

## Social Security: What Can Developing Countries Learn from Developed Countries?

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Jean-Jacques Dethier

In developed countries, social security covers workers and their dependents against old age, unemployment, health, and other risks. In developing countries, formal-sector workers have access to social insurance, and the very poor have some access to social assistance and health services, but large population groups are not covered. Extending social security coverage would require delinking social security benefits from labor market status, creating new institutions to cover currently excluded groups, financing these new programs through general taxation, improving tax collection, reducing the costs of formal-sector benefits, and increasing the costs of informal-sector benefits.

Social security is defined in the European Union as social insurance and social assistance arrangements that protect the population against various economic risks. The U.K. definition, which includes cash benefits but excludes health services, and the U.S. definition, which includes only retirement benefits, are narrower. *Social insurance* denotes publicly provided or mandated *contributory* programs that cover workers and their dependents against major life risks—essentially unemployment, health risks, and old age. Beneficiaries receive income or services in exchange for

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contributions to an insurance scheme. *Social assistance* refers to *noncontributory* transfer programs that are means tested and targeted in some way to the poor or those vulnerable to poverty and shocks. Other policy instruments—in particular, progressive taxation and various regulations such as minimum wage laws and other labor market policies—help support social security. These instruments and their effectiveness should ideally be evaluated together with pension and health insurance systems and social safety net programs.

Social insurance is a substitute for market mechanisms when such mechanisms are not economically viable or tend to exclude part of the population. It cannot operate in the same way as standard private insurance (for which each participant pays a premium equal to the expected loss plus operating costs) and cannot be financed by actuarially fair contributions. Social security is thus partly financed through taxes levied on people irrespective of their exposure to the risks that are covered. It implies substantial income redistribution across individuals. It is mainly through that redistribution that the public coverage of old age and health risks is truly *social* (rather than an actuarially neutral substitute for the market mechanism).

Social security has major social benefits, but it also has costs. Benefits arise from gains in efficiency and from a more harmonious and cohesive society. Costs arise from distortions generated on both the tax and the benefit sides, with additional distortions generated by noninsurance instruments (for example, by reducing the incentive to supply labor).

### Social Security in Developed Countries

In developed countries, social security grew massively after World War II, in times of prosperity. In the past 30 years, many countries have introduced reforms in unemployment benefits and social assistance to reestablish individual incentives thought to be threatened by existing policies. Social security systems are complex and large—ranging from 31 percent of gross domestic product (GDP) in Sweden to 16 percent in the United States. Institutional differences between countries result from history and from differing views on the role of the private versus the public sector in insurable risks. Despite some significant direct and indirect costs, social security has generated enormous benefits in terms of income maintenance, poverty reduction, and economic stability. Cross-country studies of income redistribution that examine the coverage of low-income risks by government programs show that social security has helped reduce poverty drastically, by at least 40 percent in Europe—in heavily insured countries such as Belgium and Sweden by more than 70 percent—and by 28 percent in the United States. Table 21.1 shows the anti-poverty impact of these programs in Organisation for Economic Co-operation and Development (OECD) countries.

**Table 21.1 Anti-poverty effects of government spending in selected countries, years as noted**

Country	Share of poor people in selected OECD countries by income source				
	Market income	Social insurance (and taxes)	Social assistance	Percentage reduction in poverty	
				Social insurance	Overall
Austria (2000)	31.8	9.1	7.7	71.4	75.8
Belgium (2000)	34.6	8.9	8.0	74.3	76.9
Canada (2000)	21.1	12.9	11.4	38.9	46.0
Finland (2000)	17.8	11.4	5.4	36.0	69.7
Germany (2000)	28.1	10.6	8.3	62.3	70.5
Ireland (2000)	29.5	21.2	16.5	28.1	44.1
Italy (2000)	30.0	13.7	12.7	54.3	57.7
Netherlands (1999)	21.0	9.6	7.3	54.3	65.2
Sweden (2000)	28.8	11.7	6.5	59.4	77.4
United Kingdom (1999)	31.1	23.5	12.4	24.4	60.1
United States (2000)	23.1	19.3	17.0	16.5	26.4
Average (2000)	27.0	13.8	10.3	47.2	60.9

Source: T. Smeeding, Poor people in rich nations: The United States in comparative perspective, *Journal of Economic Perspectives* 20, no. 1 (2006): 69–90.

Notes: Poverty rates are for persons living in households with adjusted incomes below 50 percent of median adjusted disposable income. The market income poverty rate includes earnings, income from investments, occupational pensions, child support, and other private transfers. The social insurance (and taxes) poverty rate includes the effects of taxes and social contributions as well as social insurance for countries where market income is gross and only social insurance in countries where it is net. The social assistance poverty rate is the same as the poverty rate on disposable income. Refunds from Earned Income Tax Credits (United States) and Family Tax Credits (United Kingdom) are treated as social assistance, as are near-cash benefits, such as food stamps and housing allowances. The percentage reduction in social insurance is the market income rate minus the social insurance rate as a percentage of the market income rate. The overall percentage reduction is the market income rate minus the social assistance rate as a percentage of the market income rate.

### Pension Systems

Pension systems in developed countries cover more than 90 percent of the labor force. All of these countries have a mandatory pension scheme, but the balance between voluntary and mandatory provision of pension benefits differs greatly. Voluntary private pension provision is widespread in countries such as Canada, the United Kingdom, and the United States, which have relatively small mandatory pensions. In countries where a large share of income is replaced under the mandatory system, those covered have no need to make any voluntary provision for retirement.

Various approaches are used to guarantee that all older people meet a minimum standard of living. OECD countries can be divided into several groups, depending on whether the link between pension entitlements and pre-retirement earnings is weak, strong, or nonexistent.

- In Canada, Denmark, Ireland, and New Zealand—where pension benefits are purely flat rate—there is almost no link between pension entitlements and pre-retirement earnings.
- In Australia and the United Kingdom, which have significant means-tested public schemes, as well as in Belgium and South Korea, the link between pension entitlements and pre-retirement earnings is weak. There are important minimum credits in the earnings-related pension plans of Belgium and the United Kingdom.
- Switzerland and the United States, which have progressive formulas in earnings-related schemes, and France and Japan, which have redistributive (minimum and targeted) programs, fall in between.
- In Finland, Italy, and the Netherlands, the link between pension and pre-retirement earnings is very strong, and the replacement rate is constant for much of the earnings range.

Pension systems also differ in the role that the public versus the private sector plays in pension provision. Where the link between pension and pre-retirement earnings is strong in the mandatory system, voluntary private provision will have a greater role. In some countries, primarily in Latin America, the private sector is involved in running the mandatory pension system. The private sector also plays an important part in pension provision in several OECD countries. In the Netherlands, Sweden, and Switzerland, occupational pensions are mandatory or quasi-mandatory. When the United Kingdom allowed workers to “contract out” of the public, earnings-related scheme in 1978, 50–75 percent of employees opted to substitute private for public provision. Sweden also recently introduced a mandatory defined-contribution scheme, while Denmark has a long-standing one. A defined-contribution scheme is one in which a periodic contribution is prescribed and the benefits depend on the contribution plus the investment return (as opposed to a defined-benefit scheme, in which a benefit based on a prescribed formula is guaranteed).

#### Health Insurance

With the exception of the United States, all developed countries now have universal health insurance. European health insurance systems offer the same services as market insurance but redistribute income by increasing participants’ contributions in proportion to their income, although benefits are more or less equal. Health systems are classified as one of three types: (1) private finance plus private production/provision of services, (2) public funding plus public provision, or (3) public fund-

ing plus private provision *plus* stringent regulation of medical spending. Successful health care provision systems can be mainly public, mainly private, or mixed. There is no perfect model, and each existing system has problems as well as benefits.

- Public funding plus public provision, as in Scandinavia and the United Kingdom, has two strengths: its abilities to contain costs and promote access. Its weaknesses include limits on consumer choice and sometimes long waits for service.
- Public funding plus private provision—for example, in Canada and Germany—scores well on access, consumer choice, and the absence of waiting lists, but not on the ability of doctors, clinics, and hospitals to contain costs; hence, it is vulnerable to upward pressures on medical spending. No country should consider this model unless policymakers are confident they have both the political and the administrative capacity to make the necessary cost containment measures stick.
- The U.S. system, relying primarily on private funding plus private provision, suffers from coverage and cost problems. In the face of diverse and competing funding sources, third-party incentives have not been contained, leading to a major cost explosion.<sup>1</sup> Despite heavy public spending, gaps in coverage remain, and access to quality care is unequal.

The key issue related to universal health coverage is how to maintain fiscal sustainability. Because medical expenditures are increasing rapidly, considerable effort is going into devising methods to contain medical spending in the face of third-party incentives—methods such as cost sharing, preferred providers, or mechanisms such as health maintenance organizations or diagnosis-related groups. Increasing cost recovery, with some exemptions for low-income persons, is equivalent to reducing the coverage of public health insurance schemes and offering more opportunities to private insurers. How much of that evolution is inherent in public health insurance systems and how much is due to the increase in the demand produced by rapid technological progress in the field or to the pressure of service producers has been debated for a long time.

#### Unemployment Insurance

Unemployment benefits decline as the length of unemployment increases. The replacement rate—that is, the ratio of benefits to wages replaced by unemployment insurance—varies widely from country to country. The gross rate has fluctuated about 10–15 percent in Japan and the United States and 35 percent in France and the Scandinavian countries in the past 30 years. But the generosity of unemploy-

ment benefits has no significant impact, in the long run, on the level of GDP. Any negative effects of unemployment benefits on employment are fully offset by a net positive impact of unemployment benefits on productivity.

Many people who are looking for work are not eligible for unemployment benefits, either because they are new entrants into the labor market or because they have exhausted their entitlement. In Greece, Italy, Portugal, and Spain, fewer than 25 percent of the unemployed receive benefits. The figure is higher in Germany (about 70 percent) and the Scandinavian countries. After a time, unemployed persons can receive social assistance payments (which are means tested and independent of past earnings) as opposed to unemployment benefits (which are paid for a limited period at a level linked to the wage earned in the previously held job).

Unemployment benefits systems (as well as minimum income guarantee schemes) are predominantly financed through social insurance contributions on earnings in France and Germany and predominantly from taxes in the United Kingdom. Social assistance and other programs (for example, family allowances or housing subsidies) represent a smaller share of total social security than pensions and health care, but they generally provide highly effective coverage of families at risk, thanks to powerful targeting. However, such transfers have an efficiency cost because they reduce incentives for low-income recipients to find employment and because increasing taxes to finance income transfer programs may reduce incentives to work and save among the middle- and high-income earners who have to pay the extra taxes.

### Could Developing Countries Adopt the OECD Model?

Because there is a strong demand for social security and better social protection for all workers in many emerging economies, policymakers are considering emulating the OECD model. The long-term goal is a universal system in which all citizens will have access to an adequate and affordable level of health services and enjoy a decent pension—or at least a minimum income—in old age. Moreover, the services provided must be efficient and of decent quality across the entire income distribution. But is it possible for them to follow the model of developed countries?

Developing countries differ structurally from developed countries in several respects:

- The annual per capita income level (US\$1,750.00 versus US\$35,000.00 on average for 2005) and the overall GDP share of social expenditures diverge greatly. For instance, developed countries spend 6.7 percent of GDP on public health programs compared with 2.8 percent in developing countries. Poverty levels are much higher and mean income levels are lower in developing countries. Labor markets are fragmented, and the informal sector is large.

- All countries, to varying degrees, devote public resources to health care, social assistance, and, for some privileged groups, pensions. But few developing countries have social insurance. Where it is available, coverage is limited to wage workers in the formal sector of the economy.
- Existing systems of social protection are fragmented. The richest population group has access to formal social insurance, and the very poor have some access to social assistance and health services. But large population groups are not covered by formal-sector social security institutions and receive no social assistance.
- Redistribution of income is limited for all of these reasons: partial coverage, the limited size of social expenditures as a proportion of GDP, the concentration of benefits in privileged sectors, and the limited progressivity of social expenditures and the tax system.

Developing countries are experiencing major difficulties in extending coverage to and increasing contributions from nonpoor, informal-sector workers for several reasons:

1. *Fiscal constraints.* Universal social insurance requires a tax base and a level of general taxation above what is currently in place in most countries. Fiscal constraints are particularly strong in low-income countries in which public spending—averaging 15 percent of GDP—is about half of what it is in developed countries.
2. *Administrative constraints.* The most important constraint is the lack of official records of income and therefore the difficulty of collecting taxes. Also, minimum income guarantees cannot be put in place if the government does not have the ability to test for means, in which case insurance against employment shocks or fluctuations in earnings must be provided through other channels. Another constraint is the potential for misuse of funds. Many programs suffer notoriously from graft, corruption, and capture of benefits by the nonpoor. Basic accountability and simplification of eligibility criteria and payment structures can help reduce fraud.
3. *Incentive constraints and increasing informality.* Social insurance produces several types of disincentives that affect the general efficiency of the economy. Though it does not increase unemployment, social insurance acts as a disincentive for people to stay in formal employment, contributing to the “informalization” of the economy. Evidence from Latin America and Eastern Europe confirms that social

insurance increases the share of workers in the informal sector. Where enrollment is voluntary or only weakly enforced (which is the norm), many workers choose an informal labor contract rather than paying a higher (though subsidized) price in the public system or taking out private insurance. Even when enrollment is compulsory, incentives to pay social insurance contributions are low (as in Argentina, where a large number of workers do not pay their pension contributions).

### Minimum Pension Schemes in Developing Countries

Whereas pension systems (including minimum pension schemes in developed countries) are strongly redistributive, yielding a sizable difference between poverty rates before and after transfer, they have limited potential to prevent old-age poverty in developing countries because of their low levels of coverage. How can a basic income be provided to the elderly in developing countries? One option would be to open existing retirement systems to all, regardless of labor market status, and provide a minimum income to all persons aged 65 and older. This is consistent with a social contract in which all citizens pool old-age income risk. In addition to this risk-pooling component, the government might also want to provide incentives to working-age persons to achieve a higher old-age income through savings. This option would require that savings be voluntary rather than mandatory, particularly because the income of a large group of nonsalaried workers is not observable.

But moving to a unified, universal system would have a high fiscal cost. This option might also weaken incentives to work in the formal sector. Therefore, several governments have chosen a more efficient policy option: lump-sum transfers financed by tax receipts. These are pensions aimed at providing a replacement income to the elderly under the poverty line. They are of two types. The first provides a minimum pension unconditionally to all the elderly. Benefits are the same for everyone regardless of income, assets, or work history. Only four developing countries have such arrangements: Bolivia, Botswana, Mauritius, and Namibia. They are easy to administer and do not require information on the income or assets of the beneficiaries. Except for Mauritius, the pension they offer is not great enough to lift its beneficiaries above the poverty line. The second type of minimum pension is also universal but subject to means testing. Five Latin American countries—Argentina, Brazil, Chile, Costa Rica, and Uruguay—have noncontributory pensions. These programs have a social assistance character in that they are targeted to the poor and disabled who cannot afford to contribute. In Brazil and Costa Rica, part of the social assistance pension benefit is financed by cross-subsidies from social insurance programs. Chile, Costa Rica, and Uruguay cover the greatest share, but Brazil has the largest number of beneficiaries—more than 8 million if the recently introduced rural pension programs are included. Rural pension programs

provide a pension corresponding to the minimum wage to all men over age 60 and to women over age 55 in rural areas. Some universal means-tested schemes apply to the *household* but not to the individual. The most famous example is the South African minimum pension. It is quite generous (one-third of per capita income), and it reaches 88 percent of the covered population. The pension is paid to men aged 65 and women aged 60 and over, and it is funded through general taxation.

Several studies have examined minimum pension schemes. In rural Brazil and South Africa, noncontributory pension schemes were found to reduce both the rate of poverty for elderly people and the poverty gap. In Latin America, a study using survey data found that a hypothetical universal minimum pension would reduce poverty almost by half among the elderly in countries where poverty rates were higher. Universal schemes have much to recommend them in terms of incentives, spillover effects, and administrative simplicity. However, their fiscal cost—which is a function of the dependency ratio and the fiscal capacity of the country—is far from negligible, even for small pensions. Given that the tax base is limited and tax revenue represents a small share of national income in developing countries, this policy option is probably not feasible for countries with a per capita GDP below, say, US\$2,500.00 or US\$3,000.00. Means testing is cheaper but less efficient in alleviating poverty. The net cost after subtracting existing transfers to the elderly—that is, means testing the minimum pension transfer—would be much smaller.

### Universal Health Insurance in Developing Countries

Out-of-pocket health expenditures are often large compared with income, and this limits access to services and pushes many households into poverty when health shocks occur. The challenge for developing countries is to increase participation in risk-pooling schemes for two population groups: the poor, who will probably never be able to pay the average cost of a health benefits package, and high-risk individuals whose health costs will be higher than they can afford for much of their lives.

Many countries have recently set up schemes for the poor, financing membership in the social health insurance system out of general revenues. Most, however, typically commit substantial errors of exclusion, largely because poor households fail to apply. For instance, Colombia reformed its system in 1993, but 10 years later fewer than 50 percent of the principal target group were actually enrolled in the noncontributory scheme. In Vietnam in 2004, about 40 percent of the poor who should have received health insurance coverage (or a free health care card) actually had done so. In China and the Philippines, evidence indicates that the “worst risks” are enrolling in rural social health insurance schemes.

To extend coverage to informal and self-employed workers—because participation in contributory health insurance is voluntary—the challenge is to find

incentives for participation and to eliminate disincentives. Enforcing a mandate for participation in contributory schemes is almost impossible. There are four (not mutually exclusive) options: (1) facilitate the participation of self-employed and informal workers through regulation, (2) improve the enforcement of mandatory participation and evasion control, (3) increase means testing for access to publicly subsidized health services, and (4) reduce the gap between contributions and benefits by delinking risk-pooling financing from labor market status, thereby shifting it away from payroll taxes, reducing the costs of participation in contributory risk pooling, and increasing the perceived benefits of participation. Where subsidized national health services and contributory health insurance coexist, informal-sector households have alternatives and tend to move between the two systems. Thus, if a country decides to make the nonpoor contribute to risk-pooling coverage, it is essential to use means testing to determine access to subsidized care.

General taxation is potentially the most efficient and equitable way to finance risk pooling—especially when employers and workers can evade payroll taxes. It depends, however, on the progressivity of tax collection mechanisms and on subsequent public spending. By delinking financing from labor market status and financing health coverage through general revenue—that is, through a broader tax base—health risks are effectively pooled across all taxpayers. This is the least regressive method and has the smallest transaction costs of all tax types (because society as a whole becomes a single pool). Moving to general taxation could also have a positive impact on the “formalization” of the labor market.

General tax financing has disadvantages, however. For providers of public health services, the payroll tax is a more dependent and secure revenue source because it is more insulated from political budget discussions and, in general, less cyclical than general taxation. Payroll tax financing creates a sense of entitlement, so governments may find it more difficult to cut health services or reduce the basic package of services offered. In developing countries, increasing the general tax allocation to the health sector to replace payroll tax financing will be difficult because their tax collection capacity and “fiscal space” are limited. It will certainly prove difficult without governance improvements in existing social insurance systems.

Policymakers have no financially sustainable options other than general tax financing and delinking coverage for nonpoor informal workers from the labor market. All other options have a high fiscal cost and perpetuate the deficit, meaning that contributions can never be enough to cover the cost of the benefits package. The only other alternatives are to reduce benefits (especially those that are perceived by workers as unlikely to be realized) or to introduce a voluntary premium to take into account the actuarial risk of the worker or household. From a purely risk-spreading perspective, this is the most efficient way of extending risk pooling to the nonpoor

in the informal sector. It allows delinking of health coverage from labor market status and makes portability of benefits easier.

### Moving toward Universal Social Security

Moving toward more universal forms of social security in developing countries would require that countries take the following steps:

- *Increase financing from general taxation.* This would decouple social security from beneficiaries' labor market status. When coverage is based on residence (or citizenship), not on labor market status, the distinction between a formal and informal worker becomes irrelevant. This option has been implemented in many OECD countries.
- *Improve the capacity for revenue collection and more effectively sanction tax avoidance.* This would expand the tax base so that the system could be financed from general taxation as much as possible. By reducing payroll taxes, this option would increase the demand for labor and would thus be potentially job creating and efficiency increasing. Of course, the transition would have to be carefully planned to provide incentives to workers to join contributory risk-pooling schemes and to incrementally foster the use of general taxation to replace these contributions over time. All these are important institutional and political challenges.
- *Create new programs and institutions to cover population groups excluded from existing social security arrangements.* The up-front costs of this approach would be lower, but it would run the risk of fragmenting the social security system, which would limit risk pooling, forgo economies of scale, be prone to pressure from interest groups to expand benefits in a fiscally irresponsible or inequitable way, face coordination problems, and hamper the portability and transferability of benefits.

Two often contradictory goals, expanding coverage and maintaining incentives for formality, have to be taken into account when designing new programs. In providing social insurance to informal workers it is important to avoid giving workers incentives to be informal. In other words, the benefits provided should hit the anti-poverty target without being more generous than formal-sector benefits. Portability of benefits across institutions is also required so that workers can move between jobs without losing coverage. A number of additional reforms would be desirable: at least for a segment of the population, increasing subsidies from general

taxation, improving “value for money” and the quality of services so that more workers would be willing to pay for social protection, reducing the costs of formality imposed by rigid labor laws (because this would reduce the cost of accessing social security), and unbundling health and pension benefits to better align the system with workers’ preferences. Recent reforms in several middle-income developing countries have often been based on some combination of the policies just listed, which are complementary.

## Note

1. *Third party* refers to any actor beyond the patient-doctor relationship (i.e., a medical insurer).

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