Mapping Income Protection Gaps
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Executive Summary

Why income protection is a global challenge

The global population is ageing. Disability rates among working-age people have risen at the same time as public expenditure constraints tighten. What resources are available for households in the event of work incapacity or premature death - what risk of poverty, what strategy for income restitution? This report examines income protection gaps (IPGs) that follow bereavement and both permanent and temporary disability. It outlines protection systems, changing policy strategies, rising risk and growing IPGs to explain the income gap problem. It will consider the varying situation in four broad geographical regions – Continental Europe, Latin America, the English-speaking world, and south Asia – to illustrate the different manifestations of such risks and the means by which they are compensated in different parts of the world.

Economic uncertainty and financial crises are corroding the economic growth rates that historically underpinned European state welfare systems, long promoted by the ILO as the ideal towards which developing nations should aspire. Faced by pressure from financial markets, governments in developed countries reduce access to and levels of income protection in the teeth of political opposition. Protection against the risk of disability or premature death is increasingly a personal responsibility. IPGs emerge as impaired lives are marginalised - as much by precarious labour markets as by more limited state help. In developing states, primacy is given to protecting the poor: governments expect burgeoning middle classes to take care of themselves.

In recent years, policy strategy has changed: state expenditure has been dedicated to ‘social investment’ in younger generations and away from subsidising social dependency.

- **In developed (OECD) countries**, schooling, training and labour market activation are the focus for policy. Work, not welfare, safeguards against poverty. People with disabilities are a focal group for such action.
  - States employ private sector agencies under regulated ‘partnerships’ of welfare delivery, including occupational pensions (with associated obligations for prematurely bereaved families) and rehabilitation for people with disabilities.
  - Access to income support tightens (exacerbated in southern Europe by ‘emergency’ benefit cuts), re-categorising partially incapacitated people as ‘unemployed’.
  - Temporary or part-time work allows people with disabilities access to work – but such jobs are not covered by public or private social protection schemes.
  - Public parsimony, visible before 2008, has been reinforced by the global financial crisis (GFC) and its consequences, mostly to the detriment of poorer populations.

- **In developing countries** state welfare is expanding, but focuses on the marginalised (frequently rural, or informal) working poor who commonly form the majority of the population. Economic growth increases the size and prosperity of urban middle classes who increasingly purchase private insurance; state-sponsored social benefits are low, short-lived or even non-existent, and public medical care is patchy and rudimentary.
  - Latin American countries imitate continental European patterns of earnings-related social benefits. Outside Brazil and Argentina these are confined to urban workers.
In southeast Asia, national provident fund systems, essentially personal savings schemes that include survivor protection, must supply all welfare needs but cover only those in standard employment.

In India, provident fund and social insurance cover is very limited and supplementary means-tested assistance is available only for the very poor, including orphans and widows.

Thus IPGs emerge as a global challenge with different profiles in different countries. As governments increasingly focus more limited resources on poorer sections of their populations, be this to activate or to supply benefits and survivors’ pensions, so they look to private agencies to protect the incomes of the rest – whether in formal partnerships, for example in European and English-speaking countries, or through voluntary provision, for example in India. Globally, fiscal privileges foster personal savings and insurances as part of a general strategy to limit state burdens: with some exceptions (e.g. Uruguay, Australia, Chile, Sweden) such systems remain voluntary.
1) What Is the Income Protection Gap?

1.1 Defining the IPG

The income protection gap addressed in this report can be defined as the reduction in household income consequent on the death or incapacitation of an adult wage earner on which that household relies, taking all public and private sources of replacement income into account.

Income gaps appear in nearly all countries when disability or death strikes, but differ in terms of access to alternative resources, the amount of support available and how the gap is measured. For example, the OECD found in 2007 that net replacement rates based on incapacity benefits for average earners were 39 per cent in Australia, varied from 43-60 per cent in the UK and were 64+ per cent in Spain. In all four countries covered by the report, additional income for dependents could raise benefit by 25 – 30 per cent¹. Results measured by equivalised income differentials found UK and Australian disabled income was 70 per cent of the non-disabled equivalent: in Switzerland and Norway it was 90 per cent and in Poland, 80 per cent. IPGs under both measures were largest in the two English-speaking nations where the cost of living was also higher².

Worldwide, approximately 16 per cent of the adult population aged over 18 is estimated to be disabled,³ defined as those whose daily activities are restricted due to physical or mental impairment. There are noticeable differences between richer countries (12 per cent) and poorer ones (18 per cent). In Europe, 25 per cent of adults aged 16+ identify as health impaired⁴. Higher rates of disability reflect population ageing (later pensionable age), increased chronic health conditions (better medical diagnosis); and the impact of economic recessions on categories of social dependency⁵. It is possible to compare national average years lost due to disability or premature death, presented here as the WHO’s Disability Adjusted Life Years (DALYs) covering countries included in this report:

¹ OECD (2007) Sickness and Disability at Work: Breaking the Barriers vol. 2: Australia, Luxembourg, Spain and the UK, OECD. Paris. High net replacement rates in Spain probably say as much about wage levels as they do about incapacity benefits. Note that these measures predate the global financial crisis and subsequent reductions in incapacity benefit levels in Spain.
³ Definition problems render this statistic problematic. The issue of defining disability is addressed in section 1.2 below.
The DALY statistics reflect mortality and morbidity rates of specific medical complaints, set against optimal life expectancy, weighted by age. ‘Optimal’ life expectation is calculated against Japanese experience (Japanese life expectancy is the highest in the world): this partly explains high rates of DALYs in India, where death occurs at earlier ages. Note that these measurements cannot be used as proxies for lost productivity or other economic assessment as they cover whole (not merely working) life experience.

The ILO distinguishes four types of protection that guard households against the risk of incapacity or premature death.

1. Work-related impairments or deaths are commonly compensated under laws that hold employers collectively or individually liable for health and safety at work. Social or commercial insurance covers the risk: payments may reflect lost earnings, the degree of impairment, numbers of dependents or any combination of these factors. Global cover is illustrated in the chart below. Nearly all countries confine protection to those in formal employment, excluding sub-contractors (the self-employed), many in part-time or temporary jobs and ‘informal’ (casual and rural) workers.

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6 WHO (2014).
7 http://www.who.int/healthinfo/global_burden_disease/GBD2004_DisabilityWeights.pdf?ua=1 gives weights given to specific diseases and injuries used in making the calculation.
This graph distinguishes different types of compensation available to workers whose health problems or death can be attributed to their employment. Mandatory social insurance requires (and voluntary social insurance encourages) all employers to subscribe to a state-run scheme, sometimes subdivided by different industrial sectors, that will compensate the injured and the bereaved. Employer liability schemes place a legal liability on employers to provide compensation and they may insure against such risk. Previous salary levels are commonly used to calculate compensation.

2. **State-sponsored social security.** Most European, Latin American and some English-speaking countries cover impaired or bereaved people, often under state pension insurance. This is sometimes supplemented by occupational or professional schemes. Those not covered by social insurance commonly have resort to means- or asset-tested social assistance. Provident fund schemes in southeast Asia provide an alternative form of protection. The following chart shows the types of cover in place.

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Social insurance schemes in continental European and Latin American countries provide earnings-related benefits based on earnings-related contributions. This type of social protection is frequently referred to as ‘Bismarckian’ after the earliest German exemplar. As benefits are designed to reflect previous income, they offer better protection than the British, Irish and Australian systems where state benefits are flat-rate and frequently means- and/or asset-tested. In other words, the best protection under Bismarckian schemes is offered to regularly employed, professional and skilled employees. However, following the global financial crisis (GFC), unemployment has risen and revenues (contributions) have fallen, forcing scheme managers and politicians to introduce restrictions on access to benefits and encouraging a switch from DB (final salary) pensions to DC individual accounts, or the equivalent. Southeast Asian provident funds are essentially individual mandatory savings plans, often run by the state. Initially designed to provide a retirement income, these offer help in the event of disability or premature death – the amount available reflecting previous savings. All contributory or savings schemes have an upper earnings cap above which additional contributions may be made, either to voluntary commercial insurance or to a state-supervised savings plan, with fiscal privileges.

3. Collective Agreements negotiated by employers and trade unions often include occupational pension systems that cover survivors and offer disability as well as retirement

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benefits. Such schemes commonly originated as a compromise offer to the demand for higher salary: they form the foundations for occupational pensions found all over the globe. They may be funded or pay-as-you-go (PAYG): more are turning towards defined contribution (DC individual accounts) and away from defined benefit (DB final salary payments). Depending on the country, a collective agreement may cover workers in a specific industrial sector or a particular professional group. In Europe and Latin America, collective agreements are legally enforceable and thus have the same obligatory requirements as state schemes.

4. Voluntary savings in most countries, tax incentives encourage personal savings or additional voluntary contributions (AVCs) to DC pensions. This is particularly important in developing countries where state provision is very low (such as Mexico or India), but is coming to play an increasingly important part in protecting the middle classes in the developed world as access to state help tightens, particularly in those Anglo-Saxon states that means-test access to state benefits.

Having briefly reviewed public support, we should recall that help for vulnerable people remains largely informal. Those in an impaired medical state tend to become self-employed to accommodate health problems. Should a wage earner die unexpectedly, relatives rally to care for the bereaved. In the developing world such strategies are commonplace: extended families serve as networks of financial services and support – not just to cope with disability and death, but to secure loans, invest in new business, help purchase a house and so on. Informal help is virtually universal: family relationship obligations have shrunk in developed economies, but have not disappeared.

1.2 Measuring the IPG

The calculation of potential gaps is complicated: this section reviews these complications and their consequences. It addresses support from public and private sectors, coverage and access issues.

It would be nice to create a chart to measure the size of the IPGs that appear when disability or premature death strikes a household. However, this report cannot to place exact numbers on income protection gaps. In our opinion, particularly for disability gaps, a number of factors, including differing definitions of disability, subjective calculations of “need”, restrictions on inflows into social protection schemes (see figure 5 below), and exclusion of informal and part-time workers make a meaningful calculation under our definition of an IPG extremely challenging. All facets of such a calculation reflect variable socio-political judgements and contexts. Yet we do know that, globally, income protection gaps exist in every country and that they are widening for the middle classes – but state preoccupations with current account balances make any extensions in public protection unlikely.

First, identifying the ‘disabled’ creates problems. As discussed below, official statistics reflect only successful benefit claims under schemes of varied coverage that often exclude part-time, temporary or informal workers and the self-employed. Self-reported disability rates are much higher than benefit claims and commonly result in lost earnings – to an extent unknown, bar the census or a survey.
Second, different compensation is offered under different types of public or private protection schemes. Payments may reflect previous salary (or be flat-rate), number of dependents, the severity of the impairment, or all of these. Alternatively they may be means- or asset-tested, reducing rights for those with savings or living with wage earners. Work-related injuries or deaths are often covered by different systems.

Third, labour market conditions, personal health and employability (disability rates being lowest among the better educated) disadvantage physically and mentally impaired job seekers. Calibrating trends over time (1970-2008), the OECD concluded disability rates reflected disguised long-term unemployment. This interpretation has been widely endorsed as it solves 'the puzzle of rising incapacity in an ever-healthier world'. However, official categories are fluid. The jobless with mental problems may resist registering as disabled as employers reject candidates with poor medical histories. Conversely, tighter HR management (target setting, benchmarking) imposed on marginal workers exposes mental or physical fragilities.

Fourth, there is little relationship between the incidence of disability and public support for its victims. The chart below measures state support for disability in OECD countries. Note how reduced access in countries with relatively high levels of protection creates larger IPGs. For example, given the superior support previously provided for disabled Swedes in contrast to their Mexican counterparts, reduced access to public support for Swedes creates larger IPGs than for Mexicans.

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12 OECD (2010): 31-4
16 Note that this does not translate into higher disability rates in countries with higher levels of protection.
Fifth, if state support is means-tested, it is based on household income, not individual earnings. This raises the question of how IPGs should be identified. To assess income gaps for people who identify themselves as disabled in terms of state benefits alone is pointless: only a minority receive them (see Figure 5 below). In OECD countries, only 25 per cent receive state benefits and occupational benefits commonly only supplement state support. IPGs are also created by tighter labour market conditions that force those with impairments to work either part-time or for below average earnings18 - a gap which is similarly impervious to accurate measurement.

Finally, should IPGs be measured in terms of net replacement rates (disability benefits, or compensation for death, set against previous salary), or lost household income consequent on disability or death? Possible answers come from OECD / EU measurements using equivalised person data to assess risk. Survey data allows the sum total household income to be divided by the number of its members. Average income in households containing a disabled person can be

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compared to the rest. The difference is measured as an income gap. However, such data is not available for Latin America or southern Asia.

Figure 5: Working age people with disabilities and recipients of incapacity benefits (2010)\textsuperscript{19}

Although IPGs cannot be assessed at the global level with any accuracy, surrogates are available for Europe. Figure 6 reveals the higher risk of suffering poverty and social exclusion experienced by self-identifying disabled people, using equivalised personal income derived from EU SILC data (2011)\textsuperscript{20}. Note the poor performance of some richer EU economies, notably Germany and the UK.

\textsuperscript{19} ILO (2014): 57.

\textsuperscript{20} ANED calculates the risk as personal equivalised income of < 60 per cent of the national median plus membership of a household where employment per adult member is < 20 per cent of standard hours. SILC = Survey on Income and Living Conditions
Figure 6: Poverty and social exclusion gaps\(^{21}\) between persons with and without disability\(^{22}\)

2) Counting the Cost: Rising Rates of Risk

2.1 Rising claims for state help

2.1.1 Ageing societies

Rising life expectancy is a great social achievement, but an ageing workforce means higher rates of disability. The EU Labour Force Survey (2011) found 48 per cent of the 26 per cent reporting a longstanding health problem were aged 55-64, whilst only 12 per cent were aged 15-24. \(^{11.4}\) per cent of respondents claimed incapacity reduced their working hours\(^{23}\): again the proportion grew with age.

Age remains central to disability distributions\(^{24}\). In Europe and the USA, de-industrialisation has left behind unskilled workers now in their 50s and 60s with physical problems derived from their previous jobs. In developing countries life expectancy (and an older workforce) grow. Since the 1950s, life expectancy at birth in India has nearly doubled and the average Latin American lifespan has increased by 15 years since 1970\(^{25}\).

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\(^{21}\) Gap: Per cent of persons with disabilities – Per cent of persons without disabilities; Age 16-64, 2011.

\(^{22}\) ANED (2014): 187: N.B. Switzerland and Ireland not included.

\(^{23}\) Ibid. 95-6.


As pensionable ages rise, a disability claim bridges the gap between declining working capacity and retirement – especially as countries (e.g. Sweden) have abolished early retirement. Moreover, employers do not hire older workers with disabilities: wage subsidies, financial help with workplace adjustments and similar incentives have marginal effects.

2.1.2 Improved medical diagnosis

Rising educational standards and better public understanding of health issues have contributed to raising official rates of disability, notably in the field of mental illness which forms the leading cause of disability for 20-34 year olds (70 per cent of claims). Mental problems can also cause premature death, due to suicide or self-harm. As diagnoses of mental incapacity vary, claimants are frequently accused of fraud - adding further stress on vulnerable populations.

According to the OECD (2012), over 50 per cent of adults with severe mental disorders and over 70 per cent of those with moderate disorders never receive any treatment. Medical treatment available is often not specialist treatment and is of too short duration to meet clinical guidelines. People with mental disorders who are in work are twice as likely to take sick leave for longer periods and their productivity is estimated to be 75 per cent below standard.

People with mental health problems are less likely find work than other disability claimants. Equally, the unemployed in poor mental health are the hardest to place: depression, stress and anxiety (possibly attributable to lack of work) are prominent. Becoming or remaining unemployed exacerbates mental health problems. As noted above (1.2), disability rates respond to tighter labour market conditions.

2.1.3 Changing labour markets

Following labour market ‘deregulation’ in developed countries, employment in service sector economies takes more diverse, ‘flexible’ (and insecure) forms. Lifelong full-time jobs are becoming less common in OECD countries. In 2014, one in five prime age (25-54) adults in Italy, Australia, Germany, the UK and Ireland worked part-time: in Poland one in four (and in Chile, one in three) was in temporary work. These jobs are not covered by state protection and proportions are higher among younger age groups.

Disability rates rose during past economic downturns as job opportunities for impaired people declined. Recessions in 1994-2008 reduced the employment chances of disabled men by 19 per cent (by 12 per cent for disabled women): their financial circumstances declined by more than 50 per cent during those years.

Unemployment rates among disabled people rose continuously 2000-08:

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28 European Risk Observatory (2014), Calculating the Cost of Work Related Stress and Psychosocial Risk European Agency for Safety and Health at Work.
34 OECD (2010): 60.
In the UK and USA, disabled people feature prominently among marginalised workers\textsuperscript{36}. Flexible labour markets create opportunities for disabled people capable of part-time work, but job insecurity imposes psychological burdens on weakened lives.

2.2 Reduced access to state help

2.2.1 Reconstructing claimant rights

Today, work is understood to be the best safeguard against poverty and this has recast approaches to disability. Medical models that interpret incapacity in terms of individual pathology are being replaced by assessments addressing physical, cultural and policy environments that limit core functions of impaired people. This approach shaped the UN Convention on Rights of Disabled People (2006) and the European Disability Strategy (2010-20). However, a perspective originating in campaigns for disabled people’s rights has been captured by politicians eager to contain burgeoning claims to state benefits\textsuperscript{37}. New regulations place obligations on employers and service providers to enable a return to work. Official assessment of claimants focuses on their personal capacity for any type of work. The ILO monitors how governments fulfil their obligations to place people with impairments in work across the globe.

\textsuperscript{35} ANED (2014): 36 Recall that most disabled are older workers and EU older workers have secure jobs.


Rehabilitation takes centre stage in treatment, most successfully for the recently disabled. For instance, the wheelchair user is socially dependent if the workplace is not adapted by ramps and lifts, public transport provides no access or IT services are unavailable. Better facilities allow working life to resume. The Netherlands pioneered this approach: there, disabled claimants no longer have separate benefit rights but form a sub-category of hard-to-place unemployed. The GFC has reinforced this approach.

2.2.2 Government focus on rehabilitation and limiting inflows

Policy has reshaped how disability is understood and benefit claims admitted. Work incapacity has been redefined and its extent reduced. Cash-strapped governments have restricted access to benefits (rather than cut benefit rates); reduced social services for disabled people; enforced stricter employability criteria; and sometimes removed benefits for surviving spouses of working age. For instance, young widow(er)s in Chile and the UK do not receive state help if under 45 years old and survivors’ benefits are earnings-tested and/or time limited in Germany, the UK, Ireland, Poland, the USA - and have been abolished in Sweden.

Incapacity is the major working-age benefit in most OECD countries and, as pressure on social budgets has mounted, so official attention has turned to employers to promote a return to work. Employers in Sweden, Switzerland and the Netherlands are constrained from dumping incapacitated workers back on the state. Rehabilitation is promoted and disability development forestalled by programmes of medical checks and workplace reviews.

In terms of public action, as stocks of disability claimants have proved hard to shift, policy attention has turned to flows. In the UK, Sweden, Switzerland and Germany as well as the Netherlands, stricter access, time-limited benefits and regular claimant reassessments contain numbers of new claimants. In southern EU member states, Euro crises have forced reductions in benefit levels as well. As a result, new claimants whose health status varies over time and whose claims for state help are denied, are reclassified as ‘unemployed’. Such strategies may protect public budgets, but IPGs still inevitably emerge.

3) Income Protection: Mind the Gap

Migration in general and the free movement of labour within the EU cut across systems of income support based on national welfare schemes. Internationally mobile workers are penalised. New schemes with global scope are urgently required. The introduction of personal (DC) pensions was supposed to solve this problem: however, with differing national taxation systems and investment ‘choices’ this advantage has never materialised.

3.1 Impact on Governments

Constrained social budgets, high unemployment and lower tax and social insurance revenues have all led to caps imposed on scheme coverage and benefit levels, cuts in state-funded services and

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reduced access to social support (2.2.2 above). Means and asset tests are more strictly enforced. While benefit expenditure has been contained, it has not been reduced as longevity has benefitted the impaired as well as the healthy and those with established claims in developed countries have proved difficult to remove from disabled registers.

In consequence of austerity, government minimum income benefits no longer protect against poverty. Politicians promote public-private partnerships between state and private insurers to create income protection schemes that bridge emerging gaps. Private health insurance has grown in Chile, Switzerland, Germany, Belgium and Australia\(^4\). In Hong Kong, employers are obliged to provide health cover. In nations with large poor populations, the primary demand on government social expenditure is to extend protection to the destitute. In India, Brazil or Mexico, wealthier households are encouraged to provide for themselves.

Across the world, tax concessions incentivise personal supplements to shrinking public provision. Examples are evident in supplementary saving under Singapore’s national provident fund scheme, German (Riester) DC pensions, in Uruguayan support for extra savings under AFAFS DC schemes, and in incentives to invest Italian TFR (severance pay) in a DC supplementary pension. Such private provision offers support in the event of disability or premature death while also permitting an early withdrawal from the labour market for those saving enough to fund early retirement.

### 3.2 Impact on Households

In developed countries, as access to social benefits becomes more difficult, household shocks can be quite profound. In the UK, 33 per cent of households drop into a lower income quintile following an unexpected adult death, with 20 per cent falling into poverty. Rising female labour market participation has made European and English-speaking countries less generous towards survivors than in Latin American states where social protection has been extended. In Germany and Poland, survivor’s benefit above subsistence is confined to those aged 50+; in Ireland and the USA, state support for survivors is income-tested.

Working to fill the gap left by a deceased partner is vital to avert poverty. In developed countries, gender is less significant as professionals tend to marry professionals. In Hong Kong and Singapore, as in Europe and Australasia, there are currently more female graduates than male. However, in more Catholic countries such as Mexico, or Muslim countries like Malaysia, lower female educational attainment and labour market participation pose a considerable problem for young widows. In southeast Asia, balances left in provident fund schemes are returned to the family in the event of premature death.

Means- or asset-tested benefits disadvantage households containing a disabled member with another wage earner in work, as income-related payments are cut or disallowed. This situation is

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\(^4\) OECD Health Statistics 2013 ([http://dx.doi.org/10.1787/health-data-en](http://dx.doi.org/10.1787/health-data-en)).

common in English-speaking countries and for growing numbers in EU member states as changing employment reduces numbers able to claim earnings-related benefits ‘as of right’ 41.

Since the GFC and subsequent Euro crises, and as Figure 5 (above) shows, numbers accessing state disability benefits are very low in Greece and Spain where the crisis has been most severe. This low incidence of reported disability may reflect ‘presenteeism’, a term denoting behaviour of impaired workers unable to survive on small benefits but fearful of losing the chance of work by admitting to any disability.

3.3 Impact on Employers

Multi-national corporations (from vehicle manufacturers like Daimler IG to insurers like Mercers) offer occupational schemes to their employees world-wide, in Latin America, India and eastern Europe. American companies operating in Europe offer unit-linked savings plans in similar fashion. Employer-based initiatives raise public awareness about new possibilities, but such corporations have not got the motive or the authority to extend protection beyond their own workforce.

The consequence of IPGs for employers stems from reduced productivity. Without support and with poor job prospects for those registered as disabled, employees may prefer to work at reduced capacity: a phenomenon known as ‘presenteeism’ (see 3.2 above). Various estimates have been made of the cost: one American study estimated an annual cost to business at over $150bn p.a. In the UK, unacknowledged mental health problems have an estimated cost of £15.1bn per year44. A recent OECD study suggested that people who continue to work while suffering emotional or physical health problems are less productive45.

If IP gaps are left unchecked, unacknowledged disability will probably lead to lower productivity for employers. This problem is exacerbated by an ageing workforce. By 2020, the largest age group of workers will be in their mid-50s.46 An ageing demographic aside, higher state pension ages and reduced retirement income due to increasing reliance on DC as opposed to DB pensions will contribute to this trend, although recent research suggests that working longer can protect against cognitive decline47.

4) Scoping Income Protection: Concluding Remarks

Europe’s welfare states are showing their age. Post-war settlements reflected national preoccupations exacerbated by conflict that are today neither pertinent to nor fiscally sustainable in a globalised world. Governments want to contain social costs, and to focus more limited resources (including rehabilitation programmes) on social investment in future generations, while encouraging or even forcing those with more substantial incomes to protect their own households against income risks. They turn to private providers: tax incentives encourage the middle classes to bridge the gap, collectively or individually. To contain IPGs, public-private partnerships seem to be the only game in town.

43 OECD 2015, Fit Mind, Fit Job, From evidence to practice in Mental Health and Work.
Such solutions, however, are deceptively simplistic. Persuading publics with expectations of, and preferences for, state help to turn to commercial solutions is difficult. Private insurers have found selling personal protection can be uphill work. Where such protection has been mandated, either premiums have proved insufficient to cover needs and have required substantial state subsidies, as in Chile; or state social insurance has been introduced to help the low paid, as in Malaysia. In Sweden, contributing publics rejected commercial options and prefer to invest newly introduced personal pensions with the default fund, the state. In Hong Kong and Australia, in contrast, mandatory commercial DC pensions, or their close equivalents, have been better received. Where such protection is voluntary, coverage remains partial. German Riester pensions, in spite of their advantages of state subsidies and guaranteed returns, have enjoyed a mixed reception, since they only guarantee the value of total contributions – and in general market-based returns have proved poor over the past 15 years. In liberal English-speaking countries commercial insurance is more established and long traditions of minimal state provision encourage its use. In southern Asia, provident schemes have fostered personal saving as a bulwark against domestic disaster, but remain under the supervision of the state, as in Singapore.

European resistance is not the simple consequence of social bigotry, but reflects real differences that distinguish state welfare from commercial alternatives – as demonstrated by the failure of the EU IORP Directive. Reducing access to benefits to protect the taxpayer is one thing; reducing it to protect shareholder interests is quite another (even if these shareholders are pension funds themselves). The principles underpinning efficient provision differ fundamentally. State welfare understands its objectives in terms of universal access, public accountability and social justice. Commercial agencies prioritise value for money, with market competition guaranteeing superior service at optimal prices. The first understands the individual as a citizen who votes for better welfare policies, the second as a customer who improves provision by exercising consumer choice. Such different perspectives are not easily reconciled – although the national provident fund schemes found in Malaysia and Singapore offer interesting examples of how this might be achieved. The existence of such tensions explains why state-sponsored, funded protection tries to ‘regulate in’ factors not necessarily conducive to market efficient performance.

Viewed historically, schemes designed to serve a single purpose have adapted to changing circumstances with mixed results. Singapore’s national provident fund demonstrates how funded systems are not necessarily more sustainable than unfunded alternatives. Introduced in the early 1950s as a funded pension scheme and extended to cover more welfare requirements (including housing in a city where property prices have rocketed in recent years), it now faces more retirees with longer lives than originally anticipated with inadequate resources. Australian mandatory life insurance requirement offers a more helpful example. Introduced to underwrite Superannuation contributions, this already serves as a partial guarantee against an impoverished old age for people suffering impairment while protecting against unexpected death. While far from perfect, this example illustrates how public-private arrangements might prove adaptable in English-speaking countries at least. Other settlements require attention to local circumstances and preferences. The

48 By contrast, an individual who had been saving in a UK DC scheme from 2000-2014 would have lost .15% p.a.
49 See Appendix Section (A) Europe: An Overview.
potential adaptability of commercial products can open up interesting possibilities as the European welfare state exemplar ceases to offer the security required.

BOX 1
Australian Superannuation and Life Insurance Cover

In Australia, superannuation (or ‘Super’ as it is known) is mandatory for all workers, paid by employers at a fixed percentage of worker earnings (9 per cent and currently rising to 12 per cent) into a fund that can offer member choice on investments. Alternatively, members can choose to invest their own fund as they see fit (Self-Managed Super Funds – SMSFs). There is a wide variety of different types and sizes of super fund – the largest include industrial funds (jointly run with trade unions), retail funds and those covering public sector workers. All are obliged to offer basic life cover, to secure super contributions until retirement. Many – notably those set up under industrial agreement – offer more, such as TPD (total and permanent disability) insurance and extra life policies to cover lost income in the event premature death. SMSF owners make their own arrangements (and commonly neglect to do so).

The strength of this model stems from the life cover offered by default with premium deducted from the super member’s account and, for large funds, the economies of scale consequent on automatic cover for large numbers of subscribers. The weaknesses stem from the opaque nature of provision, with members frequently reliant on the employer’s choice of provider (who has little incentive to secure best value for money) – and from the very minimal cover provided by law, which means it can be the member’s responsibility to elect to pay TPD insurance or supplementary life premiums (and many do not). Nonetheless, the operation of super, which has been in existence for nearly 30 years, explains why life cover is much more extensive in Australia than it is for example in the UK – and why Australian protection against permanent disability or premature death, being so closely linked with retirement savings, gains more attention than it does in other English-speaking countries.
APPENDIX I: Europe

An overview

Demographically, Europe is old: the continent has the highest average age on the planet. In western Europe, arguably thanks to state welfare systems, premature death rates are comparatively low, as shown below.

*Figure 7: Premature (15-60) death rates in Continental Europe*  

![Graph showing premature death rates in Continental Europe](image)

However, ageing populations translate into high disability rates, particularly in East European countries (possibly a legacy of communist industrial systems).

*Figure 8: Persons with disabilities by age group in Europe, 2011*  

![Bar chart showing persons with disabilities by age group in Europe](image)

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50 WHO (2013).
Disabled people have poor access to employment, despite EU policy initiatives to return people with health impairments to work. This chart demonstrates the variable success of such initiatives. Achievements in western states are stronger than in new member states.

Figure 9: Employment rate by degree of disability (age 20-64) in Europe, 2011

European social protection systems are under strain thanks to demographic ageing, labour market change and rising costs. In continental Europe, permanent work contracts and collective agreements are legally safeguarded, but current pressures to deregulate labour markets, visible before the GFC and reinforced by its consequences, are corroding conventional employment, most notably for new labour market entrants. Protection does not extend to part-time or temporary jobs, whose incidence is rising. Growing IPGs are the inevitable result.

State-sponsored protection

Welfare states originated in Europe and these schemes, promoted by the ILO, have exerted global influence. Different income protection schemes reflect different principles. European (Bismarckean) social insurance dominates in Germany, France, Spain, Italy and the Netherlands, characterised by earnings-related contributions and benefits that sustain established socio-economic hierarchies. In contrast, more redistribution is found in Nordic countries that prioritises social equality. In both systems (with the exception of Sweden’s), income protection against disability or premature death is attached to pension insurance: IPGs emerge where occupational supplementation is partial or voluntary. Post-communist states in Eastern Europe generally run smaller, weaker versions of Bismarckean systems: state protection is low and meagre, but these are poorer countries. Two EU member states (the UK and Ireland) have liberal, largely means-tested state systems (covered in Appendix II). Generally, IPGs are larger in English-speaking countries thanks to tighter access and more means or asset-tested social protection: the role of commercial insurance (private protection) is consequently more substantial.

All European states run separate schemes for work injuries: these vary in scope, organisation and financial structure. Most (especially in Eastern Europe) are state-sponsored self-funding insurance systems: Scandinavia and some southern countries (Portugal, Cyprus and Malta) include tax-funded subsidies. In Denmark, Finland, Belgium, the Netherlands and Spain (as in the UK), work injury compensation is insured by private commercial companies. Sometimes the employer is required to pay a full or part salary for an initial period, after which benefits are paid as a percentage of earnings. In Austria, France, Italy and Portugal benefits increase if disability continues after a predefined period. Permanent disability benefits are based on lost earnings alone (Austria, Belgium, France, Germany and Spain) or can include additional compensation for lost quality of life (Denmark, Finland, Italy, Sweden).

Recent developments

European monetary union, the GFC and successive Euro crises have raised unemployment, and thereby benefit costs, while reducing tax and social insurance revenues, forcing retrenchment in Bismarckean schemes. To create jobs, labour markets are deregulated. To contain public expenditure, access to benefits is tightened, pushing more marginal disability claimants onto unemployment registers. Income ceilings are reduced; social services, on which people with disabilities rely are rationed; and benefit levels frozen or cut, notably in southern Europe. Labour market activation, including rehabilitation, is now widespread but tighter labour markets militate against impaired lives finding work. IPGs grow as a result.

Inter-state labour mobility, promoted by the EU as central to the single market, has become a key issue. National taxation systems, labour laws and social security schemes impede progress. Pensions with their associated protection of the bereaved and the disabled are notably problematic. Diverse mixes - between funded and unfunded, public and private, mandatory and voluntary - raise administrative costs and create havoc for mobile workers on retirement. Under the Institutions for Occupational Retirement Provision (IORP) Directive (2003) the EC introduced pan-European
pension plans but this has had little impact\textsuperscript{53}. A number of off-the-shelf products developed by the financial services sector have not been adopted as multinational corporations like Volkswagen prefer to extend their own social protection systems for employees across Europe. This problem remains unresolved.

**Germany**

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<th>Life expectancy at birth (and at 60)</th>
<th>81 years (84 years)</th>
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<tr>
<td>Probability of dying before 70 (male)</td>
<td>33 per cent</td>
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<tr>
<td>Probability of dying before 70 (female)</td>
<td>19 per cent</td>
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Germany is ageing rapidly: 27 per cent of the population is over 60 years old and the average age is 46, the highest in Europe. For government, the German IPG crisis is born of ageing: how to support a growing population of older workers in declining health as pensionable age rises. As German social insurance funds are required to be financially self-sufficient, the initial policy response to rising claims was to increase contributions – but high labour on-costs, which approached 50 per cent of salary, pushed up unemployment as firms resisted offering new permanent job contracts. The labour force divides between older, protected workers and the rest. State policy aims to keep pension contributions below 20 per cent. Ever tighter gatekeeping and low benefits have ensured that there is no disability crisis as such, but marginal cases are transferred onto means-tested ‘Minimum Income Benefit for Jobseekers’ and labour market activation with little hope of finding work. The burden of disability or premature death on private households is growing. Current policy seeks to extend private solutions, to make more employers offer occupational solutions.

PAYG state social insurance offers income-related protection for all risks (including long-term care) covering all in insurable employment and their families. Its past generosity has crowded out private supplementation, at least until very recently. Permanent work-related injuries are paid at 66.7 per cent for salaries under 100,000 Euros p.a. (temporary disability is compensated at 80 per cent) under a separate scheme run by a not-for-profit agency. Other disability and survivors’ benefits fall under pension insurance: a full disability pension if the recipient is unable to work three hours per day and a partial pension (at 50 per cent – often below subsistence) if able to work between three and six hours. Benefits are adjusted to previous salary, years of contributions, and number of dependents. Carer allowances and accommodation adaptations are available. German health insurance provides medical care and specialist treatments. In the event of premature death, survivors’ pensions are paid in full for three months, then at 25 per cent for two years for younger partners or 55 per cent for older survivors with young children, and are means-tested after a prescribed period.

Germans with disabilities risk poverty: access to disability benefits is not easy (50 per cent of applications are refused) and rates are unattractively low. Unemployment among people with incapacities is above the EU average; employment subsidies have little impact on hiring practice. Recent labour market reforms create temporary and part-time jobs that are not covered by social insurance. Disabled people without the required contributions apply for means-tested minimum income benefit: any savings above 2,500 Euros are set off against assistance. For higher incomes,\textsuperscript{53} Guardiancich, I. (2011) Pan-European pension funds. *International Social Security Review* 64, 1: 35-54.
fiscal incentives encourage private protection to supplement state benefits for health and pensions: 11 per cent have private health cover. Tax-privileged occupational schemes and personal (Riester, DC) pensions offer life cover and disability insurance, but – as state pensions have long been generous – these are less widespread than in the UK, though they are growing.

Italy

Life expectancy at birth (and at 60) 83 years (85 years)
Probability of dying before 70 (male) 27 per cent
Probability of dying before 70 (female) 16 per cent

Italy’s IPG problem, like Germany’s, stems from population ageing, but it has been exacerbated by a weaker economy badly hit by the GFC. State benefits are being cut and female pension ages are rising, threatening family care for the old and fragile. Unemployment is high: only 36 per cent of those aged 55-64 are in work and over 40 per cent of the under-30s are unemployed. Recent legislation has extended the social protection of permanent workers to part-timers and subcontractors, but the Italian labour market still divides between insiders and outsiders – protected workers and the under-employed remainder.

State income protection against disability or premature death is provided by PAYG social insurance pensions, both complex and generous, but replaced from 1995 by a notional defined contribution (NDC) scheme. Disability benefits are based on average annual earnings over the previous five years and the number of contributory years, with subsidies for low pay. Following premature death, the survivor can claim 60 per cent of previous earnings: 80 per cent if there is a child and 100 per cent if there are two children (capped for higher incomes). ‘Survivors’ can extend to dependent nephews, nieces, grandchildren or parents over 65. Means-tested disability allowances are set at 66.7 per cent of lost earning capacity and a disability pension is payable to all with total, permanent incapacity who have no other income. Retirement and survivor income is offered either at a predefined age or as a seniority pension (which allows an early exit from the labour market after a predetermined number of years in work, a privilege fiercely defended by trade unions). Means-tested, tax-funded social assistance supports those with insufficient contributions. The 2008 crisis forced austerity: pensionable age has risen and the introduction of NDC-based pensions has been accelerated54. Under NDC plans, all payments reflect total past contributions, adjusted for age.

Work-related injuries are compensated under a separate scheme according to lost earnings and severity of damages (including physical or mental integrity). A private agency (INAIL) collects employers’ (mandatory) premiums, runs the scheme, and advises on health and safety. For an assessed degree of disability of at least 16 per cent, the pension is based on the insured’s age, gender, degree of disability, and the previous year’s average earnings.

State benefits may be supplemented by DB or DC occupational pensions but these are voluntary and cover only 25 per cent of workers. Under Italian law, severance pay (Trattamento di Fine Rapporto, or TFR) is provided to all employees leaving work: this can be transferred into an occupational or

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personal pension plan, offering cover for disability or death, established under collective agreement or on a commercial basis. Alternatively, TFR can be paid as a lump sum on retirement.

Poland

| Life expectancy at birth (and at 60) | 77 years (81 years) |
| Probability of dying before 70 (male) | 50 per cent |
| Probability of dying before 70 (female) | 26 per cent |

Polish living standards are below the EU average, but memories of a communist past reduce the appeal of state-sponsored protection. In Poland, IPGs reflect the consequences of past economic instability that has cut savings and, post-GFC, reduced state support. The IPG for families stems from the time-limited and low amounts paid to social security claimants.

Mandatory (DC) funded personal pensions, introduced in 1999, aimed to provide a retirement income while protecting against permanent disability or death. Survivors can claim 50 per cent of the deceased’s savings. However, the scheme encountered problems. High transition costs coupled with the impact of the GFC on state finances (unemployment soared and revenues fell) forced revisions. Five per centage points of an 8 per cent DC contribution reverted back to the state. Today, a mixed system includes a publicly managed NDC scheme and a mandatory DC scheme, covering employees and self-employed persons born after 31 December 1948.

State support remains meagre. State disability benefits fall under earnings-related social insurance covering all workers, including the self-employed, capped at 2.5 times a (low) legally fixed, annually reviewed average wage. A full disability benefit is only paid to claimants unable to do any work of any type; a partial pension is also available at a lower rate. Both are temporary; continuing claims revert to means-tested social assistance. If household income exceeds 130 per cent of the national average wage, no benefit is paid. Survivors’ benefits stand at 85 per cent of disability benefit, but are only paid to those over 50 who are incapable of work or raising a child (but can include parents). Compensation for work injury (up to 100 per cent salary replacement) is covered separately under rates and conditions stipulated by the Labour Code for a maximum period of six months.

Tight conditions explain low official disability rates while survey data reveals that 68 per cent of Poles live with a health problem that limits working life. Current employment rates for people with disabilities are less than one in three and their risk of poverty is four times higher than that for non-disabled households. Outside tax-privileged AVCs paid into DC accounts, voluntary insurance is virtually non-existent. Recent signs of renewed recovery attract younger, mobile and better qualified Poles back home: political demands for better protection can only follow.

Sweden

| Life expectancy at birth (and at 60) | 82 years (84 years) |
| Probability of dying before 70 (male) | 26 per cent |
| Probability of dying before 70 (female) | 18 per cent |

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Through combined public and private cover, Swedish citizens remain well protected against social risk. To control rising disability benefit costs, policy has restricted access rather than cut benefits. Assessment is centralised and strongly policed; claimants are triennially reviewed. A specific scheme for under-30s focuses training and rehabilitation on the young to prevent persistent social dependency. For a Nordic country renowned for comprehensive social cover, IPGs threaten marginal cases and part-time or temporary employees who are not covered by statutory provision or collective agreement.

Disability support was transferred from state pensions to sickness insurance in 2008: sick pay for the first 450 days covers 80 per cent of previous earnings. Subsequent admission to disability benefit, set at 64 per cent, requires complete incapacity, with partial incapacity compensated according to severity of work impairment. Tighter access has pushed some partially incapacitated people onto the unemployment register: 60 per cent of people who self-identify as work impaired are currently in (mostly part-time) work. Swedish citizens so impaired that they have never worked are entitled to a tax-funded, means-tested disability pension which is also payable to their survivors. All disability pensions offer a constant attendance allowance. Work injury is compensated under a separate scheme with its own funds, jointly administered by employers and trade unions. 100 per cent of previous earnings is paid to all totally and permanently disabled, with partial incapacity proportionately compensated: evaluation is based in part on previous salary and in part on any resulting psychological or emotional damage.

The transition of state pensions from earnings-related social insurance to PAYG notional defined contributions has eliminated survivors’ pensions. However, survivors are still compensated under jointly-negotiated occupational pensions: recently transformed from DB to DC, the largest private scheme, ITP, provides disability and survivors’ pensions automatically for DB members and electively for DC members. Funds are vested with a single mutual provider (Alecta). Supplementary cover (DC) is open to all salaried employees via ITP, with a choice of pension provider. Mandatory (DC) state personal pensions also offer a choice of provider and cover survivors if the contributor so chooses.

Switzerland

| Life expectancy at birth (and at 60) | 82.5 years (84 years) |
| Probability of dying before 70 (male) | 26 per cent |
| Probability of dying before 70 (female) | 16 per cent |

Statutory social protection in Switzerland is comprehensive and generous. IPGs are correspondingly small; over 60 per cent of those reporting as disabled are in work. As the law requires public referenda to approve any social security reform, the basic structure of state protection has remained

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58 See http://oshwiki.eu/wiki/Worker_participation_-_Sweden
59 Some older workers (born pre 1954) still have partial cover under the old scheme.
A rising incidence of new disability claims in the mid-1990s – mostly mental problems among low-paid, migrant workers and single mothers – threatened state pension fund solvency. A series of administrative changes revived the principle of rehabilitation. Employment-based assessments of new claimants were re-introduced, early workplace interventions encouraged, and voluntary guidance, retraining and job reintegration made central to claimants’ treatment. Inflows onto the disabled register peaked in 2005 and new claims subsequently fell by 45 per cent⁶¹.

Comprehensive social protection is expensive: Swiss taxes and social security contributions are high. Voluntary social protection remains widespread: over half the population elect to buy supplementary sickness insurance and fiscal incentives foster voluntary personal pension savings, forming a ‘third pillar’ on top of state and mandatory occupational pensions. Earnings-related state social insurance covers disability, retirement and bereavement. Well established commercial insurance companies manage fully-funded mandatory occupational pension schemes that supplement this cover. Benefit rates for disabled workers reflect previous salary and the severity of the disability, with total incapacity for work compensated at 100 per cent of previous wages. Partial pensions are available for less severe impairment: survivors receive benefits on a similar scale. Work-related injury is compensated at 80 per cent of previous salary under separate employer-funded insurance. Those disabled from birth receive state support. Workers with insufficient contributions (part-time or ‘mini-job’ workers) can claim means-tested assistance.

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⁶¹ OECD (2014) Mental Health and Work: Switzerland Paris, OECD.
APPENDIX II: English-speaking countries

An overview

Premature death rates in English-speaking countries are marginally higher than those found in western Europe – more so in the USA where health care resources are heavily skewed in favour of the better-off.

Figure 10: Premature (15-60) death rates in Anglo-Saxon countries62

IPGs in English-speaking countries are substantial: there are three causes. First, benefit support is low, increasingly hard to access and, except in the USA, does not reflect previous income. Second, returning claimants to the labour market commonly entails their transfer to low-grade, insecure, part-time and frequently ill-paid work – reducing household income and sometimes creating private debt. This risk is exacerbated by the third factor: cuts in social services. Personal ‘care packages’ available in the UK and currently being introduced in Australia, funded by income supplements, are assumed to cover adequate help, but do not necessarily do so. Finally, while European countries promoting work activity for disabled people impose obligations on employers, liberal Anglo-Saxon economies do not.

IPGs in English-speaking countries are a problem, in part because state benefits are designed to prevent poverty, nothing more. They do not sustain the lifestyle of better-off households. In Australia, all benefits are asset-tested (but disregards are higher than those found elsewhere). American Social Security Disability Insurance (SSDI) benefits are more generous because they include access to state funded health treatments (Medicare) in a country where medical costs are exorbitant.

A rising incidence of claims and the consequences of the GFC on public budgets have had a marked impact on scheme finances. The American Disability Trust Fund is expected to become insolvent by 2016. In the UK and Ireland (the latter’s budget being under European Commission, ECB, and IMF [Troika] surveillance in the years 2008-13) benefit levels have been frozen, essential social services for people with disabilities severely reduced and criteria determining working capacity tightened. Medical conditions are regularly reassessed. In both the UK and Australia, people with incapacities but deemed capable of work are required to undertake work-related activity or training. In the UK, the sanction of benefit withdrawal for refusal penalises claimants with psychological problems. Activation to date has had little success: 20 per cent of terminated American SSDI clients applied again within eight years. The record of British claimants is equally poor as total working capacity is rarely restored. Access to a DC pension or other personal savings can help in the immediate term, but transfers the crisis to later life when funds are used up and those with disabilities will be in no position to remedy their situation. Income protection problems are thus not solved but merely postponed.

Work injury compensation offers a partial exception: in Australia and the USA, employers (or their insurers) fund reasonably generous compensation - at 95 per cent for three months and 66.6 per cent of previous earnings respectively. Lump sums and/or continued support for survivors are also offered, subject to regulation by individual states under federal constitutions of both countries. In Ireland and the UK, in contrast, the cause of the disability makes no difference to long-term benefit support and survivors’ benefits are reliant on age. In both these countries, support for surviving spouses is far from automatic, but reflects their earning capacities.

The other side of the coin to minimal state support emerges in the fiscal compensation given to personal savings schemes in English-speaking countries – be these mandatory (as in Australian Superannuation), quasi-mandatory (auto-enrolment in DC pensions in the UK) or fiscally subsidized (401k plans in the USA). All are state-regulated and commercially managed, invested and administered schemes - forming variations on a theme of public-private partnerships of social protection. In this case designed principally to meet the exigencies of a secure old age income, but commonly offering protection in the event of premature death or disability – either as part of the main scheme (as in Australia) or as optional ‘add-on’ policies. The private sector, as subcontractor, is prominent in the provision of services for disabled people, notably those who live alone. However, deep cuts in local services are creating new dimensions to IPGs as provision is rationed and more emphasis and resources put into training and work activation. Income protection is ceasing to be a primary responsibility of government.

**Australia**

| Life expectancy at birth (and at 60) | 83 years (85 years) |
| Probability of dying before 70 (male) | 26 per cent |
| Probability of dying before 70 (female) | 17 per cent |

Australian pensions for those suffering disability or unexpected death are means-tested, bar compensation for work injuries and help for the blind. Traditional assessment is generous: claims for a disability pension are admitted for anyone unable to work whose assets are less than
A$200,000 - A$300,000 ($142,000 - $213,000 USD) - not including the family home. Contrast this with the UK savings limit of £16,000 ($24,000 USD). IPGs for most Australians thus transform into systems of wealth protection and the top earning 10 per cent of the population take out private health insurance and private disability insurance in consequence.

Work injury is compensated by employers and is commercially insured. Under conditions determined by individual states, 95 per cent of previous earnings is paid, but reduced after three months. In the event of unexpected death, a lump sum is paid to survivors and fortnightly payments made to children. These are offset against all claims for other state benefits. Those permanently and totally disabled (unable to work for 15 hours per week) may claim a means-tested A$1564 ($1110 USD) pcm. Auxiliary benefits cover caregivers, mobility, utility bills, pharmaceutical costs, etc. If the claimant is under 35, mandatory work-focused training is required. Survivors of an unexpected death can claim a means-tested A$1030 ($732 USD) pcm.

In 2012, a National Disability Insurance Scheme (NDIS) was initiated with the aim of raising social participation and labour market activation among all claimants under 65 by offering individually designed support, including training, mobility, and extra appliances, to enable a return to work. The programme is still being rolled out. In 2014, the federal government launched a medical re-review of disabled claimants with the object of redefining disability and promoting a return to the labour market. These policy shifts follow federal budget problems and reflect rising social costs.

Australia’s mandatory superannuation, a national DC pension scheme under commercial management, is fully funded by employers and covers all workers. Savings may be accessed in the event of permanent incapacity or premature death, but there is no obligation to provide for survivors. Complementary and mandatory life insurance cover guarantees superannuation contributions. A separate public health insurance scheme (Medicare) covers medical costs, supplemented by state-regulated private health insurance. Commercial insurers seek to extend private disability cover, with the benefit to the state of lower NDIS costs63.

Ireland

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<td>81 years (84 years)</td>
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<tr>
<td>Probability of dying before 70 (male)</td>
<td>30 per cent</td>
</tr>
<tr>
<td>Probability of dying before 70 (female)</td>
<td>20 per cent</td>
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Ireland’s budgets were under the aegis of the Troika until December 2013: austerity generated severe cuts in general services including disability-specific services and the abolition of early retirement. 2015 witnessed the introduction of the first non-austerity budget for seven years, but there was no increase in disability allowances or support, nor any measures to cover extra living costs that disabled people incur. In consequence, IPGs and the risk of poverty among people with disabilities remain above the EU average and this is mostly due to their non-employment64.

63 Financial Services Council (2014), op.cit.

Irish state-sponsored social insurance resembles the UK scheme: flat-rate contributions sustain rights to flat-rate benefits supplemented by means-tested social assistance. As in the UK, there is no separation of work injuries from other causes of disability: all claimants are subject to periodic medical reassessment. Unlike the UK, however, disability claims are admitted after one year on sickness benefits under a separate health insurance scheme. Support for non-working spouses and survivors is still available at up to 138 Euros ($156 USD), but is means tested if that partner’s income exceeds 100 Euros ($113 USD) per week. Disability benefits and concomitant survivors’ benefits are paid at a rate of 193.5 Euros ($219 USD) per week to all insured claimants who have paid (or whose deceased partner paid) five years’ contributions. Partial disability is compensated according to the degree of impairment. Means-tested disability (including blind persons) and survivors’ benefits can pay up to 188 Euros ($213 USD) weekly. Additional benefits may be paid for children, carers and dependent parents. Medication is covered by the health scheme, but no extra money is supplied to cover mobility or utility costs and labour market activation schemes do not specifically target people with disabilities.

Supplementary pensions (DB and DC) are widely provided in Ireland by both multinational and domestic employers. Both commonly offer either a lump sum or a pension following the death of a member in service. Neither offers compensation for the onset of disability that reduces member income.

United Kingdom

| Life expectancy at birth (and at 60) | 81 years (84 years) |
| Probability of dying before 70 (male) | 32 per cent |
| Probability of dying before 70 (female) | 22 per cent |

The IPG problem in the UK is severe. State support is low, flat-rate and arguably inadequate: awareness of benefit rights among potential claimants is poor. People with disabilities work overwhelmingly in low-paid, part-time jobs – this was 42 per cent above the EU average in 2014. Discounting housing costs, official figures for 2010-12 show 20 per cent of households containing a disabled person had incomes below 60 per cent of average earnings (commonly used as a poverty line).

In 2009, disability benefits cost more than unemployment benefits. The Coalition government’s welfare reforms aimed to correct this. ‘Losing a limb’, the UK Secretary of State for Work and Pensions remarked in 2012 ‘should not automatically entitle people to a payout.’ Under Employment and Support Allowance (ESA) £73.10 ($111 USD) (£57.90 if aged 16 to 24) a week is paid after a three-day waiting period for up to 13 weeks as capacity for work is assessed. Claimants then divide into two groups: one to undertake work-related activity, the other is a support group. ESA is paid as of right for one year for all insured workers. Thereafter, payments are income related

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65 Unlike other European schemes, workers’ representatives are not involved in benefit administration: access to UK benefits is centralised and complex.
69 Ian Duncan Smith quoted in The Telegraph: ‘500,000 to lose disability benefit’ 31 May 2012.
(means-tested). For a claimant in the support group, up to £125.05 ($193 USD) per week is payable: £102.15 ($158 USD) for those required to undertake work-related activity. Carer’s, mobility and housing allowances (etc.) are payable in addition as Personal Independence Payments. Income related ESA is subject to a household benefit cap set at £350 ($541 USD) a week for a single person or £500 ($772 USD) for a couple or a single parent with children. Survivors’ benefit is paid to survivors over 45 years and / or looking after young children. Payments start at £33.77 ($52 USD) per week at 45, mounting to £112.55 ($174 USD) at 55.

DB occupational pensions, which supplement the basic state pension, usually provide disablement income if needed; this is set off against means-tested ESA. Both DB and DC supplementary pensions may offer additional cover. DB pensions that had contracted out of part of the state pension must pay a survivor’s benefit at 50 per cent of the pension due to the deceased. Pension funds can be accessed in full at any time after age 55; like state pensions from 2016, there is no obligation to survivors and funds remain the personal property of the insured.

United States of America

| Life expectancy at birth (and at 60) | 79 years (83 years) |
| Probability of dying before 70 (male) | 38 per cent |
| Probability of dying before 70 (female) | 27 per cent |

In the USA, Social Security Disability Insurance (SSDI) is the largest federal earnings replacement programme for working-age adults. Impending insolvency in 2016 has fostered tighter access and currently only 40 per cent of claims are admitted, 15 per cent of these on appeal. It is supplemented by SSI (Supplementary Security Income), a federal social assistance programme for those with no or insufficient SSDI contributions that covers children, the blind, the elderly and people with mental problems. Work injury compensation is covered separately.

American work-related injuries are compensated under public or private employer-funded insurance, according to local state regulations. These offer 66.6 per cent of previous earnings for total incapacity in most states, with partial disability recompensed in proportion to lost earnings. Attendance allowances and dependents’ supplements are also supplied. Survivors can claim between 30 and 70 per cent of earnings, depending on state law. Other disability claimants, medically assessed as incapable of ‘substantial gainful activity’, can claim up to 100 per cent of earnings averaged since the age of 21 under SSDI. Survivors’ benefits covering unexpected death are fixed at 50 per cent of SSDI benefit up to the age of 62, but subject to an earnings test that cuts $1 for every $2 earned above $15,180 and a further $1 for every $3 earned above $41,500.

In addition to the minimum $1097 USD per month for insured applicants, SSDI offers medical services via Medicare, a substantial benefit in a country where health costs are notoriously high. In 2012, nearly nine million adults (about 3 per cent of the working population) were in receipt of SSDI benefits: as a percentage, this had more than tripled since the 1980s. Although voluntary work retraining with medical help under Vocational Rehabilitation is on offer, in 2011 barely 1 per cent of claimants left the register to return to work. There is no activity or work-related conditionality.

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attached to SSDI payments, but thanks to the scheme’s incipient insolvency, examples set by other countries are receiving serious attention\textsuperscript{71}.

US employers commonly offer supplementary private pension cover (DB or DC) which is required to offer survivors at least 50 per cent of accrued pension rights following death in service. Disability cover may also be supplied, but this is less common. Additionally, many employers sponsor joint tax-privileged saving schemes (such as 401k) that can provide support in the event of disability or accidental death – but membership remains voluntary.

**APPENDIX III: Latin America**

An overview

In contrast to Europe, average ages in Latin America are comparatively low: the median population age ranges from 27 to 34 years, in contrast to European averages of 39–46. The risk of premature death is also higher, as the following chart demonstrates:

*Figure 11: Premature (15–60) death rates in Latin America*\textsuperscript{72}

However rising longevity suggests that, in the future, population ageing will generate similar IPG problems to those currently found in most EU member states. As the following chart shows, rates of disability increase with age and greater longevity will mean higher proportions of disabled workers.

\textsuperscript{71} Morris, Z.A. (2015) op. cit.

\textsuperscript{72} WHO (2013).
The major IPG threat in Latin America today reflects the position of the individual in the labour market. All countries, most notably Mexico, have large informal employment sectors, for which there is no systematic income support; hence the low incidence of notified disability in Figure 11. For these groups, the emergency occasioned by disability, disease or sudden death is met by recourse to family help or means-tested social assistance. Among growing numbers of elderly, family forms the main protection against destitution. Yet rising female labour market participation rates in urban areas makes informal family care increasingly problematic and personal income protection in the form of state-funded pensions is essential.

Latin American income protection schemes are rooted in European labour law and earnings-related social security schemes, of which they are essentially copies. As in Europe, these systems privilege the regularly employed and better paid sections of the labour force. Those in formal employment enjoy job protection and, in some cases, fringe benefits under collective agreements, such as occupational pensions or additional health provision, all safeguarded in law. Since 2000, economic growth has extended formal employment contracts, mostly in multinational firms employing male skilled workers, raising urban household income while improving tax and social insurance

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ECLAC (2012). N.B. Disability rates are derived from official surveys executed in various years and thus comparison between countries is rendered highly problematic. Age distributions within countries remain valid.

For urban households, earnings-related state social security protects spouses and dependents in the event of disability or premature death. As in Europe, these benefits are attached to pension insurance (both state and occupational schemes) and are heavily skewed towards professionals and skilled workers.

A burgeoning urban middle class demands better standards in health and social benefits than many countries have been able to supply. As wealthier governments use extra revenue to extend protection to the poor, private providers supplement state provision. In various ways, government policies converge to generate public-private pension combinations. In 1981, Chile’s military dictatorship famously became the first to scrap social insurance-based pensions in favour of mandatory pre-funded personal accounts, but thanks to paltry personal saving capacity, government now subsidises the savings of the lower paid and provides a solidarity basic pension. Conversely, President Lula da Silva (Brazil) extended social insurance pensions to rural non-contributing workers, while offering tax incentives to corporations to create supplementary occupational and personal pension schemes. In this fashion, governments of both left and right have collaborated with commercial providers to generate mixed pre-funded and tax-subsidised income protection to meet demand.

However, current settlements are neither permanent nor perfect: promises made notably in Mexico and Brazil may provoke future fiscal crisis. While incentives are widely offered to employers to

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75 Poverty headcount ratio weighted by country population; poverty rate = US$ 4 per day.  
76 SEDLAS (2013).
formalise employment contracts, less has been done to address the situation of informal workers, except in Brazil. Workers shift between formal and informal jobs. Earnings-related income protection, funded or otherwise, depends on contribution records generated by continuous employment and switching between sectors may not secure protection in the event of a household emergency. Segmentation between formal and informal labour markets is not clean and neat. Health impairments tend to mean demotion to less secure jobs. Latin American social assistance budgets have grown over the past decade, largely thanks to extensions in social pensions that – in countries with older populations like Brazil, Uruguay and Chile – have been extended to protect against old age poverty. Should economic recession succeed recent growth, middle class households may find income security inadequate.

Argentina

<table>
<thead>
<tr>
<th>Description</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth (and at 60)</td>
<td>76 years (81 years)</td>
</tr>
<tr>
<td>Probability of dying before 70 (male)</td>
<td>50 per cent</td>
</tr>
<tr>
<td>Probability of dying before 70 (female)</td>
<td>31 per cent</td>
</tr>
</tbody>
</table>

In Argentina, a major extension of formal employment and a 60 per cent expansion in state social protection to cover two-thirds of the working population has occurred since the 1990s. Under labour law, work injuries are compensated by the employer for three to six months at full pay. Severance pay is given for total disability and re-employment by the employer is mandated for the partially impaired. All employers contribute to the Labour Risk Insurance Company (ART) which provides medical care, rehabilitation and employment retraining as required; supervises health and safety at the workplace; and registers regulated insurance companies that offer life cover and compensation for lost earnings at 66 per cent of previous wages. Rehabilitation for informal workers is provided under regional social assistance schemes.

Non-work-related incapacity is compensated by state pensions covering 66.4 per cent of salaried workers in 2011. Until 2008, this was organised solely under mandatory personal DC pensions managed by the private sector, but has since been unified under state direction to cover disability, survivors’ and retirement benefits. Pensions are now partly offered by an integrated state pension (SIJP) and partly by personal accounts (AFJP), the latter including member choice of state-registered providers offering regulated investments. In both cases, benefits are earnings-related up to a capped level. Workers’ health and medical needs are covered by Obras Sociales, a health insurance scheme jointly run by employer and trade union representatives. Local tax-funded labour market activation schemes provide publically funded jobs for the unemployed and partially incapacitated.

In addition to statutory protection, legally enforceable collective agreements may offer additional health cover, occupational pensions that include protection for survivors and incapacitated workers and other fringe benefits such as life insurance. Tax-privileged AVCs can add to AFJP accounts. IPG problems are thus largely confined to a currently shrinking informal sector, which has to turn to

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78 Baker and Mackenzie (2012) Overview of Labor and Employment Law in Latin America

79 Cerruti, P. et al. (2014)
means-tested local social assistance in the event of accident, illness or premature death. Disability costs under social assistance run to roughly 0.5 per cent of GDP\(^80\).

**Brazil**

<table>
<thead>
<tr>
<th>Life expectancy at birth (and at 60)</th>
<th>74 years (81 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probability of dying before 70 (male)</td>
<td>53 per cent</td>
</tr>
<tr>
<td>Probability of dying before 70 (female)</td>
<td>36 per cent</td>
</tr>
</tbody>
</table>

Over the last decade, poverty in Brazil has fallen and formal employment has spread (by 10 per cent 2003-11\(^81\)), reflecting annual economic growth rates of 3.6 per cent (2000-10) - although today China’s economic slowdown, rising inflation, public debt and social unrest threaten recession. If this occurs, caps on state protection may tighten as policy remains dedicated to protecting the rural poor which will raise IPGs in urban households.

State welfare provides disability and premature death benefits under an earnings-related pension system that covered 75.6 per cent of the working age population by 2011. Income protection for the disabled divides between work injury compensation, funded by employers; state insurance benefits, both paid at about 80 per cent of average previous earnings; and means-tested social assistance. The Old Age and Disability Grant is set at the minimum wage for rural workers. There are no rehabilitation programmes: a disability pension is not conditional on labour market withdrawal. Rural workers, who do not contribute to social insurance, have the same benefit rights as urban workers, who do: rural pensions are set at a minimum wage that has risen by 50 per cent (2003-10). Survivors (parents or young siblings under 21 as well as spouse and children) can claim the pension due (or, for early death, would have been due) to the deceased. Social expenditure has risen to 11.3 per cent and health expenditure to 9.7 per cent of GDP: contrast with India’s social expenditure at 2.5 per cent. As state social insurance is earnings-related, it privileges better-off urban workers: about 84 per cent of graduates are covered. Income protection risks are most severe for young families, as family support is set at minimum wage and deaths due to conflict and accident are comparatively high.

Private insurance is well established; employers commonly provide healthcare plans and life insurance, sometimes under collective agreements. Supplementary DB and DC private pension schemes cover professionals and high earners; these have expanded as state benefits fail to match inflation. Public sector employees subscribe to a mandatory DC scheme that pays a lump sum on leaving the service. About 25 per cent of the population have private cover for health, pension or private education. Encouraged since the 1960s, this is heavily skewed towards higher income earners, is subject to few legal requirements and may supply additional benefits in the event of disability or premature death. Private health standards in Brazil compare favourably with Germany or Finland. Brazilian society remains highly socially stratified, with possession of private cover

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\(^{80}\) Ibid: 26.
preferred by the middle classes\textsuperscript{82}. Market-based social services are the legacy of policies that, until 2000, fostered private social protection. Social inequality remains high.

**Chile**

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<thead>
<tr>
<th>Category</th>
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<tbody>
<tr>
<td>Life expectancy at birth (and at 60)</td>
<td>80 years (84 years)</td>
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<tr>
<td>Probability of dying before 70 (male)</td>
<td>37 per cent</td>
</tr>
<tr>
<td>Probability of dying before 70 (female)</td>
<td>23 per cent</td>
</tr>
</tbody>
</table>

Among the more urbanised of Latin American countries, Chile’s informal labour market is small and living standards are higher. IPGs are found among workers without permanent job contracts (casuals, sub-contractors, self-employed) who have to rely on means-tested help in the event of permanent injury or premature death. Work injuries are covered by mandatory employer-funded social insurance. Large firms self-insure; others enrol under either the state-run Labour Safety Institute or a private employers’ mutual scheme. The system supplies medical care and rehabilitation and pays 100 per cent of average monthly earnings for one year. Should disability prove permanent, 70 per cent of average previous earnings is paid or 35 per cent for partial disability with medical reassessments every two years. Survivors receive a capped 50 per cent of the deceased’s pension (for one year only if under 45 years old).

In 1981, Chile was one of the first countries to introduce mandatory funded DC personal pension accounts that replaced PAYG state pensions. This legacy remains reflected in a multi-tiered social protection system, covering about 82 per cent of the working population as of 2011, that also provides for survivors and workers suffering from disability. Means-tested social assistance supports informal workers. The old earnings-related social insurance pension scheme, based on tripartite contributions, is now disappearing as those it covered pass on. In its place, personal savings accounts are vested with registered insurance companies and funded by earnings-related worker contributions. 14 per cent of salary covers retirement, disability and survivors’ benefits. As most middle class and workers’ accounts are too small to sustain these costs, a solidarity insurance contribution is paid by government to about 60 per cent of personal accounts as a subsidy. Disability is assessed by lost earnings: 66 per cent or more of income lost gains a full pension and 50-66 per cent a partial pension, commonly based on an annuity. The reference pension is 70 per cent of average taxable income over the previous ten years. Separate health insurance, again paid for by the worker, covers medical costs.

As the state underwrites personal funded schemes to meet income protection risk, so it seeks to promote voluntary savings to contain future costs. Members of the state personal account scheme may make collective or personal AVCs to their fund, or for better-off contributors, to facilitate early retirement. Tax privileges encourage savings among the lower paid. IPG risk remains highest for the informal working sector where social assistance remains the major resource, providing nearly 90 per

cent of social support for the lowest income quintile in 2009 and doubling state expenditure under the Basic Solidarity Disability Pension, introduced in 2008.

**Mexico**

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
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<tbody>
<tr>
<td>Life expectancy at birth (and at 60)</td>
<td>76 years (82 years)</td>
</tr>
<tr>
<td>Probability of dying before 70 (male)</td>
<td>47 per cent</td>
</tr>
<tr>
<td>Probability of dying before 70 (female)</td>
<td>34 per cent</td>
</tr>
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</table>

Disability levels in Mexico are virtually unknown as income protection is low and covers only a fraction of the working population. Most people with work incapacities merge into the informal economy or rely on family support. This explains an unexpected disability distribution between income quintiles\(^83\): the incidence is higher for middle income earners than it is for the very poor. Mexico boasts the lowest social mobility, the lowest per capita health spending, the greatest gender inequality and lowest minimum wage of all OECD countries. It also has the second highest rate of obesity in the world (after the USA). Extreme social inequality, high levels of informal work and the highest level of infant mortality distinguish Mexico from other Latin American countries\(^84\).

Social security only covers public sector employees and formally employed private sector workers, estimated at 37 per cent of the working population in 2010. After three to five years’ contribution to mandatory personal (DC) accounts, managed by a state agency (AFORE), a full or partial disability pension can be claimed at 35 per cent of average salary over the previous ten years. Limited survivors’ benefits are also offered at 40 per cent (20 per cent for children) of previous disability benefits. Such payments are meagre. Work injuries are not distinguished for separate treatment, but the scheme draws on occupational hazard insurance reserves to subsidise their cost. Tax-privileged voluntary top-ups are encouraged under the AFORE scheme. These publically managed but privately invested social security personal accounts include voluntary sub-accounts for retirement and housing savings. However, disabilities and survivors’ benefits are only paid at a very low rate: there is no provision for rehabilitation or labour market activation (female labour market activity is very low). A reform programme introduced in 2013 increased tax-funded transfers to the poor and created a universal minimum pension in an initiative to tackle Mexican poverty, but no record exists to date of its effects.

Voluntary occupational schemes, notably additional health and retirement cover, and personal insurance are both provided by major firms or commercial insurance companies. As the Mexican economy is growing – and as government prioritises protection for poor families who desperately need it – the provision of state-run income protection or health care to people further up the income scale is unlikely.

**Uruguay**

<table>
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<tr>
<th>Description</th>
<th>Value</th>
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<tbody>
<tr>
<td>Life expectancy at birth (and at 60)</td>
<td>77 years (82 years)</td>
</tr>
<tr>
<td>Probability of dying before 70 (male)</td>
<td>48 per cent</td>
</tr>
</tbody>
</table>

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\(^{83}\) See Summary sheet for Mexico.

Probability of dying before 70 (female) 27 per cent

Uruguay stands out among Latin American countries for the high coverage of a social protection system that embraces 77 per cent of the adult population. Since 1995, mandatory personal savings have supplemented a tripartite PAYG social insurance system to offer additional funded protection in the event of disability, premature death and retirement. All but the low paid must establish a personal account with a state agency created for the purpose (AFAFS). By 2011, 84 per cent of workers were contributing to funded personal accounts. Work accidents are covered by a separate scheme run by the Social Insurance Bank and paid for by employers: the Bank assesses severity of injury / impaired earnings and pays benefits to both victim and survivors based on previous earnings (100 per cent for permanent disability with proportionate sums reflecting lost earnings in partial cases). Survivors can claim 75 per cent of previous average earnings should the victim die.

In the event of disability or premature death due to other causes, social insurance benefits cover 65 per cent of earnings as averaged over the previous 20 years for any claimant assessed as 66 per cent impaired and incapable of any work. The partially impaired (50 – 65 per cent) can claim a temporary pension of the same sum for three years, followed by a reassessment. In addition, 45 per cent of average earnings for the previous ten years can be claimed from the personal account (and, similarly, the same sum for three years for partial disability). Extra sums can be claimed for permanent attendance if needed. Survivors can claim for 12 months 66 - 75 per cent of any pension in payment should the victim die. This pension continues indefinitely if the deceased contributed for ten years.

This comprehensive scheme is capped, but tax incentives foster AVCs to personal accounts. The informal sector is limited in Uruguay, but incentives to formalise employment to extend income protection cover remain in place. Very high earners are excluded but complementary plans provide coverage outside the state scheme.

APPENDIX III: Southeast Asian countries

An overview

As this section covers two urban communities (Singapore and Hong Kong) and two much larger countries (Malaysia and India), we do not compare like with like as the last two contain substantial numbers of informal workers and policy necessarily focuses resources primarily on those below the poverty line in order to guarantee primary level education, diet and shelter for populations who need it most. India’s very high incidence of premature death can partly be ascribed to a society riven by divisions of income, caste and gender, but also reflects fractured health care rarely accessible outside major cities.

Figure 14: Premature (15-60) death rates in Southeast Asia

According to the ILO, the number of people in Southeast Asia with basic income protection of any type is estimated at around 10 per cent. The overall spending on all social programmes averages 8 per cent of GDP, the lowest of any ILO region. Targeted assistance encounters substantial difficulties in identifying who should benefit from government schemes that necessarily talk a language of rights – most notably the right to food and shelter – rather than income replacement.

The most common forms of income protection are mandatory national provident funds (NPFs). Introduced in the colonial period, these funded personal savings schemes were originally designed to provide a lump sum on retirement, but are now largely annuitised. NPFs in Singapore and Malaysia have a long history dating back to the 1950s: savings were used to fund economic development. Hong Kong introduced a mandatory privately-run equivalent in 2000. NPFs are also found in less regular form throughout India, but as they are confined to formal workers, they only cover a tiny fraction of the working population. State ownership in Singapore and Malaysia kept administrative costs low as schemes are non-competitive and funds, originally directed to government securities, are now partly invested offshore - forming over 40 per cent of GDP in both countries by the late twentieth century. Fund management is private, but subject to government

86 WHO (2013). N.B. figures for Hong Kong are not available.
87 ILO (2010), World Social Security Report 2011/12 Geneva
regulation: funds have financed urban development and infrastructure projects; schools and hospitals; and home, health and dependents’ insurance in varying combinations. In Singapore and to a lesser extent Malaysia, provident funds have evolved into personal social security savings plans; they finance a wide range of personal projects from pre- and post-school education to mortgage finance for home ownership. Such schemes have fostered habits of long-term saving while enabling regional growth and extending welfare under low-tax economies. Although access to savings before retirement is formally sanctioned, the schemes offer lump sums or draw-down income in the event of disability or premature death. Indonesia has followed the example established by Singapore and Malaysia, demonstrating the regional preference for NPFs over social insurance schemes. There are concerns that, in ageing societies, national provident funds will prove as vulnerable as PAYG pensions as a means of protecting the elderly as life expectancy lengthens.

**Hong Kong**

| Life expectancy at birth (and at 60) | 81 years (87 years) |
| Probability of dying before 70 (male) | Per cent |
| Probability of dying before 70 (female) | Per cent |

In December 2014, the population in Hong Kong was approximately 7,264,100, including almost 3,670,000 in the labour force. The labour participation rate was 60.7 per cent (69.4 per cent in male and 53.1 per cent in women). Over the past 5 years, the average annual incidence of work-related injuries was about 50,000 and work-related deaths stand at 200 people p.a.

The current social security scheme, introduced in 1966, has two main components. The first is a tax-funded, comprehensive social assistance and public welfare scheme. This offers a universal allowance to all disabled people (up to $3,050 HKD - $393 USD) unable to undertake any work, topped up by a means-tested assistance supplement of up to $5,600 HKD ($722 USD) in cases of need, plus medical care if required. The second component consists of mandatory pension insurance in the form of private provident funds (very similar to a mandatory DC pension system), with contributions capped at $30,000 HKD ($3,866 USD). Employers fund health care insurance and work-related injury compensation. Provident funds, introduced in 2000, can be liquidated in the event of permanent disability or unexpected death. Additional contributions above the statutory minimum are permitted.

Work-related compensation operates as a typical employer-liability scheme. It provides compensation for injury-related work absence at 80 per cent of average income, for the permanent loss of working ability and covers the cost of medical treatment. For a work-related death, family dependents receive a lump sum equivalent to a total of 36-84 months’ income. If there are no family dependents, the insurance company pays for funeral expenses. In March 2015, the Labour

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89 Malaysia recently added a social insurance system to complement the Malaysian Employees’ Provident Fund, but only for the low paid who are generally unable to save enough on a personal basis.
Department raised the amounts paid under 18 work-related types of injury\textsuperscript{90}. All expenditure must comply with the minimum standard.

In Hong Kong, work-related injury compensation and provident funds are run by private insurance companies. All employers must contribute. There are over 50 insurance companies in Hong Kong involved in work-related injury compensation. Insurance costs mainly come from insurance brokerage commissions and management fees. Provident funds closely resemble DC pension schemes. They are run by trustees: asset management is private, regulated by the Mandatory Provident Funds Scheme Authority which stipulates how funds are invested. Benefits reflect individual account balances. Some members of occupational pension schemes are exempted from holding a mandatory provident fund account. Additional compensation for those with insufficient savings is offered under tax-funded public welfare.

India

<table>
<thead>
<tr>
<th>Life expectency at birth (and at 60)</th>
<th>66 years (77 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probability of dying before 70 (male)</td>
<td>69 per cent</td>
</tr>
<tr>
<td>Probability of dying before 70 (female)</td>
<td>60 per cent</td>
</tr>
</tbody>
</table>

According to the 2011 census, India’s population is 1.21 billion; over 30 per cent live in urban areas and only 7 per cent are aged over 60. Between 5 and 8 per cent of Indians suffer from a disability (55-90 million people). If a breadwinner becomes disabled, household income falls by an estimated 21 per cent\textsuperscript{91}. About 300 million Indians live in poverty, most inhabit rural areas and form the primary focus for social protection policies (rural employment schemes, housing, food and fuel subsidies). In a society segregated by social caste, religion, gender and region, distributing the benefits of recent economic growth in an inclusive fashion poses great difficulties. Responsibility for health is vested in the states, while new health programmes are nationally subsidised, most health provision remains in private hands.

Excluding the well-protected public sector (including the military), work injury in the private sector is compensated by social insurance in nearly all states: coverage is very low, but is gradually extending from 790 industrial concerns in July 2014\textsuperscript{92}. This scheme offers workers earning up to 15,000 Rupees per month ($225 USD) 90 per cent of previous earnings for a temporary disability, with a permanent pension dependent on lost earning capacity. A surviving spouse can claim 60 per cent of the pension and an orphan 40 per cent. Other disabilities may be covered by mandatory provident funds and survivor insurance for workers earning less than 15,000 Rupees ($ 225 USD) per month in most Indian states. Special schemes exist for coal miners and railway workers. However, these schemes only cover about 10 per cent of the working population as approximately 90 per cent work in the informal economy. Social assistance covers the death of the breadwinner and pensions for the severely disabled in households below the poverty line at 200 Rupees per month ($3 USD)\textsuperscript{93}: about 14 per cent of people certified as disabled receive a pension\textsuperscript{94}.


\textsuperscript{92} See ISSA website https://www.issa.int/country-details?countryId=IN&regionId=ASI&filtered=false

To extend protection, national and state governments subsidise self-help, mutual, local and private insurance systems. Fund management of statutory schemes such as the National Pension Scheme and the Employees Provident Fund is private: multiple health insurance systems receive direct or indirect tax-funded subsidies. The Life Insurance Corporation and the General Insurance Corporation are the largest. The former covers 3.6 million households (2006) against the risks of disability and premature death. That said, 86 per cent of expenditure on health care is still out-of-pocket. According to the World Bank, ‘the private insurance market is still in an early stage of development’. Life insurance policies, some covering accident and disability, were held by 50 per cent of the top earning quintile. Through partnerships between the public and private sectors, the Indian government seeks to extend income protection to a greater proportion of its vast population, but fractured governance, uneven provision between urban and rural sectors and poor regulation militate against efficient health provision, explaining India’s poor performance on international comparative tables.

Malaysia

Life expectancy at birth (and at 60) 73 years (77 years)
Probability of dying before 70 (male) 52 per cent
Probability of dying before 70 (female) 38 per cent

Malaysia is a multi-ethnic country with a population of 30.19 million; there are three major ethnic groups: Malays, Chinese and Indians. The labour participation rate in 2014 was 60 per cent (76 per cent male and 44 per cent female).

Social protection for employees in Malaysia is multi-tiered according to income. It includes an Employee Provident Fund (EPF) for all regular employees not covered by the civil service pension scheme, and a joint-funded social insurance scheme run since 1969 by the Social Security Organisation (SOCSO) that covers work-related injuries and diseases and offers invalidity pensions for all workers earning less than 3,000 Ringgits ($697 USD) per month. Occupational pension schemes, founded on collective agreements, can allow an opt-out from the EPF. Social assistance is offered for impoverished elderly people who have not accumulated sufficient pension contributions. Although the formal social protection system in Malaysia appears comprehensive, its coverage is patchy and benefit levels inadequate. The state contributes to the EPF, but not to the social insurance scheme: employers contribute 13 per cent of payroll to the former and 1.5 per cent to the latter. The system is thus heavily skewed to benefit the better-off.

Social security benefits include medical treatment, disability benefits (50 – 65 per cent of previous average salary, depending on the severity of impairment), constant attendance allowance, rehabilitation, survivors’ benefit (at 60 per cent of benefit) and funeral costs. Work-related invalidity or death is compensated at 90 per cent of previous wages if disablement proves permanent: 80 per

94 World Bank (2009) People with Disabilities in India Human Development Unit: South East Asia region: 112.
95 Ibid: 114
98 The Economist Intelligence Unit (2014).
cent for temporarily disabled workers. For a work-related death, survivors (spouse unless remarried or children until 21 years old) receive 90 per cent of average daily wage. However, thanks to the cap on social insurance, benefit rates remain low.

The EPF scheme is well established and, as in Singapore, can offer support for a range of welfare costs, including education, house purchase and Hajj pilgrimage as well as protection against old age, invalidity and premature death. Generously financed (tri-partite contributions total over 25 per cent of salary p.a.), the government guarantees 2.5 per cent p.a. (compound interest) – part of the fund for high earners can be drawn down for investment in approved unit trusts. In the event of disablement or premature death, all savings can be accessed before the age of 55 to compensate survivors or an income to people with disability and to cover medical and/or social care costs. The insured person and their household can make additional contributions above the required 11 per cent of monthly earnings to their EPF fund: there is no upper limit on savings.

**Singapore**

<table>
<thead>
<tr>
<th>Life expectancy at birth (and at 60)</th>
<th>80 years (85 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probability of dying before 70 (male)</td>
<td>29 per cent</td>
</tr>
<tr>
<td>Probability of dying before 70 (female)</td>
<td>18 per cent</td>
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</table>

The population in Singapore in 2014 was 5,470,000, a figure that includes local citizens (64 per cent), permanent residents (10 per cent) and foreigners with work, visit or student visa permits (26 per cent). The labour force participation rate in 2014 was 68 per cent (77 per cent male and 65 per cent female). The average number of work-related injury cases is around 4500 p.a., including c. 75 fatalities with shipbuilding and construction supplying the highest incidence work-related invalidity and death. In addition, over 15,000 cases of occupational disease are reported every year.

Employers are responsible for work-related injuries: they either insure all employees or pay directly. Work injury compensation includes a maximum of 14 days’ full salary for out-patient services and 60 days’ full salary for hospital in-patient services, plus 67 per cent of salary for a maximum duration of 12 months. Employees can claim up to maximum compensation of $30,000 SD ($21,156 USD) for medical treatment. If the injury is permanent, compensation equals the monthly salary multiplied by a coefficient reflecting age and lost working ability. The minimum and maximum of compensation is $73,000 and $218,000 SD ($51,480 USD - $154,000 USD) assessed by lost working capacity. An additional 25 per cent of the compensation is available for full-time care if required. In the event of death, survivors receive a lump sum calculated on previous salary and age at death ($57,000-$170,000 SD).

Singapore’s Central Provident Fund is a mandatory individual saving system, operated by the Central Provident Fund Board that covers all workers, including the public sector and the self-employed. A joint contribution of employer and employed at 21 per cent of salary funds four accounts that provide for each member to cover retirement, sickness, education and housing costs. Voluntary joint additional payments must not exceed $30,500 SD ($21,500 USD) p.a. The funds are used to support households in the event of total disability (medically certified) or unexpected death.
of the fund holder – either by supplying a draw-down income or through the provision of a lump sum equal to accumulated balances.
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