only 8.4 per cent are aware of the wealth targeting criteria. Given the widespread lack of awareness of the wealth criterion, the study sought to develop an understanding of respondents’ perceptions of the effectiveness of targeting. On the whole, respondents think the targeting mechanism is working well, but perceptions are more negative among non-recipient household respondents. Many of those who do not receive the Grant – but who are not eligible because of their caste status – perceive the policy as a whole to be unfair. The qualitative data show that non-Dalit households are of the opinion that all Dalit households with young children qualify for the transfer, regardless of whether they are poor or not. Understandably, this perceived situation
is seen as unfair given that in the communities selected for this research practically all households are poor.

**The distribution process**

Respondents were asked also about the actual Child Grant distribution process, including frequency of payments, payment levels and experiences in collecting the grant. Although beneficiary households are meant to receive the Grant three times a year, on average they received it twice per year – the average frequency was higher in Saptari (2.44 times) compared with Bajura (1.64 times). Also, at the beginning of a claim it generally takes several months before households start receiving the Grant: almost 40 per cent of respondents waited longer than seven months for the first payment.

The study sought explanation as to why many payments are received late. A number of respondents suspected government corruption was to blame, with reports within some communities suggesting that government officials withhold the money, rather than delivering it to beneficiaries. On the basis of the data collected by the study it was not possible to estimate how widespread this practice may be, although other research on service delivery suggests a “culture of corruption” is characteristic in local government across Nepal (Asia Foundation, 2012). However, it seems unlikely that budget allocations in their entirety could be appropriated by local government officials. Instead, a delivery challenge would appear to be important bottlenecks in the state system, particularly at higher levels. A number of local and district officials discussed that funding from central government is sometimes not released on time, resulting in important delays in the local distribution of cash transfers, sometimes for months. Such delays may be the result of budgetary pressures in central government. According to one VDC Secretary in Bajura, whether funds are sent every four months from central government “depends on how much budget there is centrally [i.e. at the national level].”

Another factor that potentially affects the timeliness of distribution is local government capacity. Delays in the transfer from the central budget are one challenge, but there is no guarantee that the policy delivery will run smoothly even once the budget reaches local government. The study’s qualitative data suggest that a lack of human resources within many VDC offices constrains local government capacity to deliver the programme effectively and on time. Notwithstanding widespread accusations of local government corruption, it is important to bear in mind that VDC offices are expected to deliver multiple policies and perform various functions in the absence of any real decentralization of power and resources (Asia Foundation, 2012).

A large number of beneficiaries experience delays in receiving transfers and, in the yearly-period, may not receive all three payments. However, the study sought to investigate two additional points regarding those beneficiaries who do receive...
the Child Grant. How much are beneficiaries actually receiving? Do beneficiaries know how much they are entitled to? Awareness of entitlement varies considerably, with beneficiaries in Saptari having much more accurate knowledge of how much they should be receiving. While there were some inconsistencies during the fieldwork in the way that enumerators asked the question about how much households actually received, it appears that households received close to the official payment of NPR 800 for each four-month period: the average payment was NPR 780. A standard deviation of 50 in the data compiled by the study indicates some variation across households in terms of the size of payment received. The amount received in Bajura is lower, but still well above NPR 700 per payment.

However, the qualitative data shows considerable variation in terms of payments received. In both districts respondents said the child did not get full payment, particularly in the first and fifth years of the child’s life (it is not paid retroactively for the first year). As the following quote from a FGD in Bajura illustrates:

Here, we do not get money in the first year and the fifth year; by the time we do the registration and all, the child is above one year of age. And when the child has completed four years they say the child is five years and do not give the Grant.

According to the official guidelines, a child should receive the Child Grant from birth up to the day of his or her fifth birthday, but this does not seem to occur uniformly. This discrepancy suggests there is an implementation gap affecting policy effectiveness. A large part of this implementation gap concerns the transfer of diluted or distorted information, both to government officials at the local and district levels and to beneficiaries. For instance, beneficiaries often feel they do not receive the correct amount. Frequently, these feelings seem to be grounded in incomplete knowledge of the formal policy design, which is probably related to the informal and arbitrary ways in which information about the policy is first communicated to households and individuals.

Transfers tend to be paid by VDC secretaries in the VDC office, which can be at a considerable distance from some beneficiaries’ homes. For 82 per cent of the total sample, it takes less than half a day for the journey back and forth to collect the Child Grant. However, for nearly 20 per cent of the sample in Bajura it takes more than half a day to collect the Grant. Many respondents complained of the large queues that gathered around the distribution points. Part of what accounts for these gatherings of people is the time window in which recipients can collect the transfer, which varies from place to place: generally this may last for two to three days, but in some instances it was longer. The large queues and long waiting times that often accompany the distribution of Grants further constrain the capacity of beneficiaries to learn about the proper functioning of the policy. Existing information asymmetries are reinforced and sustained by the somewhat chaotic payment
distribution process, where, because of the large number of people waiting to receive payment, it becomes almost impossible to ask even a simple question to the one or two (already overloaded) local government officials.

Of course, an individual’s capacity to ask questions to those in positions of (relative) power is not simply a question of logistics. It is also rooted in state-society relations more broadly, which – depending on the particular nature of those relationships – can work to deter citizens (or at least certain groups of citizens) from “speaking out”. Particularly for Dalits, this can be very challenging owing to their long history of social exclusion (World Bank and DFID, 2006). One way governments can try to address this situation is to incorporate in the design of programmes “accountability mechanisms” permitting people to voice grievances. Such accountability mechanisms have been shown to improve programme performance (Browne, 2014). Evidence from other countries shows that even marginalized groups will express their voice if grievance redress is properly designed and enforced (see, for example, Patel et al., 2014). While, on paper, an overarching grievance mechanism exists for Nepal’s social protection programmes, including the Child Grant, we found no evidence of these mechanisms being implemented locally. As such, the survey data show a relatively low degree of awareness of grievance mechanisms: only 14 per cent of respondents said they knew how to make a complaint. Respondents who did make a complaint are on the whole not satisfied with the response: 45 per cent are not satisfied at all, and 35 per cent are only satisfied to some extent.

Four implementation bottlenecks

The analysis in the previous sections leads us to discuss four bottlenecks that exist in the implementation of the Child Grant, which act to neutralize some of the potential impacts of the programme. To address these, we propose policy recommendations in the final section.

Wealth targeting criterion

The first bottleneck is the wealth targeting criterion. The wealth targeting criterion adds another layer of complexity to overburdened local officials and may, in fact, not be viable, particularly given limited state capacity. As discussed, wealth status is determined by ownership of land assets and the extent to which these assets can be used to provide for the household. There are several problems with this.

First, it represents a very narrow idea of what constitutes poverty. Our evidence suggests a number of “eligible yet excluded” households are in fact better off in...
some ways than eligible households that do receive the grant (see the section on targeting effectiveness). This is arguably because, while the former households may not own much, if any, land (and are therefore entitled to the Child Grant), these households are more “cash rich” than others – even among those that own enough land to render them ineligible.

Second, it is clear from our evidence that, in practice, the Child Grant is not targeted in accordance with wealth status – regardless of the narrow, simplistic way in which it is currently defined. There appears to be both limited application of this particular criterion by government officials and extremely low awareness among both beneficiary and non-beneficiary households. Therefore, it is worth to consider whether it is necessary to use wealth as a targeting criterion? Our analysis of targeting errors shows modest inclusion and exclusion errors. This means that, even though the wealth targeting criterion has not been applied in practice, few non-eligible households are included – most Dalit households are poor. In other words, if the objective in Nepal is to target a poor and vulnerable population group then the caste targeting criterion is sufficient.

A third problem we see with the current wealth criterion is that it may not be implementable given real-world constraints facing service providers. It is rather challenging for VDC secretaries to measure and take into account land ownership when identifying eligible households. This, in turn, is related to questions of limited local government capacity. VDCs are expected to function as the implementing institution of multiple policies (including other social protection programmes, but also other services). However, they are typically under-resourced and under-staffed. Against this backdrop, the wealth criterion represents just one more layer of complexity for over-burdened VDC offices.

An implementation gap

The challenge of weak local government capacity is related to the second bottleneck: an implementation gap between how the policy is set out on paper at the central level and how it is operationalized locally. Policies that are designed and drafted in a particular place – the Nepali government’s “Red Book” of Directives is one good example – rarely work in practice in every respect as they are formally expected to. This is because policies mutate across space and time, becoming diluted and distorted as they “travel” from one level to the next (from national to district to local to household) (Peck and Theodore, 2012). They are subject to the nuances and variations of local governance, which include geographical differences in state capacity.

We have found this to be the case with the Child Grant. Our evidence points to a considerable gap between the formal design of the Grant and the ways government
implements it. For example, we see large variations in the methods through which information on the policy is disseminated to potential beneficiaries, as well as in the timing of the distribution of payments and in the values of transfers. On the former, VDCs appear to apply some informal, almost arbitrary, methods to raise community awareness about the Grant, such as using information brokers of various kinds (e.g. female community health volunteers). In such circumstances, the potential for flows of misinformation increases.

Regarding the timing and cash value of payments, the official policy states beneficiaries should receive NPR 800 three times a year. It is evident this does not happen in all cases. This is not to say that the policy is never followed, but in many cases beneficiaries receive less than they should and less frequently than they should. Our qualitative evidence suggests this owes, in part, to further bottlenecks within the state system: funds housed at the central level can take considerable time to reach the local level, for various reasons, which places obvious limits on VDCs’ abilities to deliver in full the policy. As discussed, there are also some claims of the incidence of corruption at local government level.

**Inadequate outreach and information dissemination**

The first two bottlenecks help account for the third bottleneck: inadequate outreach and information dissemination. Many beneficiaries possess incomplete knowledge of how the Child Grant should be accessed and its nature, particularly in terms of the registration process, knowledge of eligibility criteria and their entitlement. As might be expected, non-beneficiaries also operate on the basis of incomplete knowledge. This, in some cases, can fuel resentment towards beneficiary Dalit households that are perceived to be wealthier than non-Dalit households in the same community.

It also appears to be the case that the dissemination strategies – either intentionally or otherwise – target particular groups of people, particularly mothers. This reveals something interesting about the gendered construction of the Child Grant policy and of the way it is locally implemented. Service providers may apply their own notions of what the policy is “about”, which may in turn shape their approach to targeting and dissemination. Our evidence suggests the Grant is locally understood as a form of “nutrition allowance”, which is targeted towards mothers, as these are seen as the family members responsible for young children (the target group). In some ways, it is framed as a feminized policy; an intervention that, like the issue of (under)nutrition it seeks to address, is seen to be the concern of women (Mallett and Denney, 2014). However, the implicit assumptions behind the design of the Grant may contradict actual family practices in terms of who makes household spending decisions. As such, it is unlikely to fully realize the significant empowerment impacts that some policy-makers
and academics suggest cash transfers embody (e.g. as argued in Sabates-Wheeler and Devereux, 2004).

The survey data showed that it is not always the eligible child’s mother who collects the Child Grant: in only about two-thirds of households does the mother collect the Grant; and 45 per cent of mothers hand over the transfer to their husband after receiving it. Given these realities, it makes little sense to maintain the current gendered construction of the Grant. Fathers, husbands, in-laws and other persons are all part of the process of how it is received and spent, but, as a result of the nature of the awareness-raising strategies, these actors might have very different expectations about what the cash transfer should achieve.

**Limited formal accountability mechanisms**

The problem of information asymmetry discussed above, which has the potential to reduce the effectiveness of the policy, shares a reciprocal relationship with the fourth and final bottleneck our analysis has identified: limited provision of formal accountability mechanisms, which prevents beneficiaries from speaking out and also thus prevents the gathering of data to improve programme delivery. If potential and actual beneficiaries do not know what they are officially entitled to, it is much more difficult for them to hold the provider to account when there is a delivery failure. However, even when beneficiaries are aware of their entitlement, we found a general reluctance to speak out. Our analysis has identified three issues in particular. The first relates to the way payments are distributed locally. As stated above, distribution windows are typically quite short, although this varies, and they can become quite chaotic and disorganized. The evidence suggests this can sometimes discourage beneficiaries from raising concerns with VDC officials, or even from asking simple questions about the logistics of the Child Grant. The second issue concerns people’s lack of access to formal grievance mechanisms. While on paper there is a formal grievance mechanism, we did not find evidence of it being implemented. Finally, a culture of “not speaking out” seems to prevent many individuals from asking questions to and of their government. This is a historical condition, rooted in the uneven power dynamics underlying relationships between gender, caste and state; it cannot be easily altered. So, while there are no quick fixes, it is nonetheless important that we understand it as a key part of the context in which the Grant exists. What it means is that, even where you have formal grievance mechanisms or committees that work on paper, as a result of pre-existing structural factors there is no guarantee that people will make use of them.

These four bottlenecks that derive from the implementation of the Child Grant together generate an explanation for why its delivery may not be as effective as it potentially could be. They also speak to an issue that is at the heart of this unfulfilled potential: the noticeable absence of a process that encourages monitoring,
reflexivity and continual adaptation. The findings suggest that few attempts are made to “follow the policy” down to the local level. Rather than checking on how the policy may be mutating – which, of course, costs time and money – it is simply assumed that the process is working. But this is not sufficient. As our analysis has shown, various problems associated with the way in which the Child Grant is actually implemented limit its overall effectiveness. By investing in better monitoring, as well as in better state capacity to respond to the subsequent need to monitor data, it will be possible to learn more about how the policy “lives and breathes” – and to adjust it as necessary.

Conclusion

This research has evaluated the effectiveness of the Child Grant in Nepal for Dalit families and identified bottlenecks within the implementation process. Like other studies on social protection in South Asia, we show that inadequate delivery can limit the intervention’s ultimate effectiveness (see, for example, Babajanian, Hagen-Zanker and Holmes, 2014). On the whole, while the delivery of the Child Grant works for many beneficiaries, we found many inconsistencies between the way the policy is laid out on paper, and the way it is actually implemented. From the analysis presented here, four key findings are to be highlighted.

While general awareness of the Child Grant is high, this is often less so for specific knowledge on the rules and regulations of the registration process. Given that the processes for registration for the Child Grant and birth registration are so closely interlinked, most respondents were under the impression that they automatically receive the Grant once they obtain a birth certificate for their child; it is sometimes the case that parents do not register their children for the Child Grant after applying for a birth certificate.

Second, we find only modest targeting errors in the implementation of the Child Grant. This is good news, because it means that, in comparison with other programmes, relatively low numbers of poor, eligible households are not receiving the transfer. What is more, these low targeting errors exist despite the fact that, in practice, the wealth targeting criterion of the Grant is rarely (if ever) applied. Our analysis suggests this is to do with weak government capacity at the local level, and the additional layer of complexity that having to assess land ownership (the proxy used to judge wealth status) creates for implementers.

Third, we find that, because in many communities most households can be considered poor, targeting the Child Grant towards Dalit households may unintentionally reinforce caste difference. Our interviews with non-Dalit households showed that they are often equally as poor as Dalit ones. Targeting the Grant towards Dalit households appears to fuel resentment and jealousy, which has some potentially worrying implications for social relations within communities (see also...
Köhler, Cali and Stirbu, 2009; and KC et al., 2014, for similar findings in relation to Nepal’s Old Age Allowance). This raises serious questions about the legitimacy of excluding thousands of under-five children on the basis of caste alone. As the government of Nepal currently targets a whole range of social protection interventions towards Dalit households, these issues merit further research.

Finally, this study finds the Child Grant to be weakly monitored, which prevents positive learning and adaptation. The programme is assumed to work as it was designed, with few attempts made to examine how it might have evolved or mutated as it “travels” across the country. This is, in turn, another consequence of weak state capacity: when VDCs are expected to deliver not just one but multiple social protection policies at the local level, we find that limited human resources and a generally weak decentralization of power compromise their capacity to do so effectively. Further research could focus on tracking policy mutations as it travels from one level of government to the next in order to identify information blockages.

In moving forward, there are a number of ways in which the delivery of the Child Grant could be improved and hence achieve better outcomes for children. Foremost, it would be good to move towards more frequent or rolling forms of registration. This will increase effectiveness and may also ease the burden on VDC officials. Furthermore, it will ensure that beneficiaries start receiving the first transfer payment sooner, especially given the fact that the first year of a child’s life represents a key window of opportunity (Hoddinott et al., 2011). It is also important to improve the timeliness of transfers, and further research should investigate the payment bottlenecks across various levels of government administration. In addition, awareness-raising strategies mostly target mothers, who often do not have complete autonomy over household spending practices. Therefore, dissemination campaigns should also target husbands and parents in-law. We also suggest removing the wealth targeting criterion. It is too difficult for local officials to implement, and, based on our estimation of targeting errors, does not make much difference to targeting outcomes. Finally, it is important to provide more support to local officials who implement the Child Grant. Of particular importance is to provide more support to enable the sustained monitoring of the programme as this will help identify problems as they evolve on a continual basis.

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Nepal’s Child Grant


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Social security reforms in Kenya: Towards a workerist or a citizenship-based system?

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Abstract  With social security provisions in Kenya remaining under-reported in the more recent literature, this overview covers recent reforms in key areas of the country’s social security system. In the health sector and in old-age pension provision social security is still mainly workerist (biased toward those in formal employment), and attempts to expand coverage have had limited effect only – cash transfer programmes, for instance, have been expanded but in practice they do not universally cover the entitled categories. Thus, although the Kenyan social security system now has a considerable pro-poor social assistance component it remains biased toward those in formal employment, to the benefit of the highest income quintile.

Keywords  coverage, social policy, provident fund, social insurance, social assistance, Kenya, Africa

Introduction

Recent attempts to situate Kenya within a comparative social security framework have produced divergent results. According to Wood and Gough (2006, p. 1703), Kenya is part of the “actual or potential welfare state regimes … with high state commitments and relatively high welfare outcomes”. Later in the same work, however, the authors characterize the entire region of sub-Saharan Africa as an “insecurity regime” (Wood and Gough, 2006, p. 1706). Elsewhere, Abu Sharkh and Gough (2010, p. 40) have situated Kenya in cluster E for the year 1990, without
further describing the characteristics of the countries classified in that group. A
decade later, in 2000, Kenya belonged to cluster D, described as “middle-income
countries with relatively high spending on health and education, moderately good
welfare impacts and high literacy but with very low life expectancy”. Later in that
article, this cluster was called a “Failing Informal Security Regime: High Morbidity”
cluster analysis; neither does Seekings (2013) in his.

The focus of this contribution is not concerned with looking at the selected
variables that led to the inconsistent results of the cluster analyses reported above,
but rather with presenting an overview of social security provision in this interest-
case. Despite papers published in the 1970s and 1980s (Musiga, 1974; Witzsch,
1981; Fuchs, 1985; Neubert, 1986; Mullei, 1988), the provision of social security in
Kenya has been somewhat under-reported in the recent literature. Moreover, since
the contribution of Gsänger (1994), there have been important changes in the
Kenyan social security system, especially in the last few years. Based on a review
of the relevant literature and regular fieldwork conducted in Kenya since 2006, this
article thus attempts to characterize key areas of social security by asking the
question “who gets what and how?” (Seekings, 2013, p. 16).

As a theory-driven framework, we draw on Seekings’ (2008, 2013) proposition
to distinguish between citizenship-based regimes and workerist regimes.
Citizenship-based regimes, which focus more generally on universal rights, devel-
oped out of an earlier pauperist focus on social assistance for the poor. From this
perspective, the state, and not employment, is central to solidarity and social secu-
ritv is decommodified and more concerned with redistribution. In sub-Saharan
Africa, again according to Seekings (2008, 2013), pauperist regimes were common,
with the classical example of food aid. Non-contributory social assistance is central
to this type of regime, both in its pauperist and citizenship-based forms. Workerist
regimes, which are more common outside of sub-Saharan Africa, focus on social
insurance (in contrast to social assistance) and especially on formal economy
workers, thus benefiting the middle groups of society. With a focus on social
insurance, employment is central and a locus of solidarity, with little or no
decommodification and little redistribution. Seekings (2008, p. 27) acknowledges
that, in practice, elements of the two approaches are frequently combined.
Consequently, his statement that workerist regimes are more common outside of
sub-Saharan Africa does not mean that social insurance is absent from this region,
but that more public expenditure in sub-Saharan Africa flows into citizenship-
based and pauperist forms of social assistance. While the state-centrist approach
of Seekings neglects other providers of social security, it provides a heuristically
useful distinction.

The distinction also helps to situate Kenya within wider, global social policy trends
and in turn informs the discussion on these. The workerist approach with its focus on
contributory social insurance embedded in a tripartite and thus corporatist setting has been championed by the International Labour Organization (ILO) for many years. From the 1950s to the 1970s, inspired by modernization theories, it was generally assumed that the countries of the Global South would follow the model of the Global North and develop from agricultural societies to industrial societies (So, 1990; Deacon, 2007). The informal “sector” was seen as a transitional phenomenon that was supposed to disappear with the integration of the population into the formal labour market where it would be fully covered by social insurance. However, since the 1970s, this assumption has been called into question. It was challenged by the increasing influence of the Bretton Woods institutions, the International Monetary Fund and the World Bank, and the persistence of the informal economy in the context of the structural adjustment programmes promoted by these institutions. In this context, the notion of residual “safety nets” was popularized, including measures such as targeted cash transfer programmes for the poorest.

More recently we have witnessed a parallel social policy trend to move away from this selective and residual approach to social protection towards a more universal focus on social human rights. This re-discovery of the social human rights of citizens was reinforced by the Millennium Development Goals, but also by developments in the ILO, which became more concerned also with the needs of the poor beyond the formally employed (Deacon, 2007; Leisering, 2009). These developments reflect a core social policy debate about whether provisioning should be universal or selective through targeting (Mkandawire, 2005). Regardless, based on different ideological assumptions, different international organizations currently champion non-contributory forms of social assistance, especially cash transfers, and emphasize their contribution to poverty reduction (Leisering, 2009; Hanlon, Barrientos and Hulme, 2010). The Kenyan case also helps to answer the neglected question as to whether this shift has led to a reduction in the importance of social insurance in that country.

This article reveals diverse dynamics with both citizenship-based and workerist elements of social security in Kenya. The new Constitution, as discussed in the next section, includes social rights and is thus citizenship-based. In the health sector, as we discuss, social security is still mainly workerist. Several attempts to shift the National Hospital Insurance Fund system towards a citizenship-based health insurance have failed to date, but citizenship-based social security has expanded somewhat with the declaration of “free maternity”. Old-age provision, the focus of the following section, is persistently workerist: certain workers are privileged with a non-contributory retirement scheme, while another group of workers have been covered by a contributory provident fund (albeit that this fund is moving to

become a contributory pension scheme). Attempts to expand old-age provision to the informal economy have had limited effect. In the subsequent section, the focus is placed on the expansion of cash transfer programmes. These, however, do not provide universal coverage to the entitled categories. As we conclude, any meaningful description of social policy reforms must address the level of effective coverage.

Although the social security system in Kenya has a bias toward (male) employment in the formal economy (especially in the civil service), to the benefit of the highest income quintile, there is also a considerable pro-poor social assistance component. Overall, despite a certain shift towards non-contributory forms of social assistance as advocated by different international organizations, the role of social insurance continues. This suggests that while the frameworks of workerist and citizenship-based social security are useful at the level of specific instruments of social security, they are less useful for describing a complex regime.

**From a workerist to a citizenship-based approach in the health system?**

Kenya’s independence constitution was mainly concerned with defining its polity and protecting individual freedoms and fundamental rights following the proclamation of the Republic of Kenya in 1964. Social rights, however, were not recognized. It is thus remarkable that the 2010 Constitution of the Republic of Kenya included an article (Art. 43) on economic and social rights (Republic of Kenya, 2010). For the health sector, the new constitution guaranteed the right “to the highest attainable standard of health, which includes the right to health care services, including reproductive health care” (Art. 43 (1) a). The right to health care was reinforced explicitly in article 53, which defines the rights of children. The new constitution thus is clearly citizenship-based. This change, however, was not at the centre of public attention, which focused rather on the political aspects of the new constitution, such as the devolution of functions to county level and other provisions seeking to curtail presidential power. Devolution also concerned aspects of the health sector however – according to the Fourth Schedule, lower level health facilities and ambulance services were declared functions and powers of the counties.

In reality, the right to health care is rather hypothetical, as financial and non-financial barriers to health care persist. Currently only limited parts of the population have some form of health insurance. For 2010, the *Kenya Social Protection Sector Review* lists 2.7 million contributing members of the National Hospital Insurance Fund (NHIF), but five pages later only 367,886 contributing members are listed (Republic of Kenya, 2012a, p. 13, p. 18). The first number probably refers to membership in the formal economy and the second to membership in the informal economy. This assumption is made plausible by a report prepared for the World Bank and the Government of Kenya by Deloitte Consulting (2011, p. 19),
which cites a membership of 2.3 million in the formal economy and 0.5 million in the informal economy. Including the dependants of this total of 2.8 million members, an estimated 6.6 million Kenyans, or 17 per cent of the total population of 38.6 million (2009 census), are covered by the NHIF. However, it is clear that in the very country that “can boast the oldest compulsory insurance scheme in the whole of Africa” (Koltermann, 2004, p. 14) for formal economy workers, the vast majority of Kenyans have no health insurance.

After the National Rainbow Coalition government came to power in 2002, there was an attempt to broaden health insurance coverage by making it compulsory after a transition period. While the contributions of the poorest Kenyans would be financed with tax money, others would pay a flat-rate contribution, and half of the contributions of employees would be paid by their employers (Koltermann, 2004, p. 15). The conception of this new National Social Health Insurance Fund (NSHIF), which was supposed to replace the NHIF, was developed on the advice of the World Health Organization (WHO) and the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ). A corresponding Act was passed by parliament in December 2004, but it was never signed into law by President Mwai Kibaki. Independent sources in Kenya repeatedly attributed this to the resistance of the private insurance sector, which feared losses. There was also pressure against the NSHIF from the Treasury and from donors pushing for limited state spending (Hornsby, 2012, p. 737). Furthermore, organizations that represented employees – including many health professionals and teachers belonging to the middle class – opposed the reform, preferring the possibility of choosing private insurance coverage with tax relief (Maupeu, 2012, p. 60).

In turn, the creation of a National Health Insurance Scheme was included in Vision 2030, the country’s development programme (Republic of Kenya, 2008, p. 18). Nonetheless, a second attempt to shift the current strongly workerist health insurance system towards citizenship-based health insurance failed in 2008 in the context of post-electoral violence and a Government of National Unity. Citizenship-based social security was somewhat expanded with the declaration of “free maternity” by newly-elected Kenyan President Uhuru Kenyatta in 2013 (Künstler, 2014). However, achieving universal coverage has been limited by uneven access to health facilities. Consequently, as regards levels of maternal and child mortality, there are huge gaps between the rich and poor and across different regions (Otieno and Kibet, 2013, p. 22). Furthermore, in October 2015 a revival of the Health Insurance Subsidy Programme was announced, which, with the support of the World Bank, targets 23,000 households of elderly and disabled people in all

2. Other donors are clearly in favour of a more dominant role for the private sector. USAID, for example, supported a World Bank (2010) assessment that favoured private-sector investment in the health sector. There are thus conflicting views in the donor community.
3. The Kibaki family is assumed to be among the shareholders of companies in this sector.
counties. Currently, discussions over the concept of “Universal Health Coverage” continue in Kenya.

Currently, NHIF membership remains compulsory only for salaried employees. The contributions of these workers are deducted automatically from their pay cheques and calculated on a graduated income-based scale. There have been several unsuccessful attempts by the government to raise the NHIF contributions in the last few years. The most recent proposal suggested contributions ranging from KES 150 to KES 2,000 per month. After trade unions threatened strike action and went to court to stop the increases, a compromise was negotiated and new monthly contributions, which also cover the provision of some outpatient services, came into force on 1 April 2015 (see Table 1).

Contributions are neither progressive, regressive or, indeed, linear. There is a minimum contribution of KES 150 for monthly incomes lower than KES 6,000. As a proportion of income, the highest contribution level is paid by workers with earnings in the income bracket just above the minimum income, while the lowest is paid by middle- and high-income brackets, up to the maximum contribution of KES 1,700 for monthly incomes higher than KES 100,000. The NHIF contributions thus favour workers with higher incomes. Contributions are paid only on the salary portion of income, which means that “allowances, which can make up to half or more of most government employees income, are exempt” (Fraker and Hsiao, 2007, p. 53). The number of salaried employees evading contributions to the NHIF is difficult to assess, but has been estimated at 2 per cent by the NHIF board chairman (Jamah, 2014, p. 18). Self-employed workers and informal economy workers can join the scheme on a voluntary basis for a monthly contribution of KES 500, which also covers immediate dependant family members (i.e. nuclear families).

However, not all health expenses are covered by the NHIF. Furthermore, there are substantial co-payments. These health expenditures heighten the risk of falling into poverty (Otieno Ajwang’, 2013, p. 236). The reimbursement process is cumbersome and prone to fraud and abuse. Furthermore, the NHIF does not cover many of the health facilities that are mainly accessed by poor people, who are not reimbursed for the expenses they incur even if they are NHIF members. Finally, over many years only a small part of the budget was paid out to members in the form of benefits, while most went to cover excessive administrative costs and dubious investment projects (Koltermann, 2004, p. 14; Fraker and Hsiao, 2007, p. 52 f.). Only recently has the NHIF started to pay out more than half of its budget as benefits. The perception of paying contributions without getting benefits in return contributes to the Kenyan population’s lack of trust in the NHIF. Adding to this is an ongoing series of corruption scandals, untransparent deals, and confusion over the sacking and reinstatement of senior management.

4. KES = Kenyan shillings. In October 2015, EUR 1.00 = KES 110 approx.; USD 1.00 = KES 100 approx.
For civil servants and their nuclear families, including up to three children, the NHIF administers a special medical scheme that covers inpatient and outpatient medical services in accredited hospitals, including some mission and private hospitals. It also provides optical and dental coverage and, for the principal member, life insurance and coverage for burial expenses, graduated according to wage groups. The scheme is funded partly by the monthly medical allowance given over directly to the scheme and partly by additional government funds. Thus, taxpayers de facto additionally support the health expenses of an already rather privileged group. The effects of the structure of Kenyan taxes on gender and economic inequalities would merit a more profound analysis. However, it seems reasonable to assume that the redistribution associated with tax-funded programmes burdens the vast group of the poor, albeit not necessarily the rural poorest who have a higher level of self-sufficiency. This is supported by the overall finding of Munge and Briggs (2014) concerning regressive health-financing in Kenya.

Table 1. New contribution rates for the NHIF, as of 1 April 2015

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<thead>
<tr>
<th>Gross income in KES</th>
<th>Monthly contribution in KES</th>
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<tbody>
<tr>
<td>0–5,999</td>
<td>150</td>
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<tr>
<td>6,000–7,999</td>
<td>300</td>
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<td>8,000–11,999</td>
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<td>40,000–44,999</td>
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<td>60,000–69,999</td>
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<td>1,500</td>
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<tr>
<td>90,000–99,999</td>
<td>1,600</td>
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<tr>
<td>100,000 and above</td>
<td>1,700</td>
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</tbody>
</table>

Note: KES = Kenyan shillings.
Source: NHIF.
In addition to that provided for civil servants, the NHIF offers similar schemes to other professional groups in the formal and informal economies. Employer-based health insurance may also be managed by private insurance companies. “In 2007, there were 14 private insurance companies offering health insurance in Kenya, with membership of about 600,000 people” (less than 2 per cent of the population), including individual Kenyans insured by general insurance companies. Owing to the high cost of premiums, there is a bias towards wealthier and urban Kenyans (Chuma and Okungu, 2011, p. 6). However, this rather rich group benefits from tax relief and is thus subsidized by poorer taxpayers who cannot afford private health insurance.

Recently, several private insurance companies have started to compete with the NHIF for the informal economy market by offering low-cost health insurance products. They use different sales channels (e.g. mobile money, banks) to collect monthly contributions ranging from KES 300 to KES 1,000 for schemes with different coverage packages (inpatient and outpatient benefits, life cover, funeral expenses, paid sick days). However, trust in the private insurance sector in Kenya is somewhat limited given that several private health insurance schemes have collapsed since the 1990s (World Bank, 2010, p. xv). In the informal economy, in which women and younger Kenyans are over-represented, there are other forms of micro-insurance whose premiums are close to the lower range of low-cost private insurance. Since their introduction in 1999, about 38 Community Based Health Insurance (CBHI) schemes have emerged, whose members’ contributions cover 470,550 beneficiaries, as recent data from the Kenya Community-Based Health Financing Association show.5 Beyond these CBHI schemes, there are other micro-insurance initiatives.

To sum up, the vast majority of Kenyans are still not covered by any health insurance. Social security in the health sector is still mainly workerist; in principle, but not in practice, all formal economy workers are covered. NHIF contributions favour workers with higher incomes and these workers also tend to be covered by private insurance more often than low-income or informal workers. Several attempts to shift the workerist hospital insurance system towards citizenship-based health insurance have failed; that aside, citizenship-based social security has expanded at the national level with the declaration of “free maternity”.

Persistant workerist old-age provision

Old-age provisions are also dominated by workerist insurance. The core scheme is a non-contributory programme for civil servants (Civil Service Pension), including

5. See CBHF program at <www.kcbhfa.org>.
teachers.\textsuperscript{6} “The Scheme provides a pension of 2.5 per cent of final basic salary for each year of service on retirement from service” (Raichura, 2008, p. 12). After 30 years of service, the pension thus equals 75 per cent of the basic salary. In recent years, the number of retired civil servants and the costs of the scheme have grown considerably. In 2010, there were 209,384 pensioners covered, and government had to pay more than KES 26 billion (Republic of Kenya, 2012a, p. 5, p. 15), equal to 1 per cent of GDP (Republic of Kenya, 2012a, p. 15). In the 2014–2015 budget, KES 45.9 billion is designated for pensions, as tens of thousands of civil servants are now due to retire after the retirement age was raised from age 55 to age 60 in 2009 (Nyabiage and Some, 2014, p. 10). According to Seekings (2013), social insurance refers to nominally contributory programmes to pool risks, such as that of longevity risk. The Civil Service Pension follows the workerist logic of social insurance, even if the contributions are paid by government and not by the insured worker.

Given the increasing financial burden for government of the Civil Service Pension, over the years there have been attempts to convert it to a contributory scheme (Dau, 2003, p. 34). According to article 6(1) of the Public Service Superannuation Act No. 8 of 2012 (Republic of Kenya, 2012b) all civil servants must contribute 7.5 per cent of their monthly pensionable emoluments. This is complemented by a government contribution of at least 15 per cent of monthly payroll, according to article 6(2). However, as of August 2015, the act has still not been implemented. There is concern that by shifting part of the burden of pension financing onto the civil servants, the full implementation of a contributory pension scheme might trigger protests by these public employees, who are well organized. Were the Act to come into effect, competence for the authorization of retirement benefit payments would be with the Board of Trustees of the Public Service Superannuation Fund.

According to the Retirement Benefit Authority (RBA, 2014), in addition to public-sector pension schemes, Kenya has 1,232 retirement schemes run by fund managers. This figure means that nine out of ten companies in Kenya do not have such a scheme. In 2012, these schemes held assets of KES 381.6 billion, which is more than double the assets of the state-run National Social Security Fund (NSSF) (RBA, 2012, p. 5). More recent data from the RBA homepage indicate shrinking assets of the NSSF and growing assets of other funds.\textsuperscript{7} Most of these schemes are organized by companies for their employees or by Savings and Credit Co-operative Societies; however, there are also schemes for individuals that are generally established by private insurance companies. The information in the RBA’s 2014 report is not complete, but these individual schemes probably represent only a

\textsuperscript{6} A discussion of other schemes, such as those for the armed forces, the National Youth Services, local government employees, and various parastatals, is beyond the scope of this article.

\textsuperscript{7} See <www.rba.go.ke>.
few per cent of total assets. Some of the schemes run by private companies target the middle classes, who strongly mistrust the public NSSF and have a strong preference for private insurance and possess the means to act accordingly (Maupeu, 2012, p. 60). However, private insurance companies are increasingly also targeting the informal economy, which makes up 80 per cent of the labour force (Kwena and Turner, 2013, p. 79).

The Mbao Jua Kali Pension Scheme, for example, a public-private partnership, requires daily contributions of KES 20 (mbao is slang for 20 shillings), which can be paid by mobile phone transfer either daily, weekly, monthly, or even annually. Launched in June 2011, the Mbao Scheme ambitiously targeted enrolling a million members within the first year (by July 2011, it had 42,000 members). By March 2014, the Scheme’s 53,200 or so members had saved KES 75.8 million (Waitathu, 2014, p. 3), but contributors have neither tax incentives nor matching contributions from government or employers (Kwena and Turner, 2013). Similar to a provident fund, contributors can draw their savings as a lump-sum payment. However, this can be done without penalty after as little as a year, and thus the Mbao Scheme might be a tool for short-term saving rather than a form of old-age provision. An incentive for membership might be that the account can serve as a mortgage (Kwena and Turner, 2013, p. 94). It is too early to judge the impact of this scheme; however, it clearly shows the growing interest of the private sector in the informal economy, the financial potential of which, typically, has been underestimated.

The pillar of old-age protection in Kenya with the widest membership coverage is the NSSF, which focuses on formal economy workers. The NSSF was established as a national provident fund: a contributory scheme in which the employee and the employer each contribute 5 per cent of monthly earnings, up to a maximum (Dau, 2003, p. 29). In 2009, out of 2.1 million wage employees, 1.1 million were NSSF members (Republic of Kenya, 2012a, p. 26 f.). That small firms with one to four employees are also obliged to contribute to the NSSF has bolstered membership by 100,000. The number of salaried employees or employers evading the NSSF is unknown, but evasion is “rampant” according to a previous managing trustee, Tom Odongo (2013). Attempts to include the self-employed on a voluntary basis have had limited success; 57,000 self-employed members were included in 2012.

Distrust in the NSSF is quite generalized, as is officially acknowledged: “the public’s confidence in the Fund’s ability to deliver on its mandate is generally low” (Republic of Kenya, 2012a, p. 12). A general perception is that social protection is an excuse for officials to pillage. Previously, the administrative costs of the NSSF absorbed up to 77 per cent of total contributions (Republic of Kenya, 2012a, p. 20); billions of shillings of the contributors’ money have been lost in dubious investment deals, and managers have been sacked and summoned to court with astonishing frequency. Unsurprisingly, trade unions, the Federation of Kenya Employers, and governmental audit institutions denounce such irregularities.
Contributors are confronted with being refused access to benefits, delaying tactics and late payments (Hakijamii Trust, 2007, p. 5). The lump-sum payments made at retirement age are very low, devalued by inflation and low interest rates, and are too small to provide adequate social protection in old age: “Between 2005 and 2010, the NSSF paid out, on average, 38,000 claims per year ranging from KES 50,000 to KES 200,000” (Republic of Kenya, 2012a, p. 64). Rather than a social insurance system based on solidarity and cross-subsidization, the NSSF is viewed as an instrument for forced savings by formal economy workers; a conception based on the idea that the country needs domestic savings to finance development projects.

These conceptual shortcomings are well known, and the last two decades have seen repeated attempts to reform the old-age benefits system (e.g. Gsänger, 1994, p. 9). In 2013, the then newly-elected President Kenyatta spoke in favour of expanding old-age protection: “We will champion the rights of all Kenyans, preserving and defending them … by extending the right to social protection. … We will expand the state pensions system so that all our citizens enjoy dignity in old age” (Standard, 2013, p. 39). With the adoption of the National Social Security Fund Bill in 2013 (Republic of Kenya, 2013), the NSSF was changed from being a provident fund scheme with lump-sum payments into a two-tier (Tiers I and II) pension scheme offering monthly pension payments until death, with an option to receive part of benefits as a lump-sum payment. Under the Bill, the NSSF also provides insurance against disability, grants money for funeral expenses, and workers in the informal economy can join the scheme voluntarily.

The proposed higher contributions triggered much public discussion, and the contribution system is more complicated. There is an upper earnings limit linked to the national average earnings in Kenya, which is currently fixed at KES 18,000.8 Pension contributions are not deducted from earnings above this limit, and are thus regressive. The pension contribution, collected by the Kenya Revenue Authority, was set at 12 per cent of earnings, with the employee and employer both contributing 6 per cent. Employees’ contributions are to be directly drawn from salary and wages. There is a lower earnings limit linked to the minimum wage, currently fixed at KES 7,000 in 2015 (KES 8,000 in 2016; KES 9,000 in 2017). Contributions relating to earnings below the lower earnings limit are to be accredited to the Tier I account, and those above (and up to the upper earnings limit) to the Tier II account. It is possible to opt out of Tier II for a registered private retirement scheme. The system’s design essentially excludes low-income earners from Tier II and privately managed retirement schemes, but it does include civil servants who now contribute.9

8. This will rise to twice the national average earnings in 2016; progressing to three times in 2017 and four times in 2018 (SSA and ISSA, 2015).
9. An amendment of the First Schedule of the NSSF Act exempted civil servants from Tier II contributions.
The government intended to introduce the new contributions a few weeks after gazetting the new Law on 27 December 2013, but put the Law (Act No. 45 of 2013) on hold until the beginning of June 2014 to allow employers more time to adjust their payroll systems. In the first half of 2014, several trade unions, including those of civil servants, threatened strike action and went to court to block the new contributions, which have still not come into effect.

Furthermore, it was not clear how the transition from the old fund to the new one is going to be organized, what the tax allowable limits will be, and where the Fund’s money will be invested. Consequently, the new NSSF is hedged with considerable uncertainty, including the vexed question of its distributional effects. Central to this is the question of whether taxpayers’ money will be used to pay for pensions, or for losses incurred by the NSSF due to mismanagement and corruption. Furthermore, workers with higher salaries are privileged in the sense that they can opt out to join registered private schemes, which are generally seen as better performing than the NSSF. In this sense, the NSSF is not based on a solidarity principle, and it does not provide old-age protection for the poorest citizens.

Expanding a citizenship-based regime with cash transfer programmes?

In line with the wider trend across the Global South, Kenya has introduced cash transfer programmes (Alviar et al., 2012, p. 9). The Kenya Social Protection Sector Review (Republic of Kenya, 2012a, p. 28) lists two food transfer programmes, five unconditional cash transfer programmes, and one mixed food/cash programme. The Review states that transfer programmes are geographically overlapping, small, fragmented, and poorly coordinated (Republic of Kenya, 2012a, p. x). In contrast to cash transfers in other African countries (Devereux and White, 2010), besides donors, the Government of Kenya is also an important funder. However, the programmes are partly implemented by donors. The total spending on what are called “safety nets” equalled 0.80 per cent of GDP in 2010 (Republic of Kenya, 2012a, vii); however, 39 per cent of these expenditures were overhead costs. The use of the notion of “safety nets” is noteworthy. Popularized during the 1990s by the Bretton Woods institutions in the context of structural adjustment policies, it echoes a “residual or liberal social policy” (Deacon, 2007, p. 28).

10. Interestingly, the Orange Democratic Movement (ODM, 2007) made in its unsuccessful 2007 electoral manifesto an explicit reference to cash transfer programmes in Brazil, South Africa, and Malawi when proposing an Usawa Programme for very poor households. However, the ODM did not specify whether the proposed programme was conditional or not.
11. This survey does not cover short-term programmes or cash transfers by private charities such as GiveDirectly.
A closer look at major cash transfer programmes allows for a better understanding of recent developments in this sector. Concerning the Cash Transfer for Orphans and Vulnerable Children (CT-OVC), Alviar et al. (2012, p. 9) report a lower number of beneficiaries for 2011 than the government report indicates. The CT-OVC began with a donor-funded pilot programme in 2004, which was then approved by Cabinet, integrated into the national budget, and expanded. It targeted families with at least one orphan or vulnerable child, defined as “a household resident between 0 and 17 years old with at least one deceased parent, or who is chronically ill, or whose main caregiver is chronically ill” (Alviar et al., 2012, p. 11). Beneficiaries were told that the monthly cash payment of KES 2,000 was for the care and protection of the child, but there were no punitive sanctions for using the money differently. For the first step, districts were chosen according to poverty levels and HIV prevalence. Then a list of potential households was compiled by community members. Finally, enumerators visited the households and selected the poorest for the programme.\(^{12}\) It is therefore important to note that the programme does not cover all people living below a certain absolute poverty level. The poor living in less poor regions were excluded. The beneficiaries could access the cash at branches of the parastatal Postal Corporation of Kenya (PCK) on appointed days and had to present their identity cards (Donovan, 2013, p. 9). The administration of the programme required much time and resources, and it was vulnerable to fraud.

\[ \ldots \] the partnership with the PCK was considered a marked improvement upon a previous iteration that relied on local chiefs in rural areas to distribute envelopes of cash – a practice unsurprisingly marked by bias and patronage. And although both the head of the OVC and a World Bank representative suggested they were decently assured of the current systems reliability, the potential of fraud had motivated a shift toward an electronic payments infrastructure that used biometric fingerprinting to identify recipients (Donovan, 2013, p. 10).

The Hunger Safety Net Programme (HSNP) is the first government-led programme in Africa that from inception was conceived with an electronic delivery mechanism. Households covered received unconditional bi-monthly transfers of KES 4,600, electronically delivered into bank accounts at the private Equity Bank (Vincent and Cull, 2011, p. 46). As a mechanism to avoid fraud, beneficiaries used a biometric smart card to access their cash at small businesses whose owners were appointed as Equity Bank agents (Donovan, 2013, p. 4). These businesses were more widespread and approachable than Equity Bank or PCK branches, and had

\(^{12}\) Interestingly, a list with the names of the beneficiaries can be freely downloaded from <www.labor.go.ke>. 
an incentive for the procurement of cash. The chip on the smart card contains the account information, so that agents need not be constantly online. The payment devices were battery powered and recharged with solar panels. The chip furthermore contains the information required to verify the identity of beneficiaries by scanning their fingerprints. This was seen as more feasible than using PIN identification or ID cards (Donovan, 2013, p. 13). Among the problems reported were the lack of IDs for registration, failure of the fingerprint scanners used for enrolment due to the climatic conditions, problems with the software used to means test potential beneficiaries, the limited capacity of beneficiaries to reach an agent, and damaged fingerprints (Donovan, 2013). The registration of a secondary recipient improved access, but it also increased the potential of fraud.13 The HSNP was intended to be expanded to 1.5 million households (Vincent and Cull, 2011, p. 46), and the aspiration of its programme officials was to institutionalize rights-based social security (Donovan, 2013, p. 4).

The most recent step that has seen the expansion and consolidation of cash transfer programmes, with the exception of the HSNP, was made in February 2014 with the introduction of the Inua Jamii Cash Programme, which was enlarged in January 2015. It targets more than 200,000 persons aged 65 or older and living in extreme poverty, and 27,200 persons with severe disabilities, 253,000 orphans and vulnerable children, and finally, 10,000 poor urban households (Ongiri, 2014). Beneficiaries will receive an unconditional monthly cash transfer of KES 2,000, notwithstanding the erosion of buying power. The money will be transferred on an M-Pesa mobile phone account and made accessible via 40,000 agents across the country. During the official launch, the CEO of the company that runs M-Pesa promised to provide mobile phones for beneficiaries who were without. Delivering cash transfers through M-Pesa had been reasonably successful in a short-term emergency cash transfer project funded by the NGO, Concern Worldwide (the Kerio Valley Cash Transfer, or KVCT) (Vincent and Cull, 2011, p. 42). Interestingly, in contrast to the HSNP, where PIN authentication was not deemed feasible (Donovan, 2013, p. 13), the PIN used for M-Pesa does not appear to cause problems. M-Pesa is the most widely accessible way of transferring cash at present. Mobile network coverage and agent numbers are increasing, but market penetration is lower in rural areas. Besides convenience of access, cost efficiency is also among the advantages of this approach (Vincent and Cull, 2011). In January 2014, operational costs were budgeted at 15 per cent of the total cash transfer programme budget (Wafula, 2014b, p. 2). At present, the new Inua Jamii Cash Programme is still not very well known among the population.

13. Fraud was an issue in the domain of disability grants, where an audit in 2013 revealed KES 120 million lost to 1,400 ghost recipients (Wafula, 2014a, p. 1), which is two-thirds the number of beneficiaries in 2010.
To finance this recent expansion of cash transfers, a loan of KES 21.8 billion was provided by the World Bank. It is therefore important to bear in mind that the programme is not funded by donors; the loan has to be repaid with a low rate of interest. Also, pro-poor tax-funded programmes may redistribute in favour of the poorest of the poor, but they are a heavy burden on the poor. It is also important to note that cash transfers do not universally cover the entitled categories, and fulfilling certain criteria does not bestow any legal entitlement to a cash transfer, even if article 43(1) of the new constitution grants every person the right to social security and freedom from hunger (Republic of Kenya, 2010). Furthermore, distribution of the cash transfer has moved away from the means testing applied in the pilot phase to a formula where a considerable share of the money is equally distributed to all constituencies (Wafula, 2014b), after which a highly-politicized Constituency Social Assistance Committee decides on beneficiaries. Absent a comprehensive legal framework, it is questionable whether there is proper means testing. Poverty, furthermore, is not equally distributed in all constituencies, so that this formula benefits the richer constituencies. In other words, a poor person in a comparatively richer constituency is considerably more likely to receive a cash transfer than a poor person in a comparatively poorer constituency.

Discussion and conclusion

So, how might we address the initial question as to who gets what and how in key areas of social security provision in Kenya? It has been discussed that cash transfers do not universally cover the entitled categories. Citizenship-based social security has somewhat expanded, however, with the declaration of “free maternity”; but not all entitled women are reached. In turn, for workerist social security, there is considerable evasion of the NSSF by formal economy workers and their employers. Consequently, a meaningful description of social policy reforms has to include the level of effective coverage. A second central dimension is whether individuals, members of occupational groups, members of certain categories or all citizens are entitled to social security. Following Seekings (2008), this dimension can be called the mode of solidarity. If we conceive of these two dimensions as a continuum and not as “either or”, the diverse landscape of social security in Kenya can be summarized as in Figure 1.

Ideally, citizenship-based social security would be at the top on the right, and workerist social security would be at the middle on the right. In reality, in Kenya, there tend to be categorical rather than citizenship-based elements of social security, with varying degrees of coverage. At this level, there are some pro-poor redistribution effects. Individual tools of social protection target both formal and informal economy workers, but they have low coverage. Schemes for low-income workers, such as the Mbao Scheme, have no distributional effect. Due to its tax exemption, private health insurance
distributes towards the upper classes rather than benefitting the poor. However, the most privileged group at the moment consists of civil servants. They are universally covered by health and pension schemes whose contributions are paid by government. Indeed, the money spent on the civil service pension equalled 1 per cent of GDP in 2010 (Republic of Kenya, 2012, p. vii). Total expenditure on contributory schemes such as the NHIF and NSSF were 0.48 per cent of the GDP, while spending on “safety nets” was 0.8 per cent of GDP. Therefore not only does more money go towards social insurance, but the Kenyan social security system has a bias towards (male) employment in the formal economy, especially in the civil service.14 Beneficiaries of social insurance programmes in Kenya (including health insurance and pensions) are mostly in the highest income quintile, while those who benefit from cash transfer programmes are highly concentrated in the lower and also the middle income quintiles.15

This coexistence of workerist social insurance, targeted “safety nets” and (attempted) citizenship-based social security in Kenya is to a certain extent not new, but goes back to the immediate post-independence period at least. The most important policy document

14. The new constitution aims at balancing employment with social rights. However, as long as unpaid care work, for example, is not entitling to social protection and mainly performed by women and women are underrepresented in the formal sector, the employment bias will continue.
just after independence was Sessional Paper No. 10, proposed by the government and adopted by the Kenyan Parliament in 1965. This document stated that “the declared aim of the Government is to provide medical and hospital services, old age and disability benefits, free and universal primary education, benefits for the unemployed, and financial aid to all who need and merit it for university work” (Republic of Kenya 1965, p. 30). Highly influential in shaping this document was Tom Mboya, who as Minister for Labour in 1962 introduced the Industrial Relations Charter and with it the tripartite structure that characterizes the NSSF. Just after independence, Kenya introduced workerist social security (NSSF, NHIF, Civil Service Pension Scheme), but also citizenship-based free health care which had colonial precedents. Based on these past decisions and depending on the respective political context, changing global policy models have been selectively adopted and adapted in Kenya since then.

Non-contributory forms of social assistance as advocated by different international organizations have become more popular in recent years, but social insurance has persisted nonetheless. Indeed, as acknowledged by Seekings (2008, p. 27), there is a combination of workerist and citizenship-based elements. The frameworks of workerist and citizenship-based social security are somewhat useful at the level of specific instruments of social security, but not for describing a regime. The “disjointed set of welfare policies” observed in Kenya confirms Kasza’s (2002, p. 271) conclusion that “few national welfare systems are likely to exhibit the internal consistency necessary to validate the regime concept, and that policy-specific comparisons may be a more promising avenue for comparative research”.

Furthermore, for a comprehensive framework, we have to include care provision as another element of social security in addition to social insurance and social assistance which characterize the workerist and citizenship-based frameworks. A comprehensive framework would also include civil society and households as providers of social security. Such a framework could also systematically embrace indigenous forms of social security and take a step towards focusing on welfare regimes instead of welfare state regimes.

For informed speculation about the future direction of social security reforms in Kenya it is reasonable to assume that workerist and citizenship-based social security will continue to co-exist. Given the powerful domestic constituencies interested in workerist social security (workers in general and civil servants and teachers in particular), an expansion of benefits is more likely than a significant expansion of the group of beneficiaries. In contrast, politicians might have an incentive to expand cash transfers to uncovered regions without necessarily expanding them to universally cover the entitled categories, as this might reduce their potential for local-level patronage. Together with their own initiatives, especially in maternal health, government can depict these co-existing policies as moves towards securing the social rights enshrined in the constitution, thus gaining domestic and international legitimacy and at the same time appeasing powerful political stakeholders. This might continue as long as the question of financing these
policies is solved by incurring debt and, to a certain extent, transferred to the next
generations as a result.16

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Adjustment mechanisms and intergenerational actuarial neutrality in pension reforms

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Abstract In the context of the reform of defined benefit pension systems under population ageing, we focus on the introduction of automatic adjustment mechanisms linked to life expectancy. Our goal is to establish a relationship between changes in the key parameters of the pension system and changes in life expectancy, applying the principle of intergenerational actuarial neutrality. For a defined benefit pension scheme, we first obtain the fundamental adjustment equation and then, for particular cases, we derive different designs of automatic adjustment mechanisms depending on the involved parameter. We include a numerical application only for illustrative purposes.

Keywords pension scheme, defined benefit plan, actuarial, life expectancy, Europe, international
Introduction

Population ageing in developed countries is a major challenge for public pay-as-you-go (PAYG) pension systems, especially for those with defined benefit schemes. Recent population projections in the European Union (EU), Europop2013 (EC, 2014), assume an increase in life expectancy at age 65 by 6.9 years for males and 6.6 years for females in the EU28 (non-weighted average) between 2013 and 2080 in the main demographic scenario. As a result of all the demographic trends, the old-age dependency ratio in the EU28 will rise from 28.2 per cent in 2014 to 51.0 per cent in 2080, the proportion of population aged 65+ will increase from 18.6 per cent to 28.7 per cent and the proportion of population aged 80+ will move from 5.2 per cent to 12.3 per cent.

The financial consequence of an ageing population to pension expenditure is clear. In this sense, The 2012 Ageing Report (EC, 2012a) decomposes the overall change in pension expenditure over the period 2010–2060 in five main factors, and finds that the demographic factor will have the most serious impact on the increase in public pension expenditure over this period: +8.5 percentage points of GDP in the EU27.

For this reason, many developed countries have introduced important changes in their pension systems in recent years. One of the trends in the pension reform process in the member countries of the Organisation for Economic Co-operation and Development (OECD) consists of introducing automatic mechanisms that adjust some parameters of the pension system in order to compensate the evolution of some variable, internal or external to the pension system, which can influence the system’s sustainability. This pension policy is one of the recommendations that usually appears in the reports of the European Commission, for example in the White Paper on pensions (EC, 2012b); or in the studies of expert groups (European Actuarial Consultative Group, 2012).1

In this article, we develop a framework, under the principle of intergenerational actuarial neutrality, to help in the designs of one group of automatic mechanisms, those that link some parameter of the pension system to life expectancy. So, the aim is to provide alternative adjustment mechanisms that countries with a defined benefit pension system could implement to face the life-expectancy risk.

This article is structured as follows: the next section depicts an overview of the different focuses in the literature concerning automatic mechanisms in pension systems, noting the differences among adjustment mechanisms, balance mechanisms and stabilization mechanisms. The concept of intergenerational actuarial

1. Following American Academy of Actuaries (AAA, 2011), the first proposal to implement an automatic balance mechanism is credited to Robert J. Myers while he chaired the National Commission on Social Security Reform in United States (1982–1983).
neutrality and other related actuarial concepts are then explained. Next, we present an earnings-related defined benefit pension system and the internal rate of return is defined as the interest rate that keeps the actuarial balance between contributions and pensions throughout the life cycle. We obtain the fundamental equation that relates the parameters of the system in the base year and in a future year with different life expectancy, maintaining the intergenerational actuarial neutrality; i.e. the internal rate of return is constant. In turn, different designs from the fundamental equation are derived, all of them neutral from an actuarial point of view. Finally, a numerical example for illustrative purposes only is carried out and the main conclusions presented.

**Overview of automatic mechanisms in pension systems**

An automatic mechanism in pension systems is a rule that automatically regulates the value of one or more parameters of the system according to the level of some variable or indicator that is crucial for the sustainability or solvency of the pension system. There are different ways in the literature to classify the automatic mechanisms.

Whitehouse (2007) looks at life-expectancy risk and summarizes the four ways to adjust for increasing life expectancy in OECD countries’ pension schemes: introducing a defined contribution (funded) plan as a part of the public pension system, replacing defined benefit schemes with notional accounts schemes, linking benefit levels to life expectancy and, finally, adjusting qualifying conditions (retirement age or the years of contributions to get a full pension) to life expectancy.

Turner (2009) emphasizes the role of automatic adjustments to improve the solvency of a pension system and categorizes five groups of developed countries with similar mechanisms: traditional PAYG systems with benefit levels indexed to life expectancy, notional accounts schemes (where the link between benefits and life expectancy is a normal consequence of this system), countries with a life-expectancy indexing of the retirement age, countries with more complex adjustment mechanisms that are tied to solvency and, finally, countries that automatically adjust other parameters, such as the years of service for full benefits.

Vidal-Meliá, Boado-Penas and Settergren (2009) show the convenience of an automatic balance mechanism in the pension system. After analyzing the experiences in five countries (Sweden, Canada, Germany, Japan and Finland), they suggest the use of an actuarial solvency indicator, the solvency ratio (total assets/liabilities) as a reference to implement an automatic balance mechanism.

The 2012 Ageing Report (EC, 2012a) distinguishes between only two groups of EU Member States with regard to the type of automatic mechanism adopted: i) countries with a sustainability factor and/or other reduction coefficients that change the pension benefit depending on expected demographic (not only life expectancy)
changes, and ii) countries that have introduced a link between retirement ages and life expectancy.

From a theoretical point of view, authors such as Gannon, Legros and Touzé (2013) and Godínez-Olivares, Boado-Penas and Pantelous (2014) suggest automatic stabilization mechanisms that emerge from the solution of a mathematical programming problem with an objective of minimizing a loss function (usually of a quadratic deviation form), that reflects the costs of changing parameters, subject to the intertemporal pension budget constraint.

In summary, we can depict two broad groups of automatic mechanisms in recent pension systems reforms:

**Automatic adjustments of some parameter to life expectancy.** Although this policy has a positive effect on the sustainability of the public pension system, the main reason to adopt this approach works at the individual level: without any adjustment, an increase in life expectancy implies an increase in the expected present value of lifetime benefits for the same contribution effort. So, individuals of generations with longer life expectancies would obtain greater return than individuals of the present generation. Depending on which parameter of the system is preferred, all affecting future retirees, we have three subgroups:

- **Retirement age:** this approach compensates the increase in life expectancy by increasing the retirement (ordinary and/or earliest) age so the duration of retirement is kept constant. Examples are Denmark (expected from 2023), Italy (since 2013), Greece (expected from 2021) and the Netherlands (expected from 2025).
- **Pension benefit levels:** an increase in life expectancy implies, *ceteris paribus*, an increase in the pension wealth, so a correction in the level of annual benefit (via some reduction coefficient in the formula computing the first pension) is needed. Portugal (since 2010) and Spain (expected from 2019) compute this reduction coefficient directly through changes in life expectancy at age 65 (Portugal) or age 67 (Spain), while Finland (since 2010) computes it in such a way that the pension wealth at age 62 with a 2 per cent discount factor is kept constant.\(^2\)
- **Number of contribution years to get a full pension:** this adjustment consists in keeping constant the ratio of the contribution period for a full pension to the duration of retirement. France is the typical example of this reform.

**Automatic balance mechanisms not (only) linked to life expectancy.** The objective of these mechanisms is to strengthen the sustainability and/or the solvency of the public pension systems. In theory, an actuarial solvency indicator with both demographic and economic variables must be considered to define such a mechanism. In establishing these adjustments, all the current retirees are

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2. See Lassila and Valkonen (2007) for details.
involved through the pension indexation parameter. In addition, some of these mechanisms also affect the contribution rate or the valorization of the accrual pension entitlements. Countries with these automatic balance mechanisms are Sweden, Germany, Japan, Canada and Spain.³

- Sweden: the Swedish system computes a solvency ratio (assets to pension liabilities of the social security system) each year. If it is less than one, both the pension indexation and the notional rate of return are reduced.⁴
- Germany: under the pension-point system of Germany, the pension amount depends on the value of each point and this value is affected by the so called sustainability factor. If the ratio of pensioners to contributors rises, the value of each point is lower, reducing the pension of current and future retirees.⁵
- Japan: applies a modified indexation of pensions. The modifier is the sum of the decrease in the rate of the workforce (if the workforce increases this term is zero) and a constant 0.3 per cent (increase in the rate of life expectancy at age 65). This mechanism is activated only if the cost-price index is positive and the financial projections for a time horizon of 95 years show financial insolvency with the normal indexation.
- Canada: the financial sustainability of the pension system is evaluated every three years and a minimum contribution rate to stabilize the ratio of assets to expenditures is reported to the authorities. After that, if the legislated contribution rate is lower than the minimum, the automatic mechanism is applied: the contribution rate is increased by a half of the difference between the minimum and the legislated contribution rate and the benefits are frozen.⁶
- Spain: the indexation of pensions since 2015 will depend on the structural deficit of the pension system. This is computed with average data of total revenues and total expenditures for 11 years (comprising the past five years, the current year and projections of the next five years). Indexation of pensions must ensure that the growth rate of expenditures is equal to the growth rate of revenues minus a quarter of the structural deficit in relative terms. If the structural deficit increases, the indexation of pensions is lower. In addition, the indexation

⁴. The balance ratio of the system is equal to 1.004 in 2013, according to the Annual Report of the Swedish Pension System (Orange Report) <secure.pensionsmyndigheten.se/21952.html>.
⁵. The annual growth of the pension-point value in July 2014 was 1.67 per cent with a negative sustainability factor effect of -0.19 per cent <www.deutsche-rentenversicherung.de>.
⁶. The 26th Actuarial Report in November 2013 reveals that the minimum contribution rate to sustain the Canada Pension Plan is 9.84 per cent, so with the legislated contribution rate of 9.9 per cent contributions this is projected to be more than sufficient to cover the expenditures over the period 2013 to 2022 <osfi-bsif.gc.ca/Eng/oca-bac/ar-ra/cpp-rpc/Pages/cpp26.aspx>.
must be bounded between 0.25 per cent and the consumer price index plus 0.5 per cent.\textsuperscript{7}

Penner and Steuerle (2007) analyse some of these experiences and recommend that politicians in the United States build automatic trigger mechanisms into the budget that would slow spending growth and raise taxes. Also, Capretta (2006) suggests that automatic adjustments could be used in the United States’ pension system as enforcement mechanisms, aimed at correcting any deviation from the expected solvency path.

In this article we focus on the first group of automatic adjustment mechanisms. Our aim is to offer alternative designs that link a defined benefit pension system to the evolution in life expectancy. This variable has already been implicitly taken into account in defined contribution systems, funded or notional accounts schemes, at least partially. With recent reforms, traditional defined benefit systems have also undergone some sort of adjustments which reflect the changes in life expectancy.

**The concept of intergenerational actuarial neutrality and other related actuarial concepts**

The existence of alternative designs emerges because there are different parameters that can be adjusted to life expectancy. Each choice of parameter or combination of parameters leads to a different adjustment formula. However, all designs must respond to a common principle: the principle of intergenerational actuarial neutrality. In the absence of such adjustments, individuals from future generations, who are expected to live longer, will receive higher expected pensions than individuals from the initial generation for the same contribution record. As a consequence, some type of actuarially neutral adjustment must be introduced to equal the actuarial return of lifetime contributions and lifetime benefits for individuals from different generations.

Actuarial concepts are based on the definition of actuarial present value, the value at a specified time of a series of future payments, where each payment is multiplied by the probability the payment will be made and discounted at a rate of interest. Then, two main actuarial concepts emerge:

- Actuarial fairness: requires that the present value of lifetime contributions equals the actuarial present value of lifetime benefits. Actuarial fairness relates to the entire lifetime of contributions and benefits.

\textsuperscript{7} Owing to the structural deficit of the pension system in 2014, the expected indexation for 2015 is 0.25 per cent <www.minhap.gob.es>.
Actuarial neutrality: requires that the actuarial present value of accrued pension benefits for working an additional year is the same as in the year before (meaning that benefits increase only by the additional entitlement earned in that year).

Both concepts are related with the concept of intergenerational actuarial neutrality. Within the economic literature the concept of actuarial neutrality has been most used to compare individuals with the same life expectancy but with different effective retirement age (Queisser and Whitehouse, 2006), while the concept of intergenerational actuarial neutrality is used to compare individuals of succeeding generations with different life expectancies. Other authors, Belloni and Maccheroni (2013), refer to the concept of actuarial neutrality with the name of marginal actuarial fairness. This concept suggests that incentives (if the retirement is deferred) or penalties (if the retirement is anticipated) based on actuarial formulas should be applied when computing the first pension. Similarly, the concept of intergenerational actuarial neutrality suggests the need of some adjustment mechanism.

The concept of actuarial fairness is related also with the concept of intergenerational actuarial neutrality. These concepts require equality between the present value of contributions and the actuarial present value of pensions for each individual. Following Queisser and Whitehouse (2006), if this equality is fulfilled with an interest rate equal to the riskless interest rate, the system is actuarially fair and if it is equal to the growth of the tax base (approximately the GDP growth) the system is fiscally sustainable, an important feature for PAYG, defined benefit pension schemes (Samuelson, 1958; Aaron, 1966). In this sense, a system is (intergenerational) actuarially neutral if this interest rate remains constant at the initial level for individuals of future generations, regardless of its value. In the context of increasing life expectancy, the interest rate that produces equal present values of lifetime contributions and lifetime pensions tends to increase. So, intergenerational actuarial neutrality requires repeated ad hoc reforms or some sort of automatic adjustment mechanism to correct this trend.

A similar concept, actuarial neutrality across generations, has been used by Oksanen (2005) at an aggregate level. With an overlapping-generations framework, his condition for actuarial neutrality is that implicit pension debt (present value of the next period pension) minus financial reserves of the system remains constant in relative terms. Then, he studies the effects at the macro level of an ageing population over different pension systems (totally funded, partially funded or pure PAYG).

In this article, our approach works at the individual level. We first establish the basic equality between the present value of individual accumulated contributions and the actuarial present value of individual lifetime benefits, at the time of retirement under a defined benefit scheme. This equation relates the key parameters of a defined benefit system (retirement age, career length, contribution rate, indexation of pension and accrual rate) to life expectancy (through survival probabilities when computing the pension wealth). Then, with two basic equations, each one for an
individual of succeeding generations with different life expectancy, we obtain, as a first objective, a fundamental equation that relates the adjustments in the main parameters that are needed to face up to the changes in life expectancy, under the principle of intergenerational actuarial neutrality. This fundamental equation is a framework to design, as a second objective, specific formulas according to the parameter that we want to be linked to life expectancy. The resulting formulas are, therefore, actuarially neutral automatic adjustment mechanisms.

The fundamental equation of life expectancy indexing in a defined benefit system under the principle of intergenerational actuarial neutrality

In order to actuarially value different types of adjustment to life expectancy, a theoretical model specific to an earnings-related defined benefit pension scheme, and whose first pension is fully proportional to the contribution effort during the entire working career, is developed. This effort is measured by the average revalued earnings over the contributory period. This theoretical system, ideal from the contributory point of view, is only an approximation to reality-based systems, which incorporate certain distortions by not measuring properly the contribution effort (for example, the calculation of average earnings does not usually incorporate the entire working career) and/or by not calculating proportionally the first pension to the contribution effort (different valuations for each year of contribution, floors and ceilings, etc.).

The actuarial balance equation equals the final value of contributions and the actuarial present value of pensions at the time of retirement. Under an earnings-related defined benefit pension scheme and with wages growing at a constant rate, this equation is, after eliminating the initial wage of both sides, as follows:

\[ c \cdot V(r, \omega, j, e) = a \cdot V(\mu, \omega, j, e) \cdot A(r, \lambda, s, j, T) \] (1)

Where \( c \) is the contribution rate and \( V(r, \omega, j, e) \) is the cumulative value, at retirement age \( j \), of one unit of wage at age \( e \) (when entering the system) increased each year by the rate \( \omega \) and valued at an interest rate \( r \). In the right hand side of (1), \( a \) is the accrual rate per year of service, \( \mu \) is the rate by which the year’s contributions are revalued for the calculation of the first pension (valorization parameter) and \( A(r, \lambda, s, j, T) \) is the actuarial present value at age \( j \) of a unit pension (annuity factor) at the time of retirement, increased by the rate \( \lambda \) (pension indexation) and valued at an interest rate \( r \), where \( T \) is the last age in the mortality tables and \( s \) the probability vector of being alive at each age conditional of being alive at the retirement age.8
Equation (1) gives the interest rate, \( r \), of actuarial equilibrium. Over time, survival probability usually rises and this implies an increase in the equilibrium interest rate, so the objective of intergenerational actuarial neutrality (constant \( r \)) with different life expectancy (\( s \) variable) requires some parameters to be adjusted. Keeping constant other parameters that are not considered pension policy instruments (\( \mu \), \( \omega \) and \( T \)), the actuarial neutrality between the individual in generation \( t \) and the individual in the initial generation requires the following equation (2) to be fulfilled:

\[
\frac{c_t}{c_0} \frac{V(r, \omega, j_t, e_t)}{V(r, \omega, j_0, e_0)} = \frac{a_t}{a_0} \frac{V(\mu, \omega, j_t, e_t)}{V(\mu, \omega, j_0, e_0)} \frac{A(r, \lambda_t, s_t, j_t, T)}{A(r, \lambda_0, s_0, j_0, T)}
\]  

Equation (2) is the reference to design automatic adjustments. Depending on which parameters remain constant and which parameters must be adjusted, the size of the pension system, and which group bear the burden will be affected: if the retirement age (as is planned in Denmark, the Netherlands, Greece or Italy), contribution period (France) or accrual rate (Finland, Portugal and Spain) are adjusted, the effort rests on the future pensioners; if the contribution rate is adjusted, the cost is borne by contributors; and, finally, if pension indexation is changed the current pensioners will shoulder the burden.

**Actuarily neutral designs for the automatic adjustment**

**Linking retirement age, contribution period and accrual rate**

This group of adjustments transfers the life expectancy risk to future pensioners. Although existing pensioners also benefit from the increase in life expectancy, from a political point of view cutting existing pensions is more problematic than modifying any of the parameters that affect only future pensioners; hence, this is the pension policy instrument mainly used among countries that have incorporated life expectancy automatic adjustment mechanisms into their pension systems.

These mechanisms can be designed in different ways, which are discussed below. How they differ is more apparent than real, since in all cases the initial pension would be reduced (to compensate a longer payment period) if the individual behaviour does not change on retirement and in all cases this effect can be avoided if the individual reacts by retiring later and/or by paying contributions for a longer period of time.

8. Functions involved in the equation (1), assuming annual payments, are:

\[
V(r, \omega, j, e) = \sum_{i=1}^{\infty} (1 + \omega)^{i-r} (1+r)^{-i} \\
A(r, \lambda, s, j, T) = \sum_{i=0}^{T} (1 + r)^{-i} (1+\lambda)^{-i}s_i \\
s_i = \prod_{k=j}^{T} p_k, \text{ where } p_k \text{ is the survival probability from age } k \text{ to } k+1 \text{ (} p_T = 0). 
\]
Adjusting the retirement age and contribution period by maintaining the accrual rate per year constant. Linking retirement age to life expectancy is the most common automatic mechanism in this type of reform. The increase in the retirement age is accompanied by an equivalent increase in the contribution period. Thereupon, there are two possible designs depending if more pension entitlements are accumulated (whether the accrual rate per year, $a$, remains constant) or not (whether the total replacement rate, $a(j-e)$, remains constant).

In the first case, (the second is discussed below), replacing $(c_t, e_t, \lambda_t) = (c_0, e_0, a_0, \lambda_0)$ in equation (2) we obtain:

$$A(r, \lambda_0, s, j, T) = \frac{V(r, \omega, j, e_0)}{V(\mu, \omega, j, e_0)} \cdot A(r, \lambda_0, s, j, 0, T)$$

(3)

If $\mu = r$, equation (3) becomes $A(r, \lambda_0, s, j, 0, T) = A(r, \lambda_0, s, j, 0, T)$ and this implies a retirement age adjustment rule in such a way that the actuarial present value (or life expectancy) remains constant. In contrast, if $\mu < r$, (i.e. if contributions are revalued below the internal rate of return), the ratio in the second side of (3) is greater than one, therefore, the actuarial present value (or life expectancy) must be greater than it was initially, $A(r, \lambda_0, s, j, 0, T) > A(r, \lambda_0, s, j, 0, T)$. In this case the retirement age should be increased less than in the previous case, because if $\mu < r$ the average revalued earnings do not completely collect the increased contribution effort and this must be compensated by a smaller increase in the retirement age.

Note that equation (3) moves significantly away from the simplest rule that consists of increasing the retirement age to the same extent that life expectancy increases, since this rule would entail an over-adjustment on what is actuarially neutral.

In this type of adjustment the accrual rate per year does not change but the total replacement rate does, which will be greater because the contribution period increases. This means larger contributions and pensions, i.e. an enlarged social security system, with positive effects on the aim of pension adequacy.

Adjusting the retirement age and contribution period by keeping constant the total replacement rate. Unlike in the previous case, the increased retirement age and contribution period is now accompanied by a decrease in the accrual rate per year of contribution, in such a way that the total replacement rate remains constant: $a_t(j_t - e_0) = a_0(j_0 - e_0)$. With this condition and $(c_t, e_t, \lambda_t) = (c_0, e_0, \lambda_0)$, equation (2) is:

$$9. \text{Life expectancy is a particular case of the actuarial present value with } r = 0, \lambda = 0 \text{ and with one payment at the end of each year. Given that the evolution of the actuarial present value is less intense than the life expectancy evolution, countries using life expectancy in the design of the automatic adjustment are demanding higher corrections than the actuarially-neutral ones.}$$
Automatic mechanisms in pension systems

\[
A(r, \lambda_0, s_t, j_t, T) = \frac{j_t - e_0}{j_0 - e_0} \frac{V(r, \omega, j_t, e_0)}{V(\mu, \omega, j_t, e_0)} \frac{V(\mu, \omega, j_t, e_0)}{V(r, \omega, j_t, e_0)} A(r, \lambda_0, s_0, j_0, T)
\]

(4)

As the first quotient in the second side of equation (4) is greater than one, the actuarial present value in the period \(t\) should be greater than under the previous criterion, equation (3), and therefore, the increase in retirement age should be lower. This is a consequence of the additional adjustment through the pension amount since, unlike the previous case, a longer contribution period no longer implies a greater total replacement rate and the initial pension only increases slightly by the effect on the average earnings.

Equations (3) and (4) are the two actuarially-neutral alternatives to automatically link retirement age and life expectancy. The increase in the retirement age is higher choosing equation (3) than following equation (4), but the initial pension is also higher.

Adjusting the contribution period by keeping constant the total replacement rate. This adjustment mechanism demands a longer contribution period to get the same replacement rate. As the retirement age remains constant, this criterion is valued in the model anticipating the age of entry, \(j_0 - e_t > j_0 - e_0\), and reducing the accrual rate per year, to keep constant the total replacement rate to its initial value, i.e. adding the condition \(a_t(j_0 - e_t) = a_0(j_0 - e_0)\) in equation (2). Maintaining constant the rest of parameters and rearranging, we obtain:

\[
\frac{j_0 - e_t}{A(r, \lambda_0, s_t, j_0, T)} = \frac{V(\mu, \omega, j_0, e_t)}{V(\mu, \omega, j_0, e_0)} \frac{V(\mu, \omega, j_0, e_0)}{V(r, \omega, j_0, e_0)} \frac{j_0 - e_0}{A(r, \lambda_0, s_0, j_0, T)}
\]

(5)

If \(\mu = r\), equation (5) is reduced to \(\frac{j_0 - e_t}{A(r, \lambda_0, s_t, j_0, T)} = \frac{j_0 - e_0}{A(r, \lambda_0, s_0, j_0, T)}\), which means to maintain constant the relationship between the contribution period and actuarial present value. This design is the closest to the one implemented in France since 2009, where the contribution period for the full pension is automatically adjusted in the same proportion to the increase in life expectancy at age 61.

If \(\mu < r\), the first quotient of the second side in equation (5) is less than one and

\[
\frac{j_0 - e_t}{A(r, \lambda_0, s_t, j_0, T)} \leq \frac{j_0 - e_0}{A(r, \lambda_0, s_0, j_0, T)}.
\]

This means that the contribution period should increase to a lesser extent than the actuarial present value (or life expectancy if this variable is used), because in
this case a part of the adjustment is already included in the underestimated calculation of the average earnings.

*Adjusting the accrual rate and total replacement rate.* However, maintaining the retirement age and contribution period, countries such as Finland, Portugal and Spain have chosen to reduce the initial pension in response to a longer period of benefits. Considering that the accrual rate is the only adjustment parameter, equation (2) is transformed into:

\[
  a_t = a_0 \frac{A(r, \lambda_0, s_0, j_0, T)}{A(r, \lambda_t, s_t, j_0, T)}
\]

(6)

This type of adjustment consists of multiplying the initial accrual rate by a coefficient equal to the ratio of two annuity factors, with the survival probabilities of the base year in the numerator and the probabilities of the revision year in the denominator. As the latter tends to increase over time according to all projections, the coefficient is less than one (reduction coefficient), which means a decrease in the accrual rate and in the monthly pension of new pensioners, to compensate a longer period of benefits (the retirement age remains constant), thus the total pension valued in actuarial terms is constant. This decrease in the pension must be taken into account so that it does not affect the goal of adequacy, through the establishment of adequate minimum pensions.

Finland has been applying a similar coefficient, the so called life expectancy coefficient, since 2010, equal to the ratio of two annuity factors starting at age 62 with \( r = 2 \) per cent and \( \lambda = 0 \). Portugal, since 2010, has also been applying a sustainability coefficient formed by the ratio of life expectancies at age 65. Finally, the recent reform in Spain also incorporates a coefficient (called the sustainability factor) of this kind, based on a ratio of life expectancies at age 67 and applicable from 2019.

*Linking the contribution rate*

In a pure defined benefit system, the adjustment must rest on the system contributors and this should be the most logical adjustment, from a theoretical point of view. In fact, if a country with a PAYG, defined benefit pension scheme does not incorporate any automatic adjustment, an increase in the contribution rate to reach the fiscal balance is needed. This type of mechanism determines how the contribution rate should change to actuarially equilibrate the system as life expectancy increases. Keeping constant the other parameters in equation (2), simplifying, and rearranging, we obtain:
Equation (7) indicates how the contribution rate should increase at every review, in response to higher survival rates at each age. In particular, a multiplicative factor on the initial contribution rate equal to the ratio of two annuity factors should be applied, with new survival probabilities in the numerator and the base year probabilities in the denominator, keeping the other parameters equal to those of the base year. This multiplicative factor is the inverse of that applied in equation (6) and under normal conditions of longer life expectancy it will be greater than one, increasing the contribution rate.

This adjustment, in contrast to all previous ones, places the burden on contributors: employees and/or employers (via higher contributions) or all taxpayers (via general taxation). New and existing pensioners, who are the immediate beneficiaries of the higher life expectancy, do not support any kind of adjustment. The distribution of the increase in the contribution rate among employees, employers and taxpayers is a further decision which must assess the collateral implications on the labour market, public deficit, consumption, economic growth and welfare. The larger tax burden of this criterion and the negative economic implications explain why no system has implemented an automatic adjustment mechanism of this type.

**Linking pension indexation**

If pension indexation is the parameter linked to life expectancy, the group of all existing pensioners bears the burden. This link is politically the most unpopular, but also the most consistent because improvements in life expectancy continue after retirement. Although strict actuarial neutrality would index the pension differently depending on the pensioner age, the adjustment of the pension indexation in this model is estimated at the time of retirement and applies equally to all pensioners, so this exercise is more theoretical than real. Keeping constant the rest of parameters in equation (2), simplifying and reordering, we obtain:

$$A(r, \lambda_t, s_t, j_0, T) = A(r, \lambda_0, s_0, j_0, T)$$  \hspace{1cm} (8)$$

Here, higher survival rates mean the pension indexation must decrease to obtain the same actuarial present value as in the base year. In this case, the pensioner takes advantage of the higher rate of survival but this is compensated, from an actuarial neutrality point of view, with a lower pension indexation. This type of sustainability factor, to the extent that it affects the amount of future pension, could jeopardize the objective of adequacy, which should be taken into account through a sufficient minimum pension policy.
Experiences of reform in developed countries’ pension systems have not included in any case an automatic adjustment of the contribution rate or pension indexation to life expectancy. However, as we have outlined, several countries have implemented a more complex automatic balance mechanism affecting these parameters according to changes in both demographic and economic variables that are key determinants of the system’s solvency.

**Numerical illustration**

*Parameters of the pension system and mortality data*

In this section we assume an example of a PAYG, earnings-related pension system and, applying the mortality rates from 2012-based UK life tables\(^\text{10}\) (ONS, 2014), we obtain how the main parameters of the system should be adjusted in response to the increase in life expectancy following the equations (3)–(8). Obviously, each country with a defined benefit pension system should adapt the model according to its own parameters and mortality data.

In our numerical example, we choose an 80-40-65 formula (80 per cent total replacement rate at age 65 following 40 years of contributory service). We assume a consumer price index $\pi = 2$ per cent, a nominal wage growth $\omega = 3.5$ per cent and a nominal GDP growth of 3.5 per cent (hours worked growth rate is zero). It is also assumed that the earnings are revalued with the consumer price index ($\mu = 2$ per cent, per year) to compute the pension entitlements, although sensitivity analysis will be carried out by considering earnings that are revalued with wage growth. Furthermore, pensions are indexed with consumer price index ($\lambda = 2$ per cent).

The contribution rate is a parameter conveniently chosen so that, taking into account the mortality rates, the internal rate of return is equal to the GDP growth ($r = 3.5$ per cent) and the system is sustainable in the sense of Samuelson-Aaron at the initial time. The resulting value so that equation (1) is fulfilled is $c = 25.6$ per cent. Table 1 shows all the initial parameters of the model.

Assumptions in Table 1 imply a total replacement rate (accrual rate multiplied by the years of service) of 80.0 per cent of the average revalued earnings, a theoretical replacement rate (first pension divided by last wage) of 59.5 per cent and a ratio contributory period to life expectancy of 2.07.

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10. Historic and projected mortality rates from 2012-UK life tables (principal projection). In these tables, average life expectancy (both genders) at age 65 is projected to rise 5.5 years in the 2010–2050 period.
Evolution of the internal rate of return without adjustment mechanisms

Table 2 compares life expectancy (both genders average), which is the most understandable ageing indicator, and the annuity factor (both genders average), the variable appearing in the formulas, as the best actuarial indicator to adjust the parameters. Both indicators are evaluated at the retirement age and by considering five-year review periods. The calculation of the annuity factor also requires the indexation parameter ($\lambda$) and the interest rate ($r$) of Table 1. The dynamic evolution of the annuity factor (or life expectancy) is the main reference to measure the necessary adjustment in each parameter following the intergenerational actuarial neutrality principle. More specifically, the key indicator is a ratio of two annuity factors and is shown in the fourth row of Table 2.

It is important to note in Table 2 that the ratio of annuity factors is lower than the ratio of life expectancies if the retirement age is kept constant. The first will grow 28.5 per cent compared to 23.2 per cent for the second between 2010 and 2050, so that countries that use life expectancy to design adjustment mechanisms are demanding higher corrections than the actuarially-neutral ones.

Without any automatic adjustment parameters, the higher survival probabilities over time leads to an increasing internal rate of return which is shown in the last row of Table 2, as a result of applying the equation (1) with the survival probabilities vector of each review year. In particular, the data projected in 2050 is $r = 4.15$ per cent, implying an unsustainable system ($r > \Delta GDP$) and without intergenerational actuarial neutrality.

Results of alternative adjustment mechanisms

With an automatic adjustment linked to actuarial variables according to the equations presented, the system keeps actuarially neutral ($r = 3.5$ per cent in 2010–2050). Each row of Table 3 summarizes how each parameter must be adjusted according to the equations (3)–(8).

The first two rows in Table 3 are the results for countries that are planning to link retirement age to the mortality evolution in the future. If the design is such that a longer contribution period involves a higher total replacement rate, the retirement age should increase up to 70.55 years in 2050; however, if the total replacement rate remains at the initial level (80 per cent), the retirement age should increase less than before (up to 68.44 years in 2050) because, in part, the

---

11. The annuity factor in Table 2 is $A^*$, the actuarial present value with monthly pension payments. It is computed using the approximation with the Woolhouse formula: $A^* = A (1 + \frac{11}{24^2}) + \frac{11}{24^3}$, where $A$ is the actuarial present value with annual payments at the end of each year.
Table 1. Initial parameters of the pension system

<table>
<thead>
<tr>
<th>Variable</th>
<th>Value of each parameter in the model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirement age</td>
<td>( j = 65 ) years</td>
</tr>
<tr>
<td>Working career</td>
<td>( j - e = 40 ) years ( (e = 25 ) years)</td>
</tr>
<tr>
<td>Accrual rate per year</td>
<td>( a = 2.0% )</td>
</tr>
<tr>
<td>Wage growth</td>
<td>( \omega = 3.5% ) (nominal)</td>
</tr>
<tr>
<td>Price index</td>
<td>( \pi = 2% )</td>
</tr>
<tr>
<td>Earnings valorization</td>
<td>( \mu = 2% ) (nominal)</td>
</tr>
<tr>
<td>Pension indexation</td>
<td>( \lambda = 2% ) (nominal)</td>
</tr>
<tr>
<td>Contribution rate</td>
<td>( c = 25.6% )</td>
</tr>
<tr>
<td>Internal rate of return</td>
<td>( r = 3.5% )</td>
</tr>
<tr>
<td>Mortality data</td>
<td>2012-based UK life tables</td>
</tr>
</tbody>
</table>

Table 2. Life expectancy and annuity factor at age 65 and internal rate of return without adjustment mechanism

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
<th>2035</th>
<th>2040</th>
<th>2045</th>
<th>2050</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy ( (LE_i) )</td>
<td>19.3</td>
<td>20.4</td>
<td>21.3</td>
<td>22.1</td>
<td>22.8</td>
<td>23.3</td>
<td>23.8</td>
<td>24.3</td>
<td>24.8</td>
</tr>
<tr>
<td>( A(r, \lambda, s_i, j, T) )</td>
<td>16.9</td>
<td>17.7</td>
<td>18.4</td>
<td>18.9</td>
<td>19.4</td>
<td>19.8</td>
<td>20.1</td>
<td>20.5</td>
<td>20.8</td>
</tr>
<tr>
<td>( LE/LE_0 )</td>
<td>1.000</td>
<td>1.055</td>
<td>1.105</td>
<td>1.146</td>
<td>1.181</td>
<td>1.209</td>
<td>1.235</td>
<td>1.260</td>
<td>1.285</td>
</tr>
<tr>
<td>( A(s_i)/A(s_0) )</td>
<td>1.000</td>
<td>1.047</td>
<td>1.087</td>
<td>1.121</td>
<td>1.148</td>
<td>1.171</td>
<td>1.192</td>
<td>1.212</td>
<td>1.232</td>
</tr>
<tr>
<td>( r ) (internal rate of return)</td>
<td>3.50%</td>
<td>3.65%</td>
<td>3.78%</td>
<td>3.87%</td>
<td>3.94%</td>
<td>4.00%</td>
<td>4.06%</td>
<td>4.10%</td>
<td>4.15%</td>
</tr>
</tbody>
</table>

Source: Own elaboration and ONS (2014).

Table 3. Values of the parameters for each adjustment mechanism with \( \mu = \pi = 2\% \)

<table>
<thead>
<tr>
<th>Parameter</th>
<th>2010</th>
<th>2020</th>
<th>2030</th>
<th>2040</th>
<th>2050</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirement age (with constant accrual rate per year)</td>
<td>65.00</td>
<td>67.11</td>
<td>68.57</td>
<td>69.60</td>
<td>70.55</td>
</tr>
<tr>
<td>Retirement age (with constant total replacement rate)</td>
<td>65.00</td>
<td>66.31</td>
<td>67.22</td>
<td>67.85</td>
<td>68.44</td>
</tr>
<tr>
<td>Contribution period (with constant retirement age and total replacement rate)</td>
<td>40.00</td>
<td>42.72</td>
<td>44.58</td>
<td>45.87</td>
<td>47.05</td>
</tr>
<tr>
<td>Accrual rate per year</td>
<td>2.00%</td>
<td>1.84%</td>
<td>1.74%</td>
<td>1.68%</td>
<td>1.62%</td>
</tr>
<tr>
<td>Contribution rate</td>
<td>25.6%</td>
<td>27.8%</td>
<td>29.4%</td>
<td>30.5%</td>
<td>31.5%</td>
</tr>
<tr>
<td>Pension indexation</td>
<td>2.00%</td>
<td>1.29%</td>
<td>0.87%</td>
<td>0.61%</td>
<td>0.38%</td>
</tr>
</tbody>
</table>

Source: Own elaboration.
adjustment is supported by a smaller initial pension. Note that, under the first
design, a future retiree can mimic the second design if he/she opts for an early retire-
ment with an actuarially fair penalty when computing the first pension amount. So,
individual attitudes are as important as the automatic adjustment adopted to
evaluate the effective results of each reform.

The third row displays the results of an adjustment affecting the contribution
period to achieve the full pension, similar to the French mechanism, and shows
an increase of more than seven years in 2050. As contributing over such a long
period will be increasingly difficult, the probable effective result will be to reach
the retirement age without the full career and obtaining a smaller pension.

The fourth row, following the reforms in Finland, Portugal and Spain, assesses
the adjustment in terms of accrual rate, obtaining a drop in the initial pension of
18.8 per cent in the four decades of projection relative to the situation without
an adjustment mechanism. However, a future retiree can avoid this cut by deferring
the retirement with an extra pension, imitating the first two designs.

The fifth row shows that, if pensions are not adjusted, the contribution rate
should increase from 25.6 per cent up to 31.5 per cent (23.2 per cent in relative
terms). This implies an increase in total taxation as per cent of GDP, with serious
economic implications that should be considered in advance. Finally, the last row
shows how much the indexation of pensions must be below the consumer price
index if all the existing pensioners assume the adjustment. This involves a loss of
purchasing power for all current retirees, harming the adequacy objective.

Some sensitivity analysis

The sensitivity analysis of projected life expectancies is summarized in Table 4. We
show the results with both the low and high expectancy variant of 2012-based UK
life tables in addition to the principal projection. The low expectancy variant
assumes 2.6 years increase in life expectancy at age 65 in the 2010–2050 period
(average both genders), while the high expectancy variant assumes an increase by
8.5 years (5.5 years in the principal projection). The results are obvious: increasing
life expectancy means deeper adjustments.

An interesting sensitivity analysis is to compare the results in Table 3 with those
obtained if \( \mu = r = 3.5 \) per cent. This is the case of countries that value past earnings
with wage growth to obtain average earnings in order to calculate the pension. As
the initial pension is higher than using the price index, the contribution rate in the
model must be superior to keep the internal rate of return at a fiscally sustainable
level (the result is \( c = 33.8 \) per cent). Equations (3), (4) and (5) are simplified and
result, as expected, in higher adjustments, as shown in Table 5. The adjustments
using the equations (6), (7) and (8) do not change in relative terms.
It is also relevant to present the results that would be obtained if, in addition to the above change, life expectancy rather than the actuarial present value is used in the equations (3)–(7). Life expectancy is the preferred indicator in countries that have already implemented some adjustment mechanism, except in Finland, the only one applying the actuarial variable. It is more understandable and easy to compute, but not as close to the principle of actuarial neutrality. With this change in the reference variable, the results are shown in Table 6.

After comparing Tables 5 and 6, the most outstanding fact is that if the parameter linked is only the retirement age (first row), the adjustment is similar: it should rise from age 65 until 71.61 years in 2050. Thus, the rule of keeping constant life expectancy at retirement age is quite similar to the rule of keeping constant the actuarial present value. On the contrary, if the adjusted parameter is another, linking to life expectancy implies greater adjustments than linking to

### Table 4. Values of the adjusted parameters for alternative life expectancy scenarios

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Low variant</th>
<th>Principal</th>
<th>High variant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2010</td>
<td>2050</td>
<td>2050</td>
</tr>
<tr>
<td>Retirement age (with constant accrual rate per year)</td>
<td>65.00</td>
<td>67.74</td>
<td>70.55</td>
</tr>
<tr>
<td>Retirement age (with constant total replacement rate)</td>
<td>65.00</td>
<td>66.70</td>
<td>68.44</td>
</tr>
<tr>
<td>Contribution period (with constant retirement age and total replacement rate)</td>
<td>40.00</td>
<td>43.52</td>
<td>47.05</td>
</tr>
<tr>
<td>Accrual rate per year</td>
<td>2.00%</td>
<td>1.80%</td>
<td>1.62%</td>
</tr>
<tr>
<td>Contribution rate</td>
<td>25.6%</td>
<td>28.5%</td>
<td>31.5%</td>
</tr>
<tr>
<td>Pension indexation</td>
<td>2.00%</td>
<td>1.11%</td>
<td>0.38%</td>
</tr>
</tbody>
</table>

Source: Own elaboration.

### Table 5. Values of the adjusted parameters for each adjustment mechanism with $\mu = r = 3.5\%$

<table>
<thead>
<tr>
<th>Parameter</th>
<th>2010</th>
<th>2020</th>
<th>2030</th>
<th>2040</th>
<th>2050</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirement age (with constant accrual rate per year)</td>
<td>65.00</td>
<td>67.51</td>
<td>69.25</td>
<td>70.48</td>
<td>71.61</td>
</tr>
<tr>
<td>Retirement age (with constant total replacement rate)</td>
<td>65.00</td>
<td>66.70</td>
<td>68.44</td>
<td>70.14</td>
<td></td>
</tr>
<tr>
<td>Contribution period (with constant retirement age and total replacement rate)</td>
<td>40.00</td>
<td>43.52</td>
<td>47.05</td>
<td>49.28</td>
<td></td>
</tr>
<tr>
<td>Accrual rate per year</td>
<td>2.00%</td>
<td>1.84%</td>
<td>1.74%</td>
<td>1.68%</td>
<td>1.62%</td>
</tr>
<tr>
<td>Contribution rate</td>
<td>33.8%</td>
<td>36.8%</td>
<td>38.8%</td>
<td>40.3%</td>
<td>41.6%</td>
</tr>
<tr>
<td>Pension indexation</td>
<td>2.00%</td>
<td>1.29%</td>
<td>0.87%</td>
<td>0.61%</td>
<td>0.38%</td>
</tr>
</tbody>
</table>

Source: Own elaboration.
the annuity factor, harming future generations. In the second row of Table 6, where retirement age and accrual rate per year are adjusted, the increase in retirement age based on life expectancy (up to 69.15 years in 2050) is higher than the one based on the annuity factor (up to 68.86 years). Equally, the increase in the contribution period (51.41 years versus 49.28), the decrease in the accrual rate (1.56 per cent versus 1.62 per cent in 2050 from the initial 2.0 per cent) or the increase in the contribution rate (up to 43.4 per cent in 2050 compared to 41.6 per cent) would be higher. Life expectancy is not influenced by the pension indexation, so the last design through the equation (8) is not applicable in this case.

### Conclusions

This work has evaluated from an actuarial point of view six ways of linking some parameters of the pension system to the mortality evolution, on the basis of a general adjustment equation in a defined benefit pension system and under the principle of intergenerational actuarial neutrality.

The resulting formulas are different alternatives that countries wishing to maintain defined benefit public pension systems can put into practice since they are actuarially neutral and protect the system against life expectancy risk. The automaticity of this measure also minimizes the political risk of not adopting the necessary reforms. The political debate should be focused on what kind of adjustment mechanism is preferred by society. This will depend on the answer to two issues: what size of public pension system is the most desirable? And, which group must bear the burden of such adjustment?

If society decides not to adjust pensions, increasing the pension wealth because of higher life expectancy, current contributors will have to fund the larger size of the system through an increase in the contribution rate through

<table>
<thead>
<tr>
<th>Table 6. Values of the adjusted parameters for each adjustment mechanism with $\mu = r = 3.5%$ (formulas based on life expectancy)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adjusted parameter</strong></td>
</tr>
<tr>
<td>Retirement age (with constant annual accrual rate)</td>
</tr>
<tr>
<td>Retirement age (with constant total replacement rate)</td>
</tr>
<tr>
<td>Contribution period (with constant retirement age and total replacement rate)</td>
</tr>
<tr>
<td>Accrual rate per year</td>
</tr>
<tr>
<td>Contribution rate</td>
</tr>
</tbody>
</table>

Source: Own elaboration.
equation (7). Alternatively, fixing contribution effort (and the size of the system) implies maintaining as constant pension payments throughout the pensioner’s life but, as it becomes longer, the pension of each period will have to be limited by applying equation (8) and affecting all current retirees. The other adjustment mechanisms involve future retirees. In these cases, depending on how individuals respond to the legislated automatic adjustment mechanism, anticipating or deferring the effective retirement age, the overall effect on the pension system size could be different.

Bibliography


This volume contains a collection of papers by seven academics, mainly sociologists and political scientists. It is published at a crucial moment for the future not only of social Europe and the Eurozone, but for the European Union (EU) as a whole. Indeed, the outlook is bleak, given the unsettled aftermath of the global economic and financial crisis (the Great Recession) and the Eurozone crisis, the timetabled “Brexit” referendum, the unprecedented and growing flows of refugees from war zones to Europe, the freezing of the EU Schengen space for freedom of movement of people, persistent and rising unemployment among indebted countries across the EU, growing concerns over the impact of demographic ageing, rising public finance deficits and debts that coincide with the stalling of the former engines of growth in China, Brazil and other developing economies, recession in Russia, rumours of a possible recession in the United States, a risk of relapse into deflation in Japan, declining prices of commodities, especially oil, and ... rising global income and wealth disparities. All of which bode ill for the social dimension and the welfare state that characterized the three post-Second World War “golden” decades in Europe.

The authors explore in a comprehensive and interdisciplinary manner the roots and the driving forces of this vicious circle that started at the inception of the European integration process. It is characterized by what the authors consider as skewed political and ideological choices that led to a concept of Social Europe that was designed as a by-product of market integration, in which the role of the state was essentially to create the institutional framework for the market, promoting competition within national societies, and among national welfare states and labour markets across the EU.

These initial options have guided the EU’s founding treaties (Treaty of Rome, Maastricht Treaty, Lisbon Treaty, Stability and Growth Pact, European Monetary Union, followed more recently by the European Stability Mechanism), as well as by EU institutions and policies, generating bottlenecks on the slow path towards a Social Europe. Thus, EU activities in the areas of social and redistribution policies (via social and structural funds) as well as employment policies, the jurisprudence of the European Court of Justice (ECJ), and the Open Method of Coordination (OMC) “soft law”, are being guided by the German “ordoliberal” approach, under which “social issues” should be addressed by free market processes that boost competitiveness. This led to a strict requirement of balanced budgets and sustainable public debts, accompanied by binding rules and quasi automatic sanctions for fiscal policies, the hallmarks of the austerity measures that were imposed during the euro crisis by the “Troika” (European Commission (EC), European Central Bank (ECB) and IMF) on indebted Southern Eurozone countries who had to sign a “memorandum of understanding” to be assisted, if not rescued.

These measures had devastating outcomes on social protection, employment systems and industrial relations. They adversely affected social cohesion and the well-being of citizens, leading to the increasing disaffection of indebted countries with the EU. They may well lead Social Europe to a dead end. Ironically, the authors note that the ECB had to depart from this “ordoliberal” orthodoxy by committing itself “to do whatever it takes” to rescue the euro.

Another adverse effect of this orthodoxy has been the growing asymmetry between “negative” European integration – associated with legislation and judicial decisions that aim at liberalising and deregulating the economy, and “positive” integration – which was supposed to develop policies to correct the adverse impact of the market. Over the decades, and particularly during the recent crisis, the “negative” integration predominated, with the growth of deregulating policy that dismantled national labour laws and social protection. This asymmetry also distorted the stabilizing role that should have been played by the “social investment” approach.

The volume starts by taking stock of “Social Europe”, pointing to the growing EU initiatives over the past decade in the area of social policy (e.g. childcare, housing, social services, services of general economic interests, and social investment), an area that is statutorily reserved to the sovereign competence of Member States under the EU “subsidiarity” principle. But EU “inroads” in this policy area appear to have receded since 2012, despite (or because of?) the deteriorating social situation (rising unemployment, poverty, working poverty and inequality across the EU, clearly shown by Eurostat data). To understand how the EU became involved in social issues, the authors refer to the pillars that underpin Social Europe – namely, national social protection systems, EU law, EU “social coordination” – which emerged in the late 1990s from the soft-law OMC process, and the most recent “hard” law imposed by the heavy macroeconomic hand of the Troika on Portugal, Greece, Cyprus and Ireland – in lieu of the previous national economic policies.

As a result, there is now practically no limit to the gradual spill over of economic law into the social domain, as the EC and ECJ gradually have acquired discretionary powers of defining legal notions of what is “economic” or “social” that apply across the EU. Surprisingly, this discrete process has not even been noticed by the social actors and the traditional stakeholders of social protection. Moreover, while the EU has achieved a remarkable record as regards individual social rights in the area of discrimination and equality, it has made no progress in promoting collective social rights. It is also noteworthy that, in the wake of the Eurozone crisis, the need for containing the expansion or even reducing social protection appeared to be gradually accepted even by traditional defenders of social policy, such as the Nordic countries. The growing questioning of the validity of austerity programmes during economic slowdown among renowned economists, who previously supported them (including international agencies like the IMF, the World Bank and the OECD), did not stop the increasing prevalence of EU economic law over social policies, social rights and social protection at the national level. And yet, the authors note that there are still many potential areas were national actors can prevent the application of a solely market-driven legal space.

National social protection systems as well as wage and labour market systems are still essential bases in the economic and social fabric of EU Member States. And, despite the systematic marginalization by the EC of social policy and social protection during the past decade, it had to acknowledge its essential role as an “automatic stabilizer” during the crisis. In fact, they note that social protection has proven to be relatively resilient, despite being under constant attack, especially in Greece and Spain. In spite of the Baltic economic reform success stories, these countries have suffered growing poverty and declining wealth and social cohesion. In the absence of a significant social initiative by
the EC, the authors warn of the growing risks of damaging social dumping strategies, as social resistance movements grow in the exposed countries, especially in Spain, Greece, Italy, France and Ireland. While social actors, trade unions and citizens groups at national and EU levels are protesting against the liberal “dictat”, so far with limited success, populist movements increasingly occupy the political scene, defeating national incumbent politicians and candidates standing for the EU parliament (in 2014). The growing questioning of the free movement of workers challenges one of the main tenets of European integration. The EU is poorly equipped to address such challenges to its economic policy and its legitimacy. Reviving dialogue with the social partners over financial mechanisms, draft regulations and directives, vetting the Troika’s “memoranda of understanding” to avoid breaches of basic international conventions (e.g. adopted by the International Labour Organization and the United Nations, as well as the European Charter of Social Rights), and clarifying the role of the European Parliament, should be mobilized for defining fresh solutions to the current stalemate that undermines the legitimacy and credibility of Social Europe, and of the EU.

The book offers a useful description of the historical development and ideological underpinnings of the German “Ordoliberalism” and its lasting influence on the historical path of Social Europe and on the management of the Eurozone crisis. The ordoliberal economic school of thought emerged in Germany in the late 1920s and occupied a prominent place in the early years of the Federal Republic of Germany. It is an original variation of neoliberalism, because it does not consider that free markets are self-regulating, being based on the concept of a competitive order that is promoted, regulated and monitored by the state. Free markets that conform to these principles are “social” because they are expected to increase citizens’ welfare. This was the implicit “social programme” of the Treaty of Rome. The legacy of this approach on the design and functioning of the European Monetary Union (EMU) had decisive consequences for the path followed by Social Europe. The failure of Member States, particularly France, to balance this influence with a political union, led to a division of competences between the EU and Member States via the principle of subsidiarity, which was supposed to preserve national sovereignty in key social policy areas, while the competence of EU institutions was supposed to operate in a manner that preserves the single market. This resulted in an asymmetry – endorsed and developed by the jurisprudence of the ECJ – between economic freedoms at the EU level and basic social rights that were formally mainly based on national law and practice, but were often “encroached” upon. Such encroachment came from the operation of the single market, the EMU, and the management of the Eurozone crisis with a range of binding rules for public finances, and pressure for supply-side reforms to improve competitiveness in Member States and competition among them. It resulted in imposing strict conditionality in the rescue packages for indebted countries, and excluding a shared solidarity among Eurozone members to avoid moral hazard in debtor countries.

Since the democratic deficit has been noted in EU policy formulation, the volume includes a thought-provoking analysis of differing outcomes in federal states in social protection reforms that may help the “quasi-federal” EU system to improve its approach to the social dimension and thereby its legitimacy. Arguably, there is positive relationship between the degree of centralization of a national political system and the success and speed of implementing social protection programmes. Whereas in highly decentralized federal states there exists a variety of “veto points” that can be used by strong interest groups (business interests, certain powerful professions and societal groups – e.g. insurers, the medical profession, religious groups) that oppose social protection reforms, and can more easily block them in federal decentralized political systems – as in Canada or the United States. The European advanced
welfare states have developed earlier in countries with the most centralized political systems (Nordic countries, the Netherlands, France). The slow progress towards a European Social Model reflects the weaknesses of the EU’s supranational “federal” division of competences with Member States in the social policy area.

The Canadian experience proves that under certain circumstances a highly decentralized federal political system may actually encourage and help such reforms. In the EU, the soft law OMC process guiding the European Employment Strategy (EES) was initially given a nominal authority and influence over labour market policy issues that were previously beyond the reach of EU institutions. The real convergence and policy outcomes of many of the reforms in employment protection legislation and their effects on unemployment during the mid-to-late 1990s occurred in the early stage of the OMC, and may be the result of both the EMU and the underlying democratic accountability of the OMC. However, the heavy-handed austerity policies imposed by EU institutions have rolled back the social safety net in the indebted countries. The significant expansion of EU powers in this process has mainly been used to undermine rather than build a “European Social Model”, with no “voice” for the Member States. In contrast, the Canadian case succeeded because the increased federal power was based on a popular mandate, which expanded the welfare state through democratic process. This was achieved by a long process of conflict resolution that accompanied two major welfare reforms in Canada – namely, the introduction of a national public health care and a national (federal) Canada pension scheme and the Quebec Pension plan (at the Province level). The author analyses the veto powers exercised by politicians in the Canadian provinces to block the reforms and the talent that the federal politicians used to overcome it by mobilizing the overwhelming popular support for the reforms. Arguably, the EU institutions being supranational, it may be more difficult for them to mobilize Member States for EU-wide social protection schemes. To enable the EU to legitimately promote social protection policies applicable directly to Member States, the EU needs to develop a sense of common purpose among the Member States’ citizenry for whom those policies are supposed to serve. This is likely to be a long process.

Potential risks for the future of a democratic and Social Europe may also result from the transition that seems now to be in process at the ECB, from a monetary regulator to a political institution.

Another obvious constraint on the path towards a Social Europe is the impact of the afore-mentioned supply-side reforms that are increasingly promoted, and more recently imposed, by the EU to increase the flexibility and competitiveness of business, as part of recent austerity packages. While varying in intent and extent, all these reforms consist of a systematic deregulation of national labour legislation dealing with working time, atypical employment, dismissal and redundancy rules, and industrial relations (weakening dispute resolution and wage fixing procedures, capping minimum wages, weakening collective bargaining and collective agreements). These measures have undermined worker protection and fundamental social rights, and increased poverty and inequality. They were adopted with the limited consultation of national parliaments, bypassing national social partners and social dialogue – disregarding, thereby, not only basic international social and labour standards, but calling into question the democratic process in managing the crisis and, hence, the legitimacy of the reforms.

Against these strong headwinds, how has the concept of “social investment” – which emerged in the 1990s (inspired by the Third Way ideology) – evolved from the original approach to the welfare state that aimed at protecting people against social risks from the market, towards an “enabling welfare state” that is supposed to adapt people to the market. In this context, “social investment” is expected to
shift the welfare state functions to families and markets, by promoting an entrepreneurial culture for “a society of responsible risk takers”. Such a narrow view of social investment and of the welfare state reflects the economic interpretation of social policy, the main goal of which is to enhance competitiveness among those able to compete – from childhood onwards, through schooling and work, excluding persons who are unable to work, shrugging off social justice and depriving social policy of its social and political roles. Yet, there are at least three acknowledged reasons for developing a more social Europe: namely, to promote social justice, improve economic efficiency, and secure political support of the EU integration process. At present, the social investment strategy appears to focus on the second reason, in the apparently misguided hope that the other two will follow automatically. The same mistaken logic has been followed in the early days of the EU when its primary focus was economic integration, in the hope that it would lead to a political union. The Eurozone crisis has clearly shown the limits and the failure of this approach. More generally, the social investment approach suffers from a minimalist interpretation of social issues, including the assimilation of human development to “human capital”, a skewed vision of social inclusion, a constrained supply-side approach to address unemployment, and confining welfare reform to the economic domain, from which concepts such as solidarity, social justice, needs and rights are absent, limiting popular support for political action. Such an approach does not seem to offer a path-breaking change towards a more dynamic and attractive Social Europe.

The causes of the crisis and the responses to it have increased heterogeneity of macroeconomic performance and social cohesion among Member States, despite the convergence in national social and employment policies towards a more market-oriented social model. The EU’s crisis management approach produced contrasting results, increasing heterogeneity among Member States, most notably in terms of minimalist solidarity, with a Social Europe offering little prospects for economic, social or political convergence.

To sum up, this book suggests that “the writing has been on the wall” concerning the deadlock that threatens the European Union at a crucial moment of rising global and internal threats. It explains what went wrong and why the promising path towards a successful and politically, economically and socially balanced region seems to have gone astray. Politicians, social actors and citizens should heed the message and start thinking about the appropriate remedial U-turn.

Hedva Sarfati

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Geneva, Switzerland

Pensions and pension reforms have been the subject of heated debates around the world over at least the last two decades. It is not easy, however, to present in one book a consistent picture of these debates in different countries. This is because national pension systems differ substantially, different systems face quite distinct challenges, and thus reforms needed in each context are also quite varied. “Model” pension systems cannot simply be imported or copied from one country to another. Attempts at such imports or copying always lead to results that diverge from those expected by “copycat” reformers. For example, Nigeria recently introduced a “Chilean” pension system, but the post-reform Nigerian pension system undoubtedly shares little in common with its Chilean counterpart.

Previously, Nicolas Barr and Peter Diamond synthesized the arguments and debates as well as the experiences and implications of the reforms that have taken place over recent decades.¹ According to Barr and Diamond, pension systems have multiple objectives: preventing poverty, guaranteeing income security in old age, consumption smoothing and number of other secondary objectives. Focusing on only some of these objectives – or sometimes even on only one – often leads to policy errors and misguided reforms. The authors conclude that to meet these diverse objectives while also catering for the different needs and labour market circumstances of different groups of the population, effective pension systems must be composed of a number of pension schemes, including a basic public pension as well as earnings-related pensions, both mandatory and voluntary. Indeed, the concept of a “multi-tier” pension system is probably the most – if not the only – valuable input to the global pension debate to come out of the World Bank’s 1994 publication Averting the old-age crisis.

The UNRISD volume focuses only on countries labelled “developing” and “transition”,² but many of its conclusions are certainly valid globally. It is a collection of case studies which deal with a very broad range of pension schemes, issues and countries – from privatization (and in some countries, recent reversals of privatization) of social security in Central and Eastern Europe and Latin America, to creating or strengthening the zero-tier of the pension system in the form of non-contributory basic pensions in Chile and Bolivia, to reforms to schemes for specific population groups, like civil servants’

2. Both adjectives are rather ambiguous and intend to cover countries at very different stages of development, both of their economies and of their social protection systems. In my view, however, the term “transition” should be either abandoned or revised, while “developing” is increasingly avoided nowadays but perhaps more difficult to abandon. Some of the so-called “transition” countries have already successfully accomplished the transition from centrally planned to market economy and are fully fledged members of the European Union, while in others, the “transition to market economy” is not necessarily happening at all anymore.
pensions in the Republic of Korea or provident fund arrangements in South Africa or India (Provident funds do not necessarily provide life annuities and thus are not really pension schemes according to international labour standards). All these case studies are interesting in their own right, but what is most interesting is the attempt by the volume’s editor – Katja Hujo – to bring the conclusions of these studies, together with results of other research done by UNRISD and elsewhere, into consistent policy conclusions (included in the first and last chapters of the volume).

The case studies are divided into three parts. Part I, “Political economy issues in pension reforms”, covers chapters by Katharina Müller on pension privatization in Central and Eastern (mainly Hungary and Poland), Markus Loewe on pension provisions in the Middle East and North Africa, and Huck-ju Kwon on the reform of civil servants’ pensions in the Republic of Korea. Part II covers selected aspects of pension systems and reforms in Brazil (Marcel Abi-Ramia Caetano), India (Mukul G. Asher and Azad Singh Bali), China (Lianquan Fang), and South Africa (Fred Hendricks). Part III, “Bringing the State back in”, includes two chapters on pension reforms and re-reforms in Bolivia (Peter Lloyd-Sherlock and Kepa Artaraz) and Argentina and Chile (Katja Hujo and Mariana Rulli), as well as a concluding chapter by Katja Hujo.

The overall ambition of the book, as stated by the editor, is to look at the pension reforms in different countries from the perspective of four functions of social policy: protective (providing income security and preventing poverty), productive (accumulation of savings and demand stabilization), redistributive (redistribution of risk and income across different groups and generations) and reproductive (reducing the financial and care burden associated with ageing). Similarly to Barr and Diamond, Hujo stresses the importance of recognizing the multiple functions of pension systems, their multi-tier character and the need to integrate pension systems within a broader, more consistent and better coordinated social policy “that protects and promotes people over the entire life cycle”. Equally important are public debates, establishing consensus to secure both financial and political sustainability and guaranteeing rights, equity, fairness and justice. All these goals can be achieved only in pension systems which combine contributory and non-contributory elements, and through reforms that are able to adapt these systems adequately to changing demographic, labour market and socio-economic contexts.

A number of issues raised in the book are worth debating, but the question of privatization stands out. First attempted in Chile at the beginning of 1980s, full or partial privatization of social security pensions has been introduced since the mid-1990s in many countries, mainly in Latin America and Central and Eastern Europe. Katharina Müller re-asserts that this wave of reforms, advocated in each country according a similar set of economic arguments (“averting the old-age crisis and promoting growth”) reflects the existence of an “epistemic community: a network of professionals with a common policy enterprise, sharing faith in a set of normative and casual beliefs, having similar patterns of reasoning and using shared discursive practices” (p. 56). It is true that such an epistemic community emerged and still exists and that its intellectual as well as executive centre (in terms of the ability to – through its loans, projects and hired experts – actively impact pension reforms in many countries) has been the World Bank. However, its history began not with the famous World Bank 1994 publication, but rather with a much earlier wave of critiques going back to the 1970s aimed at the United States’ social security system. Economists and ideologues like Martin Feldstein or Larry Kotlikoff argued that the state provision of social security was both inefficient and unsustainable, and American-trained economists, who were heavily involved in the Chilean privatization of social security, treated the experience as a test case for the desired implementation of similar reforms in the United States. (Similarly, Swedish
architects of the notional defined contribution (NDC) pension design were actively involved in assisting
with NDC-type reforms in Latvia and Poland before they succeeded in implementing a similar one at
home.) Also, while the World Bank certainly played an important role in promoting pension privatization,

at least equally important – if not more so – was (and still is) the lobbying from the international financial
services sector, including banks, insurance companies, pension fund administrators and their global as-

sociation FIAP. These groups not only financed many national and international conferences and meet-

ings promoting pension privatization, but they actively lobbied at the national level and within

international organizations (even in the International Labour Organization through its employers group)

trying to influence the size and regulatory frameworks of the “mandatory and privately managed” pen-
sion tiers.

Not accidentally, this “epistemic community” was relatively successful only in countries where

institutional social dialogue was not well developed and social partners were relatively weak, and

consequently, reforms were designed mainly by a narrow group of experts representing the

“community”. Social security privatization was rejected in Western Europe and even in the United

States, where supporters of social security are very well organized. Moreover, a wave of
de-privatization, or at least a scaling down of the private tiers, following the financial and economic

crisis (unfortunately recent re-nationalizations of social security pensions in Central and Eastern

European countries are not discussed in the book), has shown how fundamentally weak and shallow

the alleged consensus around privatization in countries like Hungary and Poland actually was.

It is important to point out, that – at least in Central and Eastern Europe – support for privatization

by politicians and even by some of the trade unions should, to a large extent, be understood less as

support for a switch to private management of pension funds and more as support for a switch to a

defined contribution (DC) design of the pension schemes. In formerly communist countries, there

was a crisis of confidence in public institutions, including social security institutions, and therefore a

popular belief that private management would be more effective. At the same time, however, there

was also discontent with the excessively large scope of redistribution in the former communist regime

and a sense that the DC (or NDC) principle of purely earnings-related pensions was socially fairer than

any redistributive defined benefit scheme. The popularity of (N)DC arrangements among politicians

can be also explained by the belief (actively created by the “epistemic community”) that incentives

embedded in such “actuarially fair” schemes (where one has to work much longer to get a reasonable

pension) would relieve politicians of the burden of proposing increases in retirement ages, which was

always very unpopular and even led in some cases to a collapse of government.

Hujo’s conclusions stress the importance of guaranteeing income security in old age to all and the

role non-contributory provisions in making such a guarantee a reality – as a part of social protection

floor as foreseen by ILO Recommendation concerning national floors of social protection, No. 202

(2012). In this context, it is a pity that the authors of the different case studies did not always look

3. The notion of “actuarial fairness” is often used in the book. While one can speak about “actuarially

neutral” schemes, “actuarial fairness” has no meaning in actuarial science. This term was invented by

economists belonging to the “epistemic community” and is just another example of language being used to

promote certain ideologies and policy directions.

4. The Polish pension reformers explicitly argued that the only necessary qualifying condition was a

minimum retirement age. In the first version, the pensionable age was set at 62 for both sexes but later

changed to age 60 for women and age 65 for men, as reformers decided that attempting to increase the

retirement age for women by two years would risk killing the whole reform.
at pension systems in a more systemic and comprehensive way, in order to verify how the overall pension system in the country analysed, composed of different schemes, meets the different policy objectives outlined and how they perform in terms of population coverage and income security. For example, while public sector pensions in South Africa are a very important part of an overall system in need of improvement, the most effective – and really worth discussing in the context of this book – component of the South African pension system (not only from the point of view of poverty prevention), is the non-contributory pension, which effectively covers the majority of the elderly.

The volume concludes with a selection of questions which still await good answers and thus constitute an invitation for further research. How does pension funding (public or private, full or partial) actually contribute to economic development, and what are the advantages and disadvantages of pure pay-as-you go (PAYG) in the same context? How should pension systems and reforms respond to persistent labour market informality and spreading precarious forms of employment? How can we ensure transparency, accountability and participation at all stages of pension reform, including implementation and monitoring? What are the actual impacts on national policies of global social policy initiatives, expressed through the Social Protection Floor Recommendation or the Sustainable Development Goals?

These and other questions posed by the editor can also be understood as a promise of further research which will deepen the discussion on how pension systems in developing countries and elsewhere can most effectively meet their core objectives.

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