Coverage by other branches of social security

6

6.1 Employment injury

Most countries in the world offer some coverage for work-related accidents (see figure 2.6). Many also include "occupational disease": illness or disease related to employment. In fact, in most countries employment injury was the first contingency covered by social security; these schemes are often closely linked to occupational health and safety regulations. Many schemes also include preventive elements, aimed at improving workplace safety. However, coverage is limited to those working in the formal economy, and even there effective coverage is low with only a certain portion of accidents reported and compensated. In the informal economy prevailing in many low-income countries, conditions and safety of work are often dramatically bad, accidents and work-related diseases widespread and with no protection at all for their victims.

According to ILO Convention No. 102 (Article 32), the contingencies covered include the following accident-at-work or employment-related diseases:

(a) sickness ("morbid condition");

(b) temporary incapacity for work resulting from such a condition;

(c) total or partial loss of earning capacity, likely to be permanent; and

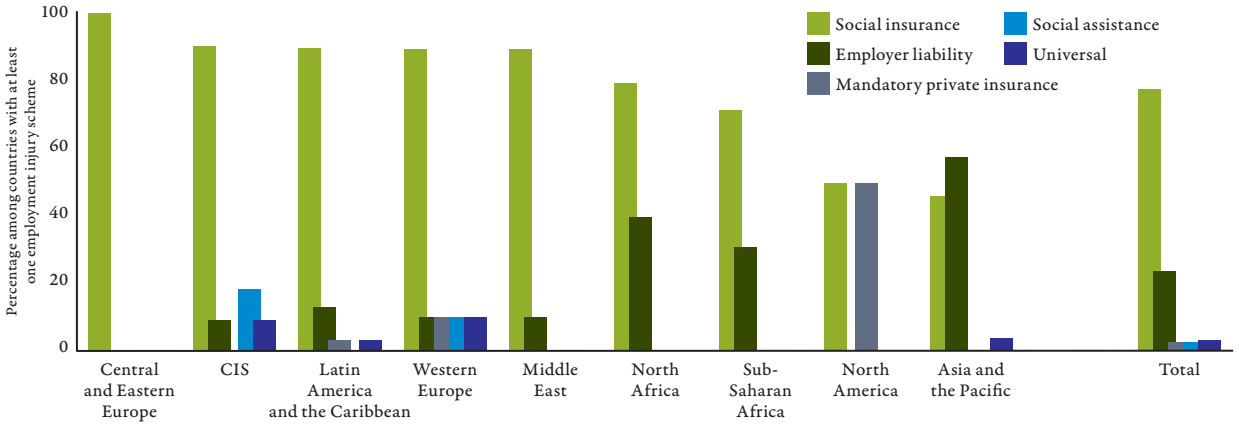
(d) the loss of support suffered by dependants as the result of the death of the breadwinner.

The range of benefits required by Convention No. 102 includes necessary medical care, sickness benefit for the period of incapacity for work, disability pension in case of loss of earning capacity, and survivors' pension in case of death of a breadwinner.

Employment injury schemes providing the above benefits are often organized on a contributory basis, sometimes constituting a separate fund, sometimes merged with other social security branches. Since it is intended to link risk at the workplace with prevention targets, most countries have decided to organize employment injury schemes separately. Because of this link between workplace risk and prevention, employment injury schemes in many countries are financed from employer contributions only, which are assessed according to the specific risks in the workplace. Contribution rates are often differentiated according to the level of risk of accident or disease in different types of economic activity; this is intended to provide an incentive to enterprises to invest in reducing the probability of accidents and in other preventive measures.

Figure 6.1 shows types of employment injury scheme by region and highlights the predominance of social insurance schemes. All countries where at least one employment injury scheme of any kind exists are included in the figure. Central and Eastern Europe is the only region where social insurance schemes represent the totality of employment injury coverage; in all other regions they are complemented by employer liability schemes, especially in Africa, Asia and the Pacific. In North America, Canada has a social insurance scheme, while in the United States private insurance is mandatory.

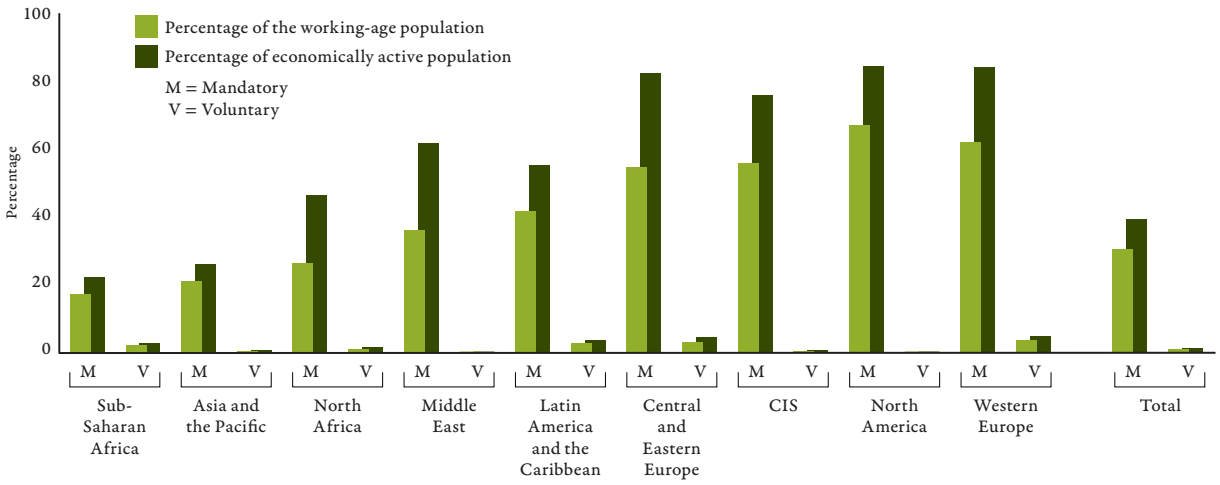
Figure 6.1 Types of scheme providing protection in case of employment injury, by region, 2008–09 (multiple responses)



Link: http://www.socialsecurityextension.org/gimi/gess/RessFileDownload.do?ressourceId=15161

Source: ILO Social Security Department based on SSA/ISSA, 2008, 2009. See also ILO, GESS (ILO, 2009d).

Figure 6.2 Extent of legal coverage by employment injury scheme, 2008–09



Link: http://www.socialsecurityextension.org/gimi/gess/RessFileDownload.do?ressourceId=15244

Sources: ILO Social Security Department based on SSA/ISSA, 2008, 2009; ILO, LABORSTA (ILO, 2009e); national legislative texts; national statistical data for estimates of legal coverage. See also ILO, GESS (ILO, 2009d).

Globally, estimated legal coverage represents less than 30 per cent of the working-age population, which is less than 40 per cent of the economically active.

However, there are large regional differences in legal coverage (see figure 6.2). In Central, Eastern and Western Europe as well as the CIS region and North America, around three-quarters of the economically active population is covered by employment injury schemes, whereas in Africa and Asia only around 20 per cent of this target group is covered (mainly by employer liability schemes).

The group most concerned by work injuries and diseases, as well as occupational accidents, are migrants, both regular and irregular. In most of the receiving countries – be they high-, middle- or low-income – a majority of migrants work in the informal economy, which is globally the most important source of jobs for migrants. This situation pertains more in developing countries, such as in Egypt where some 70 per cent of all migrants start working in the informal economy; less in Europe, where irregular migrants are estimated to represent at least 1 per cent of the population (Romero-Ortuño, 2004).

Irregular migrants are vulnerable because they lack legal protection and face exclusion, very low incomes and exploitation. Work is most often in mining, construction, heavy manufacturing and agriculture, sectors with significant impacts on health; but among the most vulnerable are women working in private households.

The majority of these workers have no social protection in case of employment-related disease or accident, and they have no money to pay for any treatment they might need (Scheil-Adlung, 2009). According to the International Centre for Migration and Health,[1] in Europe the risk of occupational accidents for migrants is about two times higher than for the local workforce. Observations in African countries indicate a high incidence of occupational diseases due to chronic and unprotected exposure to pesticides and other chemical products. Unfortunately, data on effective coverage (including access to health services) exist only for selected countries – both in terms of numbers of employees effectively covered by contributions actually paid to various insurance schemes and in terms of beneficiaries of various benefits actually paid. Figure 6.3 presents the number of active contributors (or in some cases, of protected persons) as a percentage of total working-age population and total employment. Only for selected countries is there also information available on types of employment injury benefits paid – such as sickness benefit and disability and survivors' pensions – and their levels.

Still, existing data on occupational injuries can be used to some extent to assess the number of beneficiaries, since for many countries the sources of data are either labour inspections or employment injury schemes; these therefore include injuries compensated, with the relevant benefits. What is not available on a wider scale is information on unreported and uncompensated injuries. To assess this effective coverage one would need to rely more on information collected through specialized surveys.

The ILO statistical database LABORSTA (ILO, 2009e) contains national series on occupational injuries.[2] They represent the official statistics provided by the relevant national agencies to the ILO Department of Statistics, for publication in the annual ILO *Yearbook of Labour Statistics* (ILO, 2009i). The national agencies are requested to provide the data in conformity with the most up-to-date international statistical guidelines in this field, currently the Resolution concerning statistics of occupational injuries (resulting from occupational accidents) adopted by the Sixteenth International Conference of Labour Statisticians (ICLS) (Geneva, 1998). The Resolution contains the following definitions for statistical purposes:

(a) *occupational accident*: an unexpected and unplanned occurrence, including acts of violence, arising out of or in connection with work which results in one or more workers incurring a personal injury, disease or death;

as occupational accidents are to be considered travel, transport or road traffic accidents in which workers are injured and which arise out of or in the course of work, i.e. while engaged in an economic activity, or at work, or carrying on the business of the employer;

(b) *commuting accident*: an accident occurring on the habitual route, in either direction, between the place of work or work-related training and

(i) the worker's principal or secondary residence;
(ii) the place where the worker usually takes his or her meals; or
(iii) the place where he or she usually receives his or her remuneration;

which results in death or personal injury;

(c) *occupational injury*: any personal injury, disease or death resulting from an occupational accident; an occupational injury is therefore distinct from an occupational disease, which is a disease contracted as a result of an exposure over a period of time to risk factors arising from work activity;

(d) *case of occupational injury*: the case of one worker incurring an occupational injury as a result of one occupational accident;

(e) *incapacity for work*: inability of the victim, due to an occupational injury, to perform the normal duties of work in the job or post occupied at the time of the occupational accident.

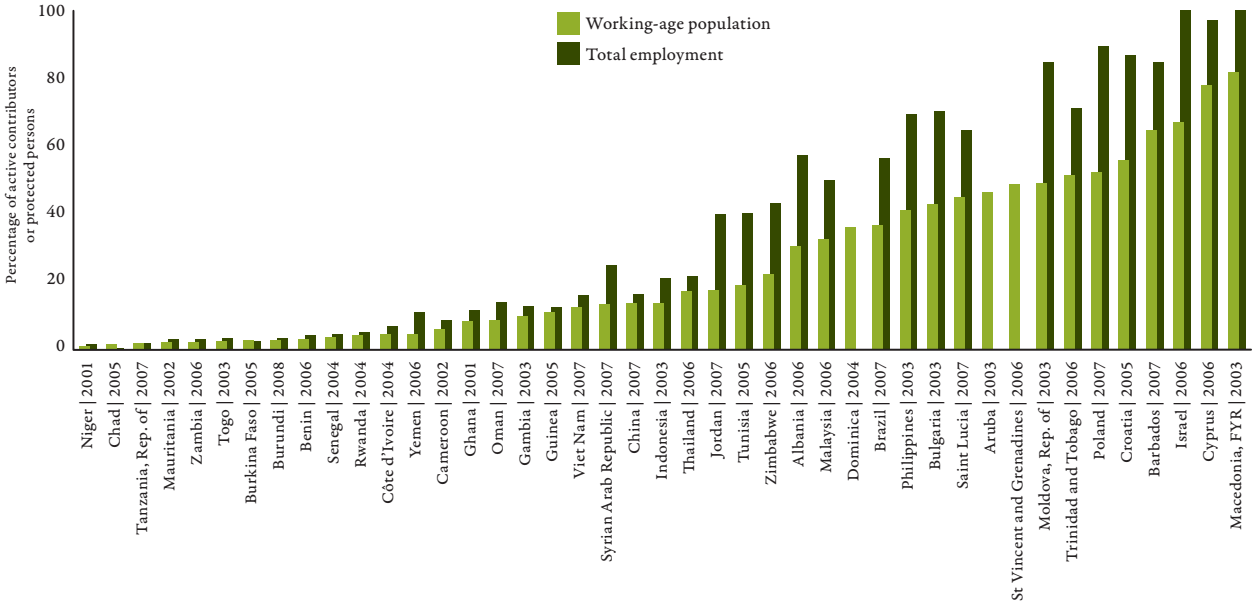
The Resolution also recommends that the statistics should cover all workers regardless of their status in employment (i.e. both employees and the self-employed, including employers and own-account workers), and the whole country, all branches of economic activity and all sectors of the economy.

The following are generally excluded: cases of occupational disease (an occupational disease is a disease contracted as a result of an exposure over a period of time to risk factors arising from work activity) and cases of injury due to commuting accidents. The Resolution suggests that "where it is practical and considered relevant to include injuries resulting from commuting accidents, the information relating to them should be compiled and disseminated separately".

[1] http://www.who.int/workforcealliance/knowledge/en/ (accessed in 2009).

[2] The following text is based on methodological explanations included in LABORSTA (http://laborsta.ilo.org).

Figure 6.3 Active contributors or protected persons as a percentage of working-age population and employment, latest available year



Link: http://www.socialsecurityextension.org/gimi/gess/RessFileDownload.do?ressourceId=15163

Sources: ILO Social Security Inquiry (ILO, 2009c); ILO, LABORSTA (ILO, 2009e) and KILM (ILO, 2009h) for total employment used as a denominator. See also ILO, GESS (ILO, 2009d).

The type of statistics shown for a particular country depends on the source used. Data on occupational injuries are most frequently obtained from occupational accident reporting systems (e.g. to a labour inspectorate) or employment injury benefit schemes, although surveys of establishments and of households are used in a few countries. The type of source determines the coverage of the statistics. In many countries, the coverage of reporting requirements or injury compensation, and thus the coverage of the statistics, is limited to certain types of workers (employees only in many cases), certain economic activities, cases of injury with more than a certain number of days of incapacity, and so on. The type of source is shown after the country name in the LABORSTA tables, followed by the type of injury covered (reported or compensated).

The statistics relate to cases of occupational injury due to occupational accidents that occurred during the calendar year indicated. Total days lost as a result of a case of injury are included in the statistics for the calendar year in which the occupational accident took place.

Care should be taken when using these data, particularly when making international comparisons. The sources, methods of data collection, coverage and classifications used differ between countries. For example, coverage may be limited to certain types of workers (employees, insured persons, full-time workers), certain economic activities, establishments employing more than a given number of workers, cases of injury losing more than a certain number of days of work, and so on.

The workers in the particular group under consideration and covered by the source of the statistics of occupational injuries (e.g. those of a specific sex or in a specific economic activity, occupation, region, age group, or any combination of these, or those covered by a particular compensation scheme) are known as the workers in the reference group. The number of workers in the reference group varies between countries and economic activities and from one period to another, because of differences or changes in the size and composition of employment and other factors. In order to make comparisons between countries, activities and over time, the differences in numbers need to be taken into account, e.g. by calculating comparative measures, such as frequency, incidence and severity rates.

It should be borne in mind that a rise or fall in the number of cases of occupational injury or in the rates of injury over a period of time may reflect not only changes in conditions of work and the work environment, but also modifications in reporting procedures or data collection methods, or revisions to laws or regulations governing the reporting or compensation of occupational injuries in the country concerned. Where possible, the data are classified according to economic activity and sex.

6.2 Maternity protection

Maternity protection was one of the first issues to be considered by the ILO in its first year, leading to the adoption of the Maternity Protection Convention, 1919 (No. 3). This Convention was revised in 1952 and became the Maternity Protection Convention (Revised) (No. 103) with an accompanying Recommendation (No. 95), the same year as the adoption of the Social Security (Minimum Standards) Convention (No. 102). Further revision took place in 2000 when the International Labour Conference adopted the Maternity Protection Convention, 2000 (No. 183), with its accompanying Recommendation (No. 191). This Convention and Recommendation are the most recent ILO standards.

Maternal health is also highlighted in the ILO Social Security (Minimum Standards) Convention, 1952 (No. 102), which states that benefits in case of pregnancy and confinement and their consequences shall include at least prenatal, confinement and postnatal care either by medical practitioners or by qualified midwives, and hospitalization where necessary.

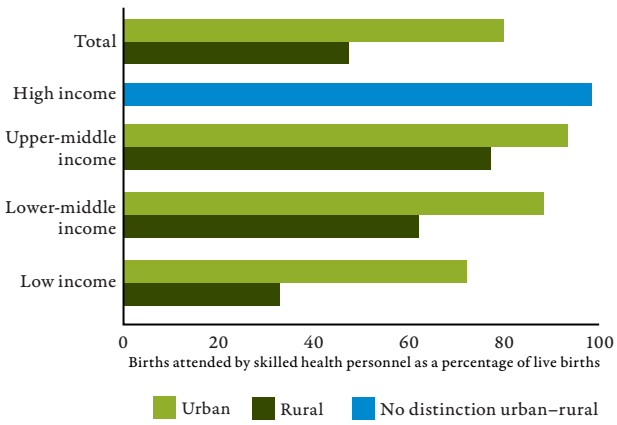
This is of high relevance, since women and young children are especially affected by a lack of access to adequate health care (UN, 2009f). Reducing maternal, neo-natal and under-5 mortality is globally among the greatest challenges of social health protection; it concerns 11 million children who die before the age of 5, and 500,000 mothers dying during maternity (WHO, 2005). The problem is exacerbated by the fact that in many poor households health care for men and boys is generally prioritized over health care for women and girls (Dercon and Krishnan, 2000; Kabir et al., 2000).

Most countries show significant inequities in access to maternal health care as a result of place of residence, as illustrated in Figure 6.4. It shows inequities between urban and rural areas in countries at different levels of income: in lower-income countries differences between rural and urban areas in access to maternal health services are much larger than in higher-income countries (a ratio of 3.3 as opposed to 1.7).

Gaps in financial protection and poor availability of quality services are among the core reasons for under-utilization of health services in developing countries. Figure 6.5 shows differences in access to maternal health services by wealth quintile in countries at different income levels: again, inequalities in access to maternal health services are greater in lower-income countries.

In addition, low levels of female literacy and subsequent poverty or unemployment create financial barriers for women to access health care independently of their families. In many countries, the female unemployment

Figure 6.4 Inequities in access to maternal health services* in rural and urban areas, latest available year (percentage of live births)

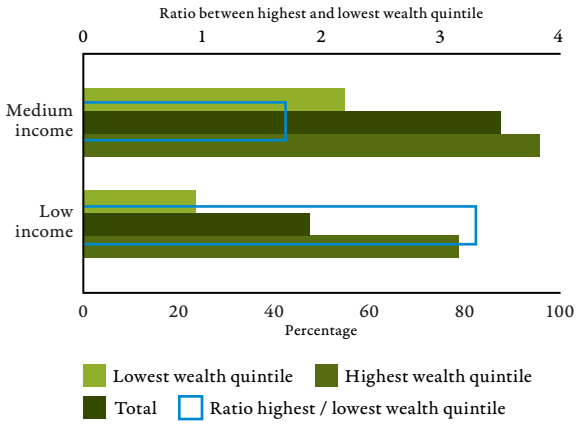


Link: http://www.socialsecurityextension.org/gimi/gess/RessFileDownload.do?ressourceId=15526

Note: * Inequities in access to maternal health services are measured by births attended by skilled health personnel as a percentage of total live births in the same period. Detailed information by country is available in table 28 of the Statistical Annex.

Source: ILO calculations based on WHOSIS (WHO, 2009a), various years. See also ILO, GESS (ILO, 2009d).

Figure 6.5 Inequities in access to maternal health services* by wealth quintile by national income level of countries, latest available year



Link: http://www.socialsecurityextension.org/gimi/gess/RessFileDownload.do?ressourceId=15527

Note: * Inequities in access to maternal health services are measured by births attended by skilled health personnel as a percentage of total live births in the same period by wealth quintiles. Detailed available information by country is available in table 28 of the Statistical Annex.

Source: ILO calculations based on WHOSIS (WHO, 2009a), various years. See also ILO, GESS (ILO, 2009d).

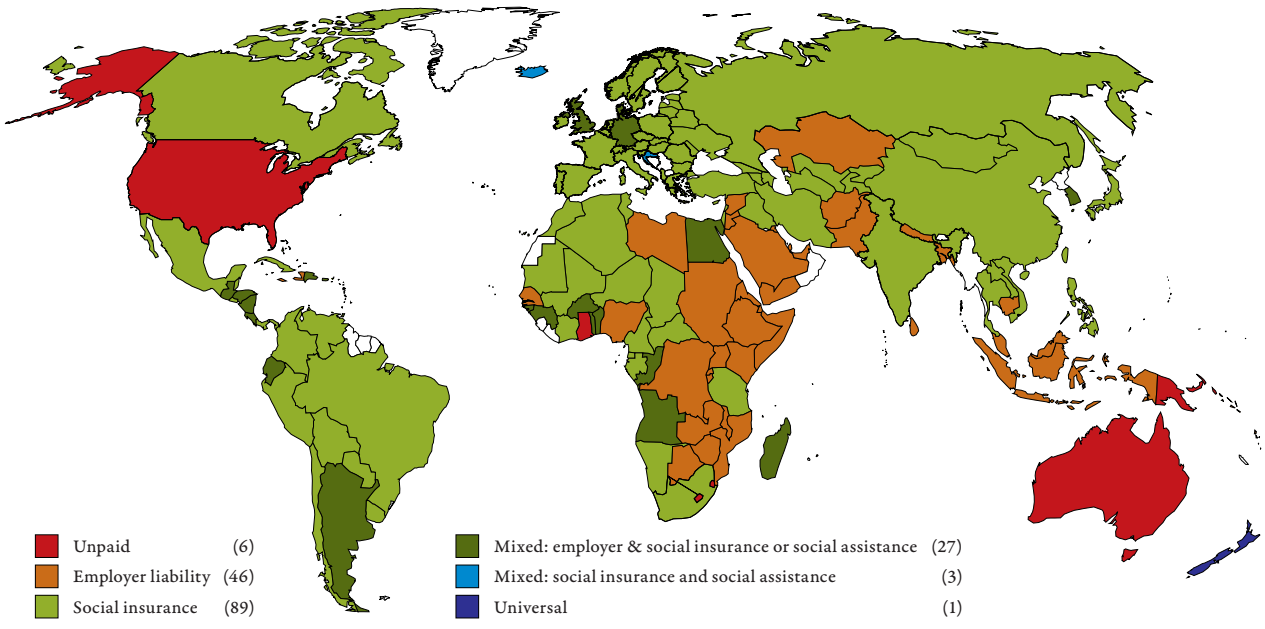
rate is much higher than the rate for men, which points to a high degree of dependency of women. In particular, women are often not able to acquire and/or spend the financial resources necessary for seeking health care and have to depend on their husbands and families.

Consequently, extending and improving social health protection for women is an important strategy for increasing women's access to maternal health services. This can be combined effectively with strategies focused on women's employment.

Among the many issues currently related to maternal health are the following. Health-care facilities are inaccessible for many households, especially in rural areas, due to the long distance to the facilities and the cost associated with travel. More pronounced, however, is the problem of a shortage of qualified staff and of modern and functional medical equipment and supplies. This lack of access affects women in particular, since the main factors of maternal mortality are obstetric complications and complications of unsafe abortion, which could be avoided through better access to good quality reproductive health care, antenatal care, skilled birth attendance and access to emergency obstetric care. For example, more than half of the births in sub-Saharan Africa are not attended by skilled health personnel (UN, 2009f). Additionally, the health effects of HIV, malaria and other diseases increase the risk of maternal death. These diseases are particularly widespread in Africa, where two-thirds of all people with HIV live, the majority of them women.

A possible approach to addressing these barriers consists in defining essential benefit packages that guarantee access to health services; this was observed in 2007 in 55 out of 69 low- and middle-income countries (WHO, 2008, p. 27). The benefit packages provided through health protection schemes were reformed with a view to creating more equity and effectiveness, and the addressing of issues related to the conflicts inherent in approaches of universality versus targeting the poor, rationing of care, and quality. However, many of the reforms resulted in limitations of access to health care that are key for achieving global health priorities, such as those established in the Millennium Development Goals on maternal and child health care; they also

Figure 6.6 Maternity legal provision: Types of programmes worldwide, 2009



Link: http://www.socialsecurityextension.org/gimi/gess/RessFileDownload.do?ressourceId=15283

Notes: 1. In the United States there is no national programme. Under the Family and Medical Leave Act leave is unpaid as a general rule; however, subject to certain conditions an employee may choose or an employer may require the employee to use accrued paid leave (such as vacation leave, personal leave, medical or sick leave or paid medical leave) to cover some or all of the leave she/he is entitled under the Act. A cash benefit may be provided at the state level. For example, in California, since 2004 female and male employees have been entitled to receive up to 55 per cent of their salary for six weeks to take care in particular of a newborn or adopted child. It is financed by a .08 per cent increase in state disability insurance contributions from employee pay cheques.

2. There is currently no paid maternity leave in place in Australia at the federal level. In its 2009/2010 budget the Government for the first time allocated money for a paid parental leave (PPL) scheme. The PPL scheme will be available to parents for births and adoptions that occur on or after 1 January 2011. Parents will be able to lodge PPL claims from 1 October 2010. It is expected that legislation for the scheme will be introduced to Parliament in 2010.

Sources: ILO Social Security Department based on ILO, 2009j; SSA/ISSA, 2008, 2009; United Nations, 2009c. See also ILO, GESS (ILO, 2009d).

missed adjustments to demographic and epidemiological changes, needs and perceptions and resulted in inefficiencies in the provision of services (ibid.). Countries where benefit packages have been successful have focused on integrative approaches without limiting packages to low-cost or very basic interventions (ILO, 2008h).

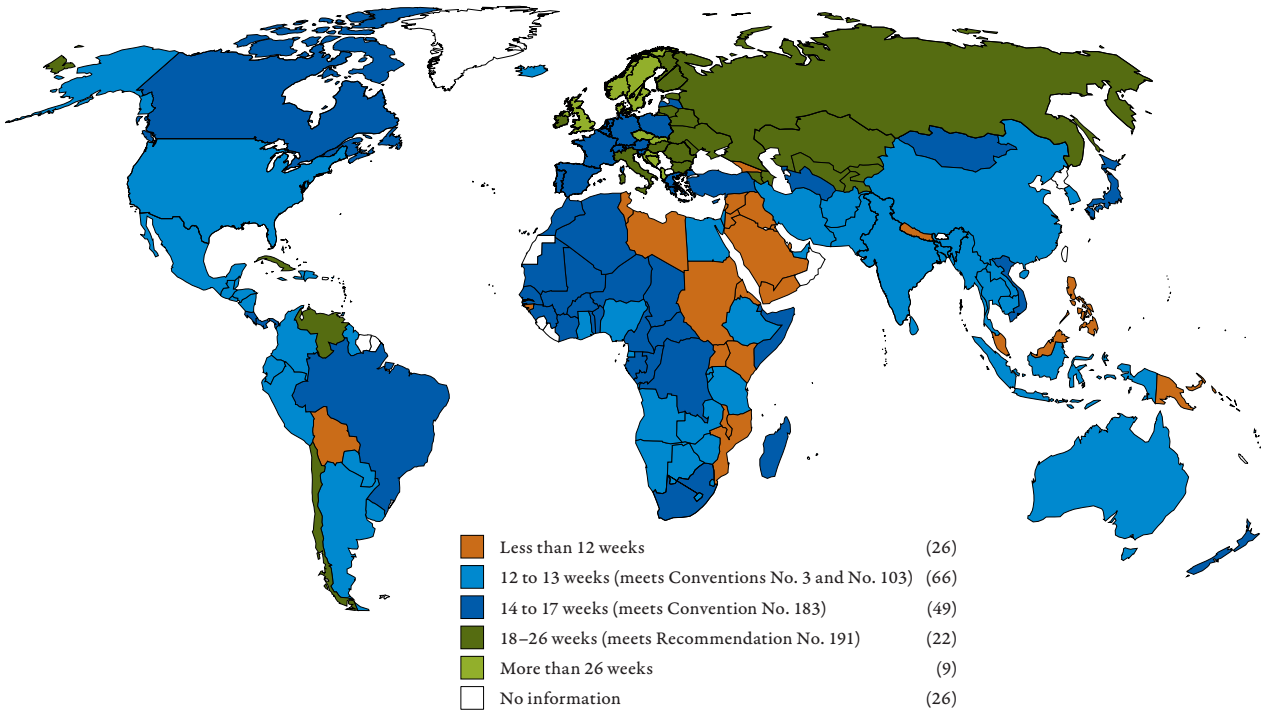
In Thailand, the benefit package provides for a comprehensive range of health services. It includes ambulatory services, inpatient services, free choice of providers, maternal benefits, and prevention and rehabilitation benefits provided by public and private providers.

In Ghana, the benefit package of the NHIS includes general out-patient services, in-patient services, oral health, eye care, emergencies and maternity care – including prenatal care, normal delivery, and some complicated deliveries. Only specialized services, such as HIV antiretroviral drugs, VIP accommodations and so on, are excluded from the health insurance package. According to the Legislative Instrument (LI), which accompanied Act 650, about 95 per cent of all essential or common health problems in Ghana are covered.

Legal provision for maternity protection today ranks third among social security branches providing cash benefits, after employment injury and retirement pensions (see figure 2.6). Some kind of legal provision exists in a majority of countries (90 per cent of high-income countries, 80 per cent of middle-income countries and over 50 per cent of low-income countries). However, these provisions usually apply only to women employed in the formal economy and thus in many low- and middle-income countries only this minority enjoy benefits from maternity protection schemes. Figure 6.6 shows the types of programme existing in the nearly 180 countries for which information is available. The majority of these schemes are of the social insurance type: in two-thirds of countries, and in 52 per cent as the main or only programme; in others as a complement to employer-funded or assistance schemes. In just over a quarter of countries, maternity benefit during maternity leave should be paid directly by employers (so-called employers' liability) as legislated in the labour code or similar acts. Table 20 in the Statistical Annex presents more detailed characteristics of the existing schemes in different countries.

Convention No. 102 defines the contingency creating the entitlement to matenity benefits as "pregnancy and confinement and their consequences", including a resulting suspension of earnings. Two types of benefit should be provided: medical care, and a cash benefit to compensate suspension of earnings. Article 49 of

Figure 6.7 Legal duration of maternity leave worldwide, 2009 (weeks)



Link: http://www.socialsecurityextension.org/gimi/gess/RessFileDownload.do?ressourceId=15165

Sources: ILO, 2009j; United Nations, 2009c. See also ILO, GESS (ILO, 2009d).

the Convention specifies that the medical care should include at least

> (a) pre-natal, confinement and post-natal care either by medical practitioners or by qualified midwives; and (b) hospitalization where necessary. The medical care ... shall be afforded with a view to maintaining, restoring or improving the health of the woman protected and her ability to work and to attend to her personal needs... The institutions or Government departments administering the maternity medical benefit shall, by such means as may be deemed appropriate, encourage the women protected to avail themselves of the general health services placed at their disposal by the public authorities or by other bodies recognized by the public authorities.

The cash benefit paid throughout the whole period of maternity leave should be no lower than 45 per cent of previous earnings (in the case of social insurance earnings-related provision) or of typical low earnings (in the case of flat-rate categorical benefit).

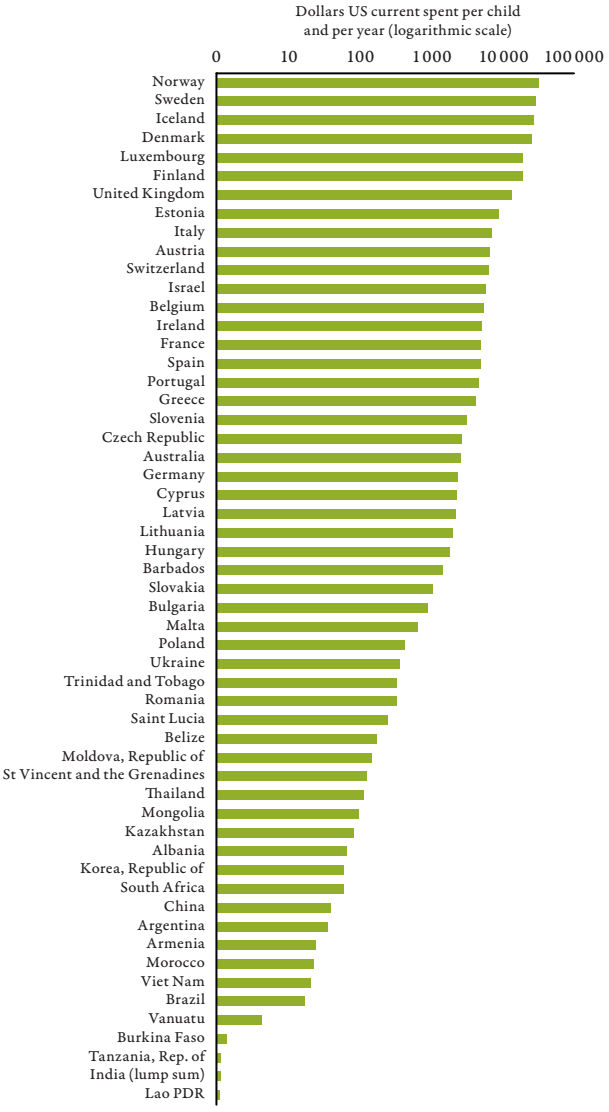
The Maternity Protection Convention, 2000 (No. 183), increases the above minimum requirements. Cash benefits should be provided throughout the duration of maternity leave, which should not be shorter than 14 weeks. Cash benefits should be at a level which ensures that the woman can maintain herself and her child in proper conditions of health and with a suitable standard of living. Where cash benefits are based on previous earnings, the amount of such benefits should not be less than two-thirds of the woman's previous earnings. Where other methods are used to determine the cash benefits, the amount of such benefits should be comparable.

Figure 6.7 presents an overview of maternity leave duration according to the requirements of Conventions No. 3, No. 103 and No. 183, and Recommendation No. 191.

Convention No. 183 urges member States to ensure that maternity benefits are accessible to a large majority of women in the country. Where a woman does not meet the conditions to qualify for cash benefits under the labour code or social insurance scheme, she should be entitled at least to adequate benefits from social assistance funds, subject to the means test required for such assistance.

Medical benefits should be provided for the woman and her child in accordance with national laws and regulations or in any other manner consistent with national practice. Medical benefits include prenatal, childbirth and postnatal care, as well as hospital care when necessary.

Figure 6.8 Amounts spent on paid maternity leave per year and per child, selected countries, latest available year (US$ current)



Link: http://www.socialsecurityextension.org/gimi/gess/RessFileDownload.do?ressourceId=15166

Sources: Annual social security expenditure on maternity leave from ILO Social Security Inquiry (ILO, 2009c), and ESSPROS (European Commission, 2009a). Annual crude birth rate from United Nations, 2009b. See also ILO, GESS (ILO, 2009d).

Again, detailed information is lacking for some countries on what effective coverage is and what the actual benefit levels are. There is sometimes information on the amount spent on maternity benefits per year. Using information about the number of children born and estimates of coverage, it is possible to calculate the level of spending per child. Figure 6.8 shows the amount in dollars spent on paid maternity leave per newborn child and per year in selected countries.