Chapter 8
The search for a new social policy agenda

Livelihoods in today's world are subject to a range of insecurities. These are acute in contexts where few people work with an employment contract and the associated rights to work-related benefits, and where domestic production processes are increasingly exposed to fluctuations and recessions in global markets. When earnings and incomes have plummeted and jobs have disappeared, people have little to fall back on. Not only are formal social protection mechanisms missing in many developing countries for the millions of women and men who work in the informal economy, but contingencies such as ill-health, childbirth and old age are themselves powerful drivers of impoverishment, as earnings fall and assets are depleted to purchase health care in increasingly commercialized contexts.

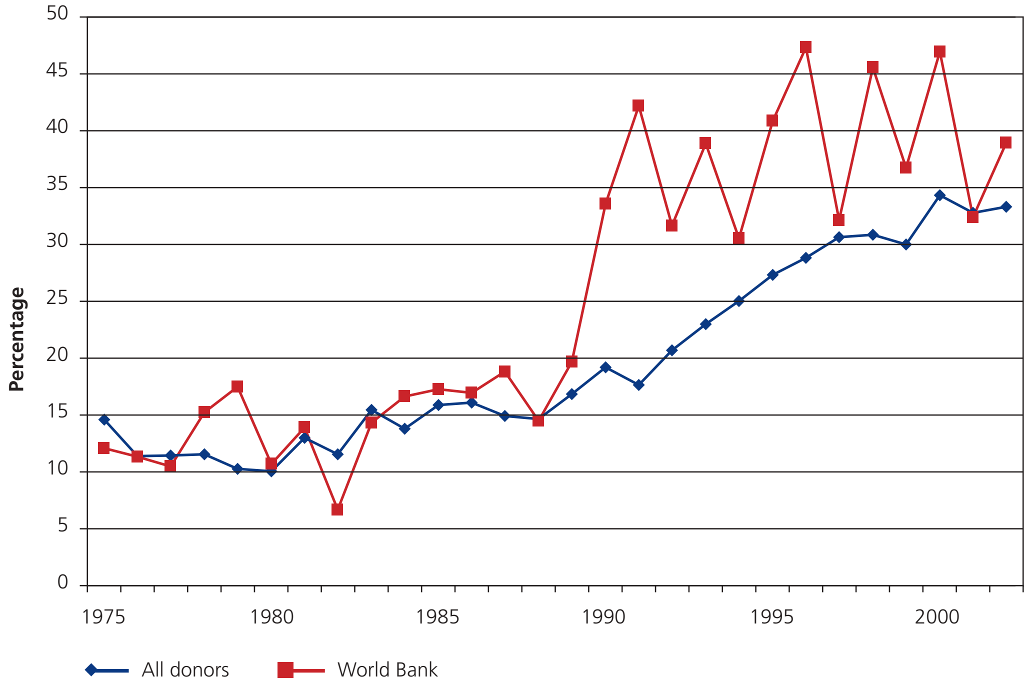
There has recently been more recognition of these realities. The 1990s saw a dramatic shift in global policy pronouncements acknowledging the vital role of social policy to the development process. That this was not just a rhetorical shift is apparent from figure 8.1, which shows that the social sectors now account for nearly one-third of all donor funding to developing countries.[1] This was a far cry from the "market fundamentalism" of the early 1980s, which focused narrowly on "getting prices right", and never mind the social consequences.

The period of austerity in the social sectors was a direct outcome of the virtually universal and standardized pattern of reform imposed as a condition of loan and adjustment packages. Social spending was drastically curtailed, and "user fees" were imposed for health, education and other social services. By the late 1980s it became increasingly evident that the poverty and social disruptions caused by stabilization and adjustment were not the "transitional phenomenon" or "frictional difficulties" the international financial institutions (IFIs) had initially assumed; they were pervasive, long-term and systemic. Studies into the impacts of adjustment and popular opposition to key adjustment-related measures combined to bring into question the orthodox policy prescriptions of the day.[2]

By 1990 the World Bank had accepted that adjustment packages paid too little attention to social privations, and that it would be wise to prevent the "depreciation of human capital" during the adjustment process. The dilemma of how to increase social support while remaining within the constraints of stabilization and fiscal propriety was resolved by attempting to "target" social expenditures to those populations most in need. Certain existing expenditures were reallocated, for example from secondary to primary education; and supplementary programmes or "safety nets" for the poor were created. The underlying thesis in social sector restructuring was residualist: social welfare institutions should come into play only when the "normal" structures of supply—the family and the market—broke down.[3] The safety nets put in place often came too late: they waited for people to "fall" rather than tried to prevent them from falling in the first place; they were too narrowly targeted and even mistargeted; and they were not commensurate with the scale and nature of poverty and deprivation in the context of adjustment.[4]

By the late 1990s, the view that the vulnerabilities experienced in many developing countries required institutionalized systems of social protection—a view informed by the history of the European welfare state—began to fall on more receptive ears. A crescendo of criticism and civil society activism helped

Figure 8.1 Share of official development assistance (ODA) to developing countries for social infrastructure and services (1975–2002)



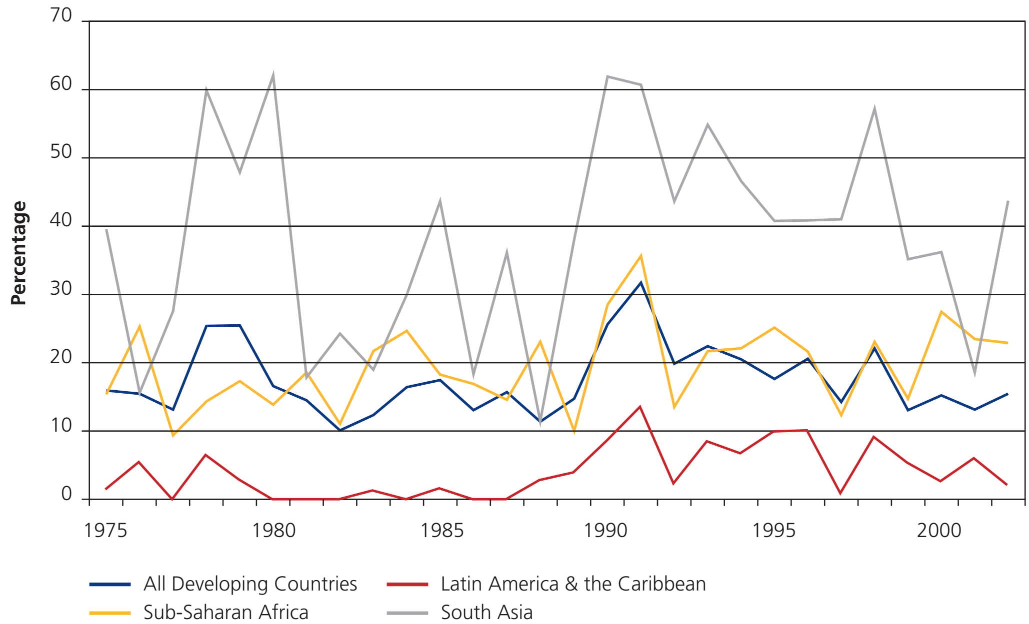
Note: Social infrastructure and services includes education, health, population programmes, water supply and sanitation, government and civil society, and other social infrastructure and services.
Source: Calculated from OECD 2004a.

restore levels of public social spending in several countries, including Chile, Sri Lanka, Tunisia and Mexico (see table 3.3). A concern for "the social" resurfaced in unlikely quarters; even the International Monetary Fund (IMF) was compelled to give explicit recognition to the importance of social policies.[5] The World Bank's mindset change was indicated by the subject of its **World Development Report 2000/2001: Attacking Poverty**; this identified "social risk management" as the most sustainable basis for poverty reduction.[6] Building on critiques of philanthropy and drawing on notions of "participation", this proposed to avoid a "culture of dependency" by helping the poor develop the capacity "to cope with, mitigate or reduce" their risks.

A shared vocabulary of "poverty", "social protection", "participation" and "citizenship" became widely applied; but the consensus it indicated was more apparent than real. Diverse interpretations of the causes of social disadvantage, and equally diverse views of the necessary social policy responses, continue to vie for attention. The World Bank carries power and prominence in the policy arena, due to its weight as a lender to social sectors in developing regions, especially in South Asia and sub-Saharan Africa (see figure 8.2), and because of its leadership of the "poverty reduction strategy paper" (PRSP) process which it began to promote in 1999. At the policy level, however, its residualist approach to social policy, based on the notion of the state as "gap-filler", is in conflict with a concept of social policy which holds that its purpose is redistributive and that the state has to be a major player. This position is advocated by many organizations, activists and academic networks.[7]

In the "social risk management" framework, the state is only expected to provide "social safety nets for risk coping" and "risk

Figure 8.2 World Bank's share of total ODA for social infrastructure and services, selected regions (1975–2002)



Note: This variable has been calculated for each region as World Bank's ODA for social infrastructure and services divided by the ODA from all donors for social infrastructure and services. These include education, health, population programmes, water supply and sanitation, government and civil society, and other social infrastructure and services.
Source: Calculated from OECD 2004a.

management instruments" to be operated where or when the private sector fails; there are strong continuities here with the earlier generation of minimal safety nets. In the **World Development Report 2004: Making Services Work for the Poor** acknowledgement is given to the need for "governments to invest in purchasing key services to protect poor households"; it is also allowed that: "making services work for poor people means making services work for everybody while ensuring poor people have access to those services".[8] But this report speaks with many different voices, and its impact on the operational guidelines for Bank lending to the social sectors is still far from clear.

In contrast, the redistributive view of social policy underlines the importance of equity and universal social provision. In the context of a developing society, it perceives the state as having a central role to play not only as the regulator of institutions and structures, but also as a significant provider. In situations of widespread poverty, where insurance mechanisms for the poor are ineffective, and there is likely to be serious underprovision by private providers, the case for public intervention by the state is very strong.[9]

The underlying assumption of much recent literature on social policy from the IFIs is that targeted public provision is the way to achieve greater social inclusion. This assumption, however, is open to question. Means testing and targeting are often the last resort of unequal societies; they can trap people in poverty and they can enhance inequality, rather than deal with inequality through redistribution; they are also very demanding in terms of state administrative capacity. At the same time more inclusive systems—where access is a publicly debated issue, where cross-subsidy occurs, and different social classes come across each other in the same institutions—are likely to be associated with more progressive behaviour by the state.[10]

European experience suggests that countries with the lowest poverty rates have income transfer systems that include universalistic basic flat-rate benefits financed from general tax revenue, public earnings-related benefits financed by employer and employee contributions, as well as social assistance supplements for those still in need. Universalistic basic pension benefits and child allowances are particularly effective in keeping vulnerable groups—the elderly, families with many children, and single mothers—out of poverty. The second major pillar of a comprehensive approach to improving the life chances of the majority of the population is the provision of good quality and universally accessible education and health care.

The fundamental principle behind social policy is that vulnerabilities and risks require collective responses. This is because many people, especially people with low incomes, cannot afford the services provided by the modern private sector, whether these are health or education services, or insurance premiums of various kinds. Attempts to create long-term formal and informal savings (by low-income people themselves and by external agencies) often founder because of the pressing needs of the present. Efforts to co-insure among poor people only, without the wider pooling of risk which comes from including the better-off, are bound to fail, as the core social insurance principle (contribution in relation to income, and benefit in relation to need) is absent. This is why social policies that are founded on principles of universalism and solidarity (risk-sharing)—with strong cross-subsidies from the better-off—tend to be more sustainable, both financially and politically.[11]

This debate about key principles forms a backdrop to considerations of gender in the context of social policy. For reasons which seem inexplicable, the gender premises and implications of the social policy reform agenda have largely been ignored.

GENDER: THE "SILENT TERM"

Both the process of social policy reform and its outcomes are inescapably gendered. And both tend to operate to the detriment of women, especially to women in the least well-off sections of society. Yet mainstream debates on social policy have failed to engage with these concerns; gender has indeed been the "silent term".[12] This omission has characterized both sides of the debate, including those aligned with the residualist and targeted policy perspective espoused by the World Bank, and those associated with the redistributive and universalist school of thought.

What, then, would a gender perspective add to current social policy debates? The first point to underline is that, while social sector reforms have on the whole been detrimental to women, it would be a mistake to assume that women were social policy beneficiaries, as citizens with social rights, prior to the neoliberal policy turn. Indeed, seen from a gender perspective, the 1960s and 1970s were not a "Golden Age". The fact that the formal economy remained small in most developing countries meant that job security and work-related benefits were privileges available to only a small stratum of workers in most countries, most of whom were male.

In Latin America, male-dominated trade unions were the principal beneficiaries of corporatist social contracts through which wages, working conditions and social security were negotiated.[13] While women may have benefited as wives or daughters of "male breadwinners", a pension in old age or entitlement to maternity leave remained distant dreams to the majority. The little security that there was came from paid work where it could be found, from marriage, kin and community, from the church and also through the "protection and patronage" of informal employers.[14] In sub-Saharan Africa, women's small informal groups for credit and mutual help were also popular, especially among market women and traders. But the effectiveness of many of these systems in providing social protection is often limited by their low capital base.

However, while the early effort at formal social protection in many developing countries could have been reformed, extended and built upon in order to cover a much wider range of people, there has in fact been a reversal over the past two decades; in many regions there has been a strong thrust towards the commodification of social services and social protection. Hence, the "male breadwinner model" is being eroded not by gender-equitable reform of state-based entitlements, but by their drastic reduction. These have been replaced by market-based, individualized entitlements for those who can afford them: private pensions, private health insurance, private hospitals, private schools, private retirement homes, private paid care for children and old people.[15]

The impacts of commodification are likely to be felt most strongly by women. The factors explaining why the pressures have gender-differentiated impacts include the following:

- Gender bias in intrahousehold resource allocation: Social norms in many parts of the world, especially South and East Asia, favour boys and men over girls and women in allocation of resources within the household. Where low-income families have to pay for access to services such as emergency health care, the needs of boys and men are likely to be given a higher priority than those of women and girls.
- Gender stratification in markets: Women tend to be more cash-constrained than men, given their disadvantages in labour and credit markets; this is likely to restrict their ability to access market-based services and social protection for themselves and their children. Where women have been traditionally responsible for a significant part of their own and their children's health and education expenses, as is the case in many parts of Africa, their problems are more acute. Where women work, they are also likely to accumulate fewer employment-related social benefits than men, given that they typically work for fewer years, earn less, and are more likely to be informally employed.
- Gender ordering of the unpaid care economy: When formal service provision remains out of reach, informal carers—mothers, sisters, grandmothers, daughters—have to provide unpaid care. Social sector reforms often make unjustified assumptions about the availability of women's and girls' "free" time for caring work.
- Gender stratification in the public social care sector: The working pressures generated during reform, including loss of wages in public sector services, are likely to fall most heavily on women workers, given that they are predominantly located at the lowest rungs of skill, authority and remuneration.

These issues are elaborated in the sections that follow.

GENDER ORDERING/ STRATIFICATION AND INSTITUTIONAL CHANGE

Given the limitations of space, the chapter has selectively chosen to focus on health sector reforms (relevant to many low-income developing countries); pension reforms (more relevant to middle-income countries); reforms and innovations in social protection schemes to include informal workers (both low and middle-income countries); and anti-poverty programmes targeted on low-income women. The education sector is omitted, since an extensive literature and ongoing analysis already exists.[16]

The following analysis of the systemic changes in the social sectors demonstrates how institutional reforms are affecting men and women differently. One of the main contributions of the "welfare regime" literature was to move away from a simple measure of public expenditure and to look at the institutional content of welfare states, in terms of such issues as conditions of eligibility, coverage, and the nature of benefits.[17] The importance of institutions in mediating the link between public expenditure and welfare outcomes is now widely acknowledged. As the **World Development Report (WDR) 2004** stresses, there is no simple relationship between public spending on health and education and outcomes; it is the institutions—seen in the WDR mainly in terms of accountability of service providers to poor clients—that matter. Here, some of the institutional changes that current social sector reforms have brought about are assessed through a gender lens—a perspective with which neither **WDR 2004** nor the first generation of "welfare regime" theorists have seriously engaged. The chapter does not provide a gender-disaggregated analysis of public (and donor) expenditure on the social sectors.

Health sector reforms and gender[18]

Health has been a key area of social sector reform. From a gender perspective, health is especially important, not only because men and women need different types of health support to sustain well-being, reproductive care for women being the most obvious example, but because institutionally health systems are gendered structures, reflecting gender inequalities in the wider society. Hierarchies in the health service usually find men in the senior positions as doctors, policy makers and administrators; while women predominate in lower-status professions and jobs, such as nurses, paramedical staff and orderlies.

The services offered to women often fail to recognize social and cultural norms which deny women decision-making capacity over health-related behaviours, for example, over sexual relations and the use of contraception for child spacing. Meanwhile, where services and personnel are sensitive to women's needs, especially those of the seriously disadvantaged, this can help redress some of the discriminations and difficulties they face. This may be reinforced by the fact that most day-to-day working relations between health care staff and clients tend to be relations among women; they usually take place in the context of mother and child health (MCH) concerns. The woman-to-woman confidence that can build up during routine interactions provides opportunities for promoting health-related behavioural change.

Donors have been heavily involved in the design of health sector reforms in many economic-crisis countries. The standard package is essentially based on the liberalization of clinical care and drugs provision, emphasizing commodification and the use of market mechanisms; the reduction of government; decentralization of delivery systems; and greater attention to cost-effectiveness in government spending. The model usually includes some or all of the following features:

- Retreat of government towards a mainly regulatory and priority-setting role, with responsibility for direct provision of services in public health and for ensuring access to primary care for the poorest.
- Liberalization of private clinical provision and pharmaceutical sales, and the promotion of a "mix" of public, private and voluntary providers.
- Increased contracting-out of government-funded services to independent groups and companies.
- An increase in the autonomy of hospital management and finance; some hospital privatization.
- A shift from tax-based financing mechanisms towards insurance, including mutual insurance schemes.
- The decentralization of health delivery systems to local government control.
- User charges for government-run health services, for government-provided drugs and supplies, and for community-based health services.

This section addresses the impacts of health service reforms on women's access to, and utilization of, health services as users of health care services (for themselves and their dependents); on women's work conditions as health sector workers; and on women as providers of unpaid care, especially when formal mechanisms fail to meet the need for care.

Health care charges: The impact on users

In many countries, reforms to the health sector have been implemented in a context of generalized and severe poverty, and often in the wake of an economic crisis marked by worsening diets and increasing workloads.[19] The period of reform has also coincided with the spread of HIV/AIDS and the severe physical, economic and social strains the epidemic has imposed on families, especially in Africa. Thus needs and demands have grown at the same time that free or affordable health care has become more difficult to access. User fees, first introduced into hospitals in the early 1980s, have since been extended to lower-level government health facilities such as health centres and subcentres providing basic care and emergency treatment. A number of studies have confirmed that user fees and ineffective exemption systems lead to the exclusion of those unable to pay. While few studies have looked specifically at gender-differentiated impacts, studies of reproductive health trends in Zimbabwe, Tanzania and Nigeria show that the introduction of user fees in MCH facilities has been associated with a decline in admissions of pregnant women, and increased morbidity rates during or after birth in both mothers and the newborn.[20]

In India, the 1990s saw a substantial increase in private health provision at the cost of public health care.[21] Growing privatization of services seems to have excluded or marginalized rural people, particularly women in the 15–29 age group as well as tribal populations. This reflects the relative lack of value attached to girls and women compared with boys and men: while both are affected by the lack of affordable services, scarce family resources may be stretched to take boys for treatment while the illness of girls is regarded as less significant and correspondingly neglected. Cases of untreated illnesses were common among the poor, and more common among women and girls.[22] Meanwhile, it is also true that widespread improvement in reproductive health facilities over time has had an important positive effect on maternal and child mortality and morbidity rates.

Where fees are charged for any kind of professional health care, women suffer disproportionately given their and their small children's MCH needs, and their reduced access to cash and income-earning opportunities. Where it is customary for women to be held responsible for the bulk of expenditures on their children such as food, medical treatment, clothing and school expenditures, which is the case in much of sub-Saharan Africa, the burden on women of fees and charges is particularly onerous. Many forms of mutual support for health care exist in poor communities: for example, payment of birth attendants in kind, free care for indigent mothers, sharing domestic work to allow others to work for cash, and mutual loans and gifts. African societies in particular abound in mutual savings schemes run for and by women. However, there is also evidence that falling incomes and economic crisis undermine women's participation in these networks of mutual financial support.[23]

The growth of health insurance

In the face of strong popular opposition to user fees, health financing reforms have recently begun to focus on schemes of health insurance. In the context of social health insurance for those in formal employment, the key gender question is that of equity. Since a small proportion of the population enjoy formal employment, and since these employees are among the most skilled and educated in the society, such schemes mainly cover more advantaged, male-breadwinner members of the workforce. Although these schemes usually cover dependants, still the number of women that can be reached is small.

Given their limited reach, an alternative mechanism of health care financing which aims to promote the inclusion of poor and vulnerable groups is mutual health insurance (MHI). These schemes have mushroomed in recent years, and in sub-Saharan Africa have taken the form of community-based schemes of voluntary prepayment. Premiums can be paid in instalments; local committees can decide to exempt members unable to pay; and accommodation can be made for those with unsteady or seasonal incomes, by postponement to harvest-time or some agreed date.

Although this is a promising development, these schemes show the same drawbacks as other types of community saving and loan programmes. Rapid start-up may be followed by dwindling membership, unaffordable contributions and payment collection problems.[24] It appears that building on existing co-operative savings and loan schemes has better success, since existing patterns of solidarity exist and can absorb some of the administrative costs. This is the case with the Integrated Insurance Scheme run by SEWA in Gujarat, India (discussed below). However, donors are more inclined to support new stand-alone schemes.

Health sector reforms and women health workers

Research on the privatization of health services and the impacts on the medical workforce appears to ignore gender, at least explicitly. However, since in most countries this workforce is predominantly female and women predominate in lower-status occupations, the downward pressure on wages is likely to have hit women workers particularly hard. While at the upper end, the private clinics frequently appear to provide nurses with better working conditions than the public sector, the same does not apply at the lower echelons, where private employers try to keep down costs by reducing wages and abandoning training. Those who employ trained staff on decent wages find themselves undercut by those who do not.[25] As a result, the poorest women users pay fees they cannot afford to low-paid and low-skilled women medical personnel: a vicious circle of gender disadvantage.

Liberalization, privatization and commodification have contributed to the crisis in health care, and to the strains and demoralization experienced by nurses working in public facilities. There are accusations of abusive behaviour, especially towards

Box 8.1 Women health workers on the ward: A snapshot from Tanzania

This kind of thing [bad behaviour] happens, and it is because of poor morale, low commitment, severe overwork and low salaries. Imagine, you are a nurse on duty for 12 hours. You start at 6 am, you may get away at 7.30 pm. You may have a ward of 40 or 60 seriously ill patients. In gynaecology, you are likely to have several emergencies, some operations, postoperative patients, very sick patients. You are two trained people at best. How will you divide yourself? You are constantly overworking and under pressure. You are worried about family problems and commitments. For 12 hours you do not know what is happening to your children. And you may not have as much as a cup of tea. Then there is the problem of the commitments of other staff. You are a nurse by profession. The doctor, who is supposed to be responsible, works his official hours and goes away, he waits to be called. You are there, someone is bleeding, she needs to be operated, and you cannot help. There are no facilities. People are suffering, and the other staff are not on duty. The means to save this lady are not available. If someone is supposed to be on duty and is not there, what can you do as a nurse? There are no infusions, no emergency drugs. Relatives rush to send the sick person to hospital, then we are not in a position to save the patient.

Source: Mackintosh and Tibandebage 2004b (fieldwork notes, 1998).

low-income, low-status patients and individuals regarded as socially reprehensible.[26] There are also problems which nurses have to confront on a daily basis. Some of these are explained in box 8.1 by a matron in a maternity hospital in Tanzania.

Health sector liberalization appears to have widened the gap in wages and working conditions between doctors and nurses. Many doctors benefit from additional private practice, and the “going rate” for informal payments to doctors tends to be substantially higher than for nurses. Moreover, nurses have more contact with patients than doctors (one of the main points in box 8.1), and when the service falls apart they take most of the strain. This helps to account for the departure of many nurses abroad, with “pull” factors in the North converging with “push” factors in the South (see chapter 7). Typically, the bulk of incentives aimed at retaining health care staff in the home country are focused on doctors. Given that nurses and ancillary workers provide the backbone of health services virtually everywhere, rising out-migration has serious effects which ripple out to the health centres and clinics providing the primary provision on which many low-income women depend.[27]

Health sector reform in both high and low-income contexts has been presented by its promoters as a force for change, away from services run in the interests of staff, to services run in response to patient demand. But this can lead to losses in decent working conditions and wages, as recent International Labour Organization (ILO) research in Eastern Europe has demonstrated.[28] A different way of framing these issues is suggested by an approach which owes much to gendered considerations. The Health Workers for Change (HWFC) projects in Africa and elsewhere have built efforts to improve health care quality on the observation that the interpersonal aspects—such as respect and ability to listen to a patient—are important to care quality, and that these relational aspects are gendered. Female health workers have a different working style than men; women patients also have special needs, and in certain circumstances—sexually transmitted disease, for example—are fearful of discrimination and abuse. The HWFC projects have therefore built up collaboration between staff and patients, and sought to shift behaviour in gender-sensitive directions.

Unpaid care and the crisis of care

In most countries, women continue to assume a disproportionate share of unpaid work and caregiving. It has been estimated that activity worth US$16 trillion takes place every year without being recorded as part of the global economy, and that of this, 69 per cent (US$11 trillion) is the unnoticed contribution of women in households and the informal sector.[29] As women struggle to bear the increasing burden of both paid work and unpaid care in a relentless economic climate and, in rural areas, from a dwindling environmental resource base, their physical condition may suffer. Since the paid work they engage in is usually a survival strategy rather than an act of liberated choice, the irony of their entry into the workplace is that they may earn too little even to offset their extra physical needs. Meanwhile, health sector reforms propose a degree of devolution of health care activity onto the community.[30] This strategy fails to recognize that this means imposing a further burden, unpaid, onto volunteers who will invariably be women. Women, therefore, are being involuntarily landed with the social fall-out from service depletion brought about by reforms, as well as invisibly shouldering an extra economic burden.

The epidemics of HIV/AIDS which have overtaken many African countries have brought an existing crisis of health care into sharp relief. In 2001, of the estimated 40 million people in the world with HIV, 28 million or 70 per cent were in Africa. Africa also accounted for 90 per cent of the 58,000 children under the age of 15 who had died of AIDS. The vast nursing care burden represented by these figures has overwhelmingly fallen on women and girls. Since the economically active age group (15–49 years) suffers the highest levels of infection, much of the load has to be borne by the elderly. This includes care of and economic support for orphaned grandchildren, of which AIDS has produced over 12 million in Africa. In places where resources for health and welfare services are already extremely scarce, home-based care and "community care" are the fall-back policy response. Essentially, formal care-service structures have devolved responsibilities onto informal structures with the sanction of the neoliberal policy agenda, an echo from the earlier analysis of what has happened in the workplace (see chapter 5). Thus policy decisions about service delivery and drug regimens in the face of HIV have particular implications for women. The notion of "community care" appears gender-neutral; but within communities, the time, work and responsibilities of this care invariably default to women.[31]

Thus it appears that health sector reform has been built on a number of hidden or inexplicit gendered assumptions. These include assumptions that women's access to household resources or their external networks of mutual support are robust enough to find the money for fees; that women's work burdens can be expanded to include more responsibility for care; and that the needs of health-care staff (especially lower-level staff) and those seeking care are inherently contradictory. Further dubious assumptions include the notion that the governance structures established for decentralized health system management will inevitably reflect women's needs better than previously centralized systems. Another key issue is financing: whether the decentralization of responsibilities is accompanied by an adequate redistribution of resources from the central government; where decentralization is mostly a means for the central government to reduce expenditure, the outcome is likely to be growing disparity in the quality of the services between poorer and more affluent local communities. It is certainly not clear from the available evidence that any of these assumptions were warranted, even before the devastating impact of HIV/AIDS.

The gender implications of pension reform

Reform of public pension programmes has taken place in a large number of countries around the world over the last decade. In many developing and transition countries, pension schemes had been facing serious problems even before the economic crises of the 1980s and 1990s. In Latin America, for example, the maturing of pension systems had already led to a deterioration in the ratio of those contributing to those drawing pensions by the end of the 1970s. Both employers and employees, especially the self-employed, did not pay their contributions; pension schemes were also being drained by the heavy costs of privileged pensioners, for example, those in the military, and the high administrative charges paid to unaccountable bureaucrats running the schemes. These problems were aggravated when economic crisis struck. The shrinking of formal-sector employment produced a sudden decline in the number of contributors. At the same time high inflation meant that real wages declined and so did the real value of contributions. All of these factors created a perception of crisis in pension systems.[32] Thus their reform became an integral part of structural adjustment programmes, with significant input from the IFIs.

While there was a general consensus that existing systems were bankrupt and required urgent reform, there was no corresponding consensus on a desirable replacement model. In many countries IFIs and domestic reformers argued that privatization was the way forward. Their grounds included that privatization would ensure greater financial viability, closer links between contributions and benefits, reduced administrative costs and the promotion of capital markets. Significantly, issues of equity and redistribution—across generations, across class and across gender—were excluded from the debating positions of advocates of privatization.

A recent comparative analysis of pension reforms in eight Latin American countries shows that the neoliberal reformers were not strong enough to impose their preferred model in all countries.[33] Rather, the nature of reforms was shaped by the balance of power between the neoliberal reform coalition on the one hand, and its opponents—unions, pensioners and opposition parties—on the other. The full privatization model took hold in only two of the eight countries, namely Chile (regarded as the prototype) and Mexico; in four others—Peru, Argentina, Colombia and Uruguay—it was watered down, and in Costa Rica and Brazil it was strongly resisted. Pension reforms in three Central and Eastern European countries had a parallel experience.[34] Only one—the Czech Republic—was able to resist the pressure from IFIs for privatization, while the other two—Poland and Hungary—have chosen partial privatization and become front-runners of radical pension reform in the region.

In none of the debates surrounding the adoption of reforms in either region do concerns with gender equity appear to have surfaced. Yet the move towards privatization has major gender implications. The fact that pension benefits in privatized systems are strictly determined by the overall amount of money contributed by the insured person, and that women typically earn less money and work for fewer years than men, means that women receive considerably lower benefits. Since women's higher life expectancy is taken into account in most private systems, women's benefits are further comparatively depressed.

In public systems with defined benefits, there are generally similar gender discrepancies. But women's disadvantages are usually mitigated by generous minimum pensions, by the fact that life expectancy does not affect benefit levels, and by credits given for years spent caring for children. The last feature was particularly strong in the ex-socialist countries, where the "caring credits" were financed by cross-subsidy within the pension system. In both Poland and Hungary the rules with respect to "caring credits" have changed, with the result that those taking leave receive lower pensions than if they had stayed in employment. This is a retrograde step: credits given for caring are not charitable gestures but an acknowledgement that social and economic "contributions" can take different forms over a person's lifecycle.

The implications of these reforms are not the same for all women. The shift towards privatization and individualization works in favour of those women who are active in the labour market, earn high incomes, and do not take "leave" for care-related reasons. But for the majority of women who have a weaker labour-market position or intermittent careers because of care duties towards children or elderly relatives, the reforms mark a serious regression.

A larger point here concerning the values underpinning social policy, or in this case pension policy, is that redistribution and solidarity do not have much place in private fully funded pension schemes. Nor is the failure of the private system to provide equity and inclusion being compensated for by increased efficiency. In fact there is considerable evidence to show that the private system is less efficient than the public system it has replaced. While claims were made that pension privatization would reduce wasteful administrative costs, this has not in fact happened. Instead, the pressures of competition require large numbers of sales personnel working on commission and large advertising budgets, which appear responsible for driving administrative costs upward.[35]

While the move towards privatization of pensions has been strong in recent years, it is important to emphasize the diversity of ways in which countries provide old age security. South Africa's system of state social assistance to elderly people, which is discussed below, is one example of a non-contributory pension plan. In Brazil, the expansion of social insurance to workers in informal and rural employment has resulted in a large increase in coverage. These schemes demonstrate innovation in pension provision models in the developing world.[36]

Innovations in social protection for informal workers

Formal insurance schemes are beyond the reach of people working in the informal economy. Barriers to entry include high premiums, having to present a pay slip, and inflexible procedures such as being required to contribute exactly the same amount monthly year-round. There are, however, a variety of ways of building systems of social protection for informal workers. The ILO is making concerted efforts to extend existing social security benefits to new categories of workers. In the field of micro-insurance, the emphasis is on building grassroots schemes. There has been a great deal of experimentation with social insurance in general, and health insurance in particular. Many of these have attempted to reach women, and especially poorer women.

The following examples illustrate that it is possible to build schemes that reach many informal workers. While in practice there is great variability in the extent to which social protection schemes actually redistribute across generations, social classes and genders, the very idea underlying these schemes is that the state has a responsibility to provide social protection, and that this should facilitate at least some degree of redistribution. By extending the coverage of existing social protection programmes to new groups of informal workers, and by facilitating cross-subsidies, some valuable efforts are being made to increase the inclusion of existing social protection mechanisms. It is not surprising that more inclusive social systems are being forged in contexts where there has been a great deal of social struggle and soul-searching about social responsibility (Chile, Brazil, South Africa), and where there is an ideological commitment to social equity (Costa Rica).

SEWA's Integrated Social Insurance for women informal workers [37]

The Integrated Insurance Scheme (IIS) has been successfully built over 20 years by the Self-Employed Women's Association (SEWA) in Gujarat, India. A subsidy is provided by the Indian government to two large insurance corporations to offer some of their services to disadvantaged groups, including those belonging to SEWA. SEWA has thus managed to build partnerships with government and the insurance industry on favourable terms, and has also been inspiring in its ability to continuously respond to members' needs. Today, IIS provides a comprehensive package of social insurance benefits to over 100,000 informal women workers.

SEWA attributes some of the success of IIS to the interaction between its different programmes: the SEWA Bank, into which annual premiums are paid; health education, which heightens members' awareness of health problems; and literacy training. SEWA does receive donor support to cover the scheme's administrative expenses, but SEWA's solidarity and unity also make a critical difference, with a large part of the administrative work being done by the members themselves.

Challenges include the fact that, although the scheme is oriented to poor women, some of SEWA's poorest members cannot afford the premiums, which have to be set at a rate that ensures viability over time. There is also concern that the health facilities to which the health insurance gives access are far from adequate.

Health benefits for women temporeras in Chile [38]

As already noted in chapter 6, there has been a striking growth in the export of horticultural products from Latin America in recent years, with increased employment of seasonal women workers or *temporeras*. In Chile, social protection benefits originally restricted to full-time workers have recently been extended to include them.

The majority of both men and women *temporeras* work at below the legal minimum wage; a few women earn high wages for a short period of the year, but the average earnings of women are lower than men's, with significantly more women in the lowest-earning group. Chilean workers can choose private or public health insurance, but affiliation requires them to pay contributions year-round. Temporary workers were not motivated to affiliate to either type of scheme, given this requirement. As a result, *temporeras* were only able to obtain care by applying to the health services as "indigents".

Over time, pressure from the *Servicio Nacional de la Mujer* (SERNAM) in Chile has led to a number of changes in the

Box 8.2 Extending coverage to domestic workers

Countries differ as to whether domestic work is classified as formal or informal work. In many, domestic workers are classified as "self-employed" despite the reality of an employment relationship. The vast majority of domestic workers are women, often still in their teens or younger, and living away from home; working conditions are characterized by long hours, low pay and lack of autonomy.

The relationship between employer and domestic worker is a complex mix of mutual dependence and matriarchal authority. Although the domestic worker has little say over her life, there may be voluntary measures of assistance such as with health costs, school fees or training if she is young, or the school fees of her children. These are not contractual obligations and depend on the whim of the employer. There is no long-term security.

Since they are dispersed in people's homes, domestic workers are very hard to reach or organize, and it is difficult to provide them with social protection. However, in certain countries, especially in Latin America, both informal and formal organizations have taken up their cause. In 2002, South African domestic workers (and seasonal agricultural workers) came under the scope of the Unemployment Insurance Fund. Their enjoyment of this insurance depends both on workers asserting their rights and making sure employers do not evade payments to the fund.

Source: Lund 2004.

working terms and conditions for women *temporeras*. These include the provision of childcare facilities for horticultural and other agricultural workers, and the establishment of four national commissions, on Health and Safety at Work, Childcare, Pesticides and Training, to deal at the policy level with conditions of temporary workers. In 2000 the regulations on health insurance were amended. The required contributory period for year-round coverage was reduced first to three months, and then to 60 days, to enable *temporeras* to participate.

Other examples where labour protection mechanisms have been extended to non-standard and informal workers include provisions for domestic workers, an extremely vulnerable and hard-to-reach group (see box 8.2).

Innovative health and pension provision for informal workers in Costa Rica [39]

An unusual example of a scheme initiated by government to bring informal workers who do not qualify for formal social security provision under the social security umbrella comes from Costa Rica. Unlike the statutory scheme for temporary workers in Chile, this is at present a voluntary scheme, covering access to health care and to a pension savings scheme.

Costa Rica has a long history of extensive social security coverage for its relatively small and homogeneous population, but demographic and labour market changes are presenting new challenges to social protection. These changes include a rapid growth of women's involvement in paid work and employment, mostly in the services sector and on poor terms relative to men. The expansion of the informal economy, which includes strong participation by women, has led to lack of social insurance coverage for an increasing proportion of the Costa Rican workforce. In the mid-1990s, the privatization of pensions was strongly resisted by civil society groups coming together under the auspices of the Forum of National Concertation. The outcome was a Law of Protection of Workers, which included a voluntary insurance scheme.

This scheme is open to independent workers, those who are self-employed, and those who receive no salary or wage, such as family workers, housewives and students. It is aimed at those who have never contributed to a health or pension plan, or who have done so only for too short a period to gain adequate benefits. All those from families with a per capita income lower than the basic basket of food products determined by the Statistics Institute are entitled to join. The state contributes

0.25 per cent of the reference income, while the independent worker contributes 7.25 per cent; the individual's contribution can vary downwards to 4.75 per cent.

At present the scheme is voluntary, but by 2005 it will become statutory and all independent workers will be required to enlist. This is intended to increase the numbers of those in contributory schemes: at present a remarkable 74 per cent of independent workers already contribute to the health insurance scheme, while only 24 per cent contribute to the pension insurance. This is partly because poor Costa Ricans are able to enjoy a non-contributory pension. A country with a good history of social provision is thus attempting to adjust to changes in the labour market in flexible ways, including establishing links between contributory and non-contributory schemes.

South African old age pensions [40]

This scheme evolved from a safety net pension for poor whites, later extended to coloured people in 1928 and Africans in 1944. The African population, however, faced more stringent means tests and received much lower pension benefits than whites during the apartheid era. The end of apartheid led to full parity in entitlements and to a rapid rise in take-up rates among Africans. Women at age 60 and men at age 65 become eligible to receive a monthly old age pension (OAP) from the state, if they qualify through an income-based means test.

These pensions have become recognized as making a distinct contribution to poverty alleviation, both for pensioners themselves, and for people in their households. A large proportion of older people in South Africa, especially in low-income rural areas, live in three-generational extended families. The pension is the individual entitlement of the pensioner, but there is extensive income pooling and a large part of it enters the common household purse. Thus ageing women workers in the informal economy, and other disadvantaged elderly women including retired domestics and widows, have a guarantee of partial economic security in their late years. This protects them in their own right against the vulnerabilities associated with old age, and gives them an earned place in the household. At present, the system reaches 80 per cent of the African elderly population and an insignificant number of whites.

Although the scheme is non-contributory and paid from general revenue, the OAP is judged to be sustainable and affordable. In fiscal terms, the government allocates an annual increase, which in the last few years has been an increase in real terms. Demographically, the numbers of ageing people constitute a small fraction of the population. The HIV/AIDS epidemic has reduced longevity, and proportionally fewer people are likely to reach eligible age. However, among those who already have done so, many are already taking on the responsibility for looking after and supporting children whose parents have died of AIDS. Thus the OAP has become for many a vital contribution to household security.

Learning from innovatory schemes

SEWA's IIS provides convincing evidence that social insurance for informal workers can be successful and sustainable. However, such robust examples are hard to find. A rare example from Africa is Umoja wa Matibabu katika Sekta Isiyo Rasmi Dar es Salaam (UMASIDA), an insurance scheme specifically for informal workers, men and women street vendors in Dar es Salaam, Tanzania. UMASIDA was initiated in 1995 following an ILO intervention, and rapidly grew to some 1,500 workers and 4,500 of their family members. It gave access to primary health care services at selected private facilities, and care for referrals at government hospitals. While UMASIDA is encountering some financial difficulties with the affordability of fees, it has been more successful in sustaining its membership than many other mutual health schemes.[41]

One of the secrets of success, notably with SEWA's IIS, is responsiveness to members' needs. Flexibility is also a hallmark of the Chilean and Costa Rican governmental approaches. In Chile, access to health insurance was extended to a formerly uncovered group of workers, the waged seasonal workers. Costa Rica built a voluntary insurance scheme for health and for old age pension for independent and unremunerated workers. However, both these schemes have been introduced relatively recently, and it is too early to assess their performance.

The extension of social protection to informal and dispersed workers necessarily involves additional administrative costs. Both Chile and Costa Rica grafted their innovations onto an existing administrative system for delivering social security, and both countries have relatively small populations. SEWA draws on the solidarity and unity that it has nurtured over many years, with a large part of the administrative costs being borne by the members themselves. None of the case studies looked at how employer contributions might be secured. In the absence of favourable organizational circumstances, financial sustainability may require a long-term subsidy.

The Costa Rican case shows that informal workers find it easier to insure against ill-health than to save for old age. SEWA also finds that its health insurance tends to attract older members who are more likely to experience illness than the average member—a common problem of insurance schemes. Another SEWA lesson is that the quality of the health care which will become accessible has to be considered when inviting people to join a scheme.

The examples of these innovatory approaches also show that the role of the state in being able to deliver to large numbers of people through existing and new institutions is likely to be critical. This is clear from the South African OAP, and the Chilean and Costa Rican schemes. So we need to revise the call for the state to "get back in", acknowledge how it is "already in", and look at ways of making these interventions even more effective. Finally, the provision of some kind of basic income—whether in the form of universal, or near-universal, flat-rate pension, or child allowance—can avoid stigma while reducing the opportunities for bureaucratic discretion. It can also have the additional advantage of being relatively simple and cheap to administer.

ANTI-POVERTY PROGRAMMES: "TARGETING" WOMEN BUT GENDER-BLIND?

Over recent decades, several governments and non-government organizations have implemented anti-poverty programmes specifically aimed at poor women. Micro-credit programmes are the best-known. But less international attention has been given to a genre of poverty relief programmes directed specifically at poor women in their capacities as community members, mothers and carers. In Latin America, for example, the severe social crisis associated with structural adjustment propelled many low-income women into diverse community projects aimed at meeting the day-to-day needs of poor urban and rural families. These projects had their roots in a much longer history of community welfare associated with Christian philanthropy.[42] The success of some of these programmes during the 1980s attracted both donor and government attention and funding.

In the recent past and in the present, efforts have been made to incorporate the new emphasis on "participation" and "empowerment" currently fashionable in national and international policy circles into some of these programmes. Whether these features of democratization are merely rhetorical add-ons, or whether they have been successfully institutionalized, and with what implications for gender equality, are questions worth exploring in relation to many such schemes. However, only one appropriate state programme is examined briefly here: the *Oportunidades* programme, or *Progresa/Oportunidades* as it is often referred to, introduced in 1997, reorganized and extended since under the administration of President Vincente Fox which came to power in Mexico in 2000.

Progresa/Oportunidades is the most extensive programme of its kind in Latin America. It provides cash transfers and food handouts to approximately five million poor rural households, but on the condition that they send their children to school and visit local health centres on a regular basis. This targeted programme therefore attempts to combine short-term and long-term poverty reduction objectives, along the lines of the "social risk management" approach advocated by the World Bank. The emphasis is on "co-responsibility": in return for the entitlements provided by the programme, certain obligations are assumed by the participants. These are mothers from poor families who are expected to ensure the obligations of school attendance and health care usage.

The programme has been welcomed by some as positive in making the cash transfers directly to women, because they can be more trusted than can men to use them for family welfare purposes. But despite this effort to "empower" women, evaluations of the programme have identified various other gender problems.[43] These arise in addition to well-known problems associated with targeting: exclusion of some families who should be in the target group, stigmatization of those identified for assistance, and the creation of community divisions. In addition, there are concerns that the programme has intensified the women participants' unpaid workloads and has done little to strengthen their labour market skills. Because "they were paid by the government", the women were expected to perform community work such as cleaning schools and health centres, unlike those not in the scheme.[44]

Despite the focus on women, little effort has been made to bring in a gender equality angle into the programme, for example by involving fathers in some of the unpaid volunteer work, or in taking children to school and to local health clinics. Hence the programme is based on, and reinforces, traditional gender divisions by making its transfers conditional on "good motherhood"—a policy stance reminiscent of the 1920s and indicative of considerable continuity in social policy.[45] Women's active involvement in the design and management of the programme has not been sought, nor have opportunities been provided for collective action by members—organizational initiatives which would have substantiated a claim of fostering women's real "empowerment".

There are lessons to be learned from the *Progresa/Oportunidades* experience. While government poverty relief programmes increasingly recognize the contributions that women can make to development, the benefits of such recognition to women themselves remain elusive. Despite the lip-service paid to gender equality, little attention is paid in donor evaluations to the way in which the interests of children may be pushed at the expense of their mothers. WDR 2004, for example, holds up *Progresa/Oportunidades* as an exemplary anti-poverty programme.[46] For all *Progresa/Oportunidades* has achieved by way of improvements in child nutrition and primary school attendance (especially of girls),—social objectives that are undoubtedly highly valued by many of the women involved in this programme—it has also had its blind spots and biases. There is not even a passing reference in the WDR to the way in which the programme has built upon, endorsed and entrenched a highly non-egalitarian model of the family, where women effectively become a "conduit of policy"[47]—ensuring that resources channelled through them translate into greater improvements in the well-being of children and the family.

Not only are such programmes subsidized by women's unpaid work, but there is little recognition that many women in low-income communities are of necessity often working for cash, in jobs or self-employment. Programmes such as *Progresa/Oportunidades* miss the opportunity of being transformative by responding to the expressed needs of many low-income women for affordable and reliable childcare facilities and job training to advance their autonomy and income security. In the absence of such measures, there is a real danger that care-centred and child-centred programmes will further entrench existing gender inequalities, and make it even more difficult for women to engage in paid work and pursue other options of their own choosing.

In assessing anti-poverty programmes, social protection schemes or government service delivery, a key question that must be asked is whether the expectations raised by the emphasis on participation, rights and citizenship are being fulfilled. Are women in particular able to acquire the presence and voice needed to ensure that their interests are fully integrated in policy making? Liberalization policies and the assault on the state explain some of the reasons for the persistence of biases against women. But there are also broader political questions about viewpoints and interests that triumph in politics, and in policy making and service design: political debates about what constitutes a healthy society and women's place within it, about what people's obligations are towards each other, and the state's obligations to its citizens. These issues are addressed in section 3 of the report.

Notes

1 See note in figure 8.1 for an explanation of what items are included under "social sectors".
2 Cornia et al. 1987.
3 MacPherson and Midgley, 1987:134 cited in Vivian 1995:21.
4 Vivian 1995.
5 IMF 1998 and 2000 cited in Mkandawire 2001.
6 World Bank 2001c; Holzmann and Jorgensen 2000:28.
7 UNDP 2003; ILO Socio-Economic Security in Focus Programme; UNRISD Programme on Social Policy in a Development Context; Globalism and Social Policy Programme (GASPP).
8 World Bank 2003a:133,60.
9 Devereux and Sabates-Wheeler 2004.
10 Mackintosh and Tibandebage 2004b:167; Huber 2002.
11 Baldwin 1990; Barr 1998; Mkandawire 2001; Lund 2004.
12 Mackintosh and Tibandebage 2004a.
13 Molyneux 2004.
14 Molyneux 2004.
15 Elson and Cagatay 2000.
16 See UNESCO 2003; other reports scheduled for 2005 are likely to cover this issue comprehensively.
17 Esping-Andersen 1990.
18 This subsection is based on Mackintosh and Tibandebage 2004a.
19 Jackson and Rao 2004 provide evidence for India.
20 Kutzin 1994; Walraven 1996; Ekwempu et al. 1990; Abdullah 2000.
21 Baru 2003.
22 Sen 2003.
23 Sources cited in Mackintosh and Tibandebage 2004b.
24 Tibandebage 2004.
25 Tibandebage and Mackintosh 2002.
26 Jewkes et al. 1998, cited in Mackintosh and Tibandebage 2004b.
27 Mensah 2004.
28 Afford 2003.
29 World Bank 1995 cited in Mackintosh and Tibandebage 2004b.
30 World Bank 2003a:144–5.
31 Lund 2004.
32 Huber and Stephens 2000.
33 Huber and Stephens 2000.
34 Steinhilber 2004.
35 Diamond and Valdes-Prieto 1994:309.
36 Barrientos 2004.
37 Chatterjee and Ranson 2003; ILO 2001, cited in Lund 2004.
38 Barrientos and Barrientos 2002.
39 Martinez Franzoni and Mesa-Lago 2003, cited in Lund 2004.
40 Ardington and Lund 1995; Case and Deaton 1998; Case 2001; Lund 2002.
41 Tibandebage 2004.
42 Jelin 1990; Molyneux 2004.
43 The evaluations are summarized in Molyneux 2004.
44 Molyneux 2004:29.
45 Molyneux 2004:36.
46 World Bank 2003a:30–1.
47 Molyneux 2004.