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Formal Social Protection for Older People in Developing Countries: Three Different Approaches

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ABSTRACT

The paper examines social protection for older people in three middle-income countries: Argentina, Thailand and South Africa. It focuses on income support, health services and the provision of care, as well as considering the effects of these policies on social exclusion. The paper locates each country's different social protection programmes within a broader welfare regime model. It finds an interesting variety of approaches to pension and health provision, which range from generous universalism to minimal means-testing. However, it finds much less innovation in areas such as long-term care and intermediary services. The paper challenges generalisations about old age social protection in developing countries, and argues that the different experiences of these three countries could provide useful lessons for social protection in many parts of the world.

Over the past decade awareness about population ageing in developing countries has gradually increased. This has been paralleled by efforts to identify policies which will effectively meet the challenges of ageing in a southern context. These efforts have mainly focused on the experiences of industrialised economies. On one hand, this reflects the longer history of population ageing in developed countries. On the other, it fits within a wider paradigm of North to South knowledge transfer. Partly because of this, policy debate has been dominated by controversies about public and private administration of pension programmes (World Bank, 1994). Much less has been done to assess and compare the full range of policies which have already been implemented in some developing countries.

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This paper compares social protection for older people in three middle-income countries: Thailand, Argentina and South Africa. It begins with a general discussion of each country's present welfare regime. It goes on to focus on various aspects of social protection for elders: income support, health provision and care services. The paper also considers the effects of these policies on the social exclusion of elders, as well as their carers. It identifies considerable innovation and variety in policies for older people across the three countries. This variety partly reflects wider ideological differences regarding the role of the state in social protection. It also reflects other contextual differences including institutional path dependency. The varied policies identified in this paper call into question the narrowness of existing debates and highlight the need for sharing experiences between developing countries.

WELFARE ORIENTATION, AGEING AND SOCIAL PROTECTION IN THAILAND, ARGENTINA AND SOUTH AFRICA

As with any group, it is helpful to understand social protection for older people with reference to the broader welfare regimes within which it is located. Esping-Andersen's discussion of welfare regimes in the West has been highly influential, although efforts to extend it to low and middle-income countries have met with mixed success (Esping Andersen, 1990, 1996; Gough, 2001; Barrientos, 2001). This paper seeks to apply the Esping Andersen framework, observing that policies for elders in the three countries studied here partly correspond with each of his approaches.

Table 1 presents comparative data for Argentina, South Africa and Thailand, and highlights a number of important contextual differences. Argentina is the more 'developed' of the three, with a relatively high human development score, as well as higher per capita GNP and urbanisation. This is also reflected in its relatively aged population structure. Thailand presents a picture of rapid change. Levels of urbanisation and per capita wealth are lower than in Argentina, but both have roughly doubled over the last decade. Thailand is also experiencing rapid population ageing. The situation in South Africa is less promising. While per capita wealth is higher than in Thailand, the economy faces severe structural problems. Largely as a result of the AIDS epidemic, less than half of the current population is expected to survive until 60 years of age. This will considerably slow down the rate of demographic ageing.

In many ways, Thailand is characteristic of the liberal welfare state regime, with low levels of public expenditure on social policies relative to average per capita income, and an ethos of delegating welfare provision

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TABLE 1. *Indicators of population ageing and per capita wealth for Argentina, South Africa and Thailand.*

	Argentina	South Africa	Thailand
Population aged 65+, 1990 (%)	12.9	5.9	6.7
Population aged 65+, 2010* (%)	13.6	6.0	10.8
Human Development Indicator, 1998	0.847	0.70	0.75
People expected not to survive to age 60 (%), 1995–2000	16.5	50.5	25.8
Urban population (%), 1998	88.9	49.9	20.9
GNP per capita, US$ ppp, 1999	11,324	8,318	5,559

*median variant projection
Sources: World Bank (2001), United Nations Population Division (1999), United Nations Development Programme (2000).

to families and employers. In 1997 state social expenditure was only 5.9 per cent of GDP, and private financing accounted for slightly more than half of funding for the education and health sectors. Until the late 1990s expenditure on formal safety nets specifically targeting the poor was well below that of other East Asian countries (Gough, 2001). Concerns about the needs of older people did not feature prominently in the country's influential Five-Year Plans before 1997 (Warnes, 1996). However, the welfare system contains some interesting features of relevance to older people. They include a means-tested monthly allowance, and cards which offer free access to primary health care.

Argentina is taken as an example of a country whose old age policies have historically corresponded quite well with the corporatist/conservative welfare state regime (Huber, 1996). The country started to experience population ageing as far back as the early twentieth century, and therefore has a long experience of policy-making for older people (Lloyd-Sherlock, 1997a). The existence of large elderly cohorts, many of whom are well educated and with past experience of political activism, has led to the emergence of old age pensioners as an important political lobby.

Taken as a whole, Argentina's welfare system has taken a sharp turn towards a more minimal, liberal regime over the last decade – a common fate for much of Latin America and beyond (Barrientos, 2001). However, aspects of the welfare system concerned with current cohorts of older people have largely retained their corporatist hue. Until recently, the cornerstone of social policy in Argentina has been state managed occupation-based social insurance. This offered protection against a range of contingencies, such as old age and disability, for selective parts of the formal labour force. Health insurance has been provided mainly through a separate system managed by trade unions for their own affiliates. These health funds did not provide cover for workers after retirement: this con-

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tingency is met by another health fund specifically for pensioners.

The process of extending social insurance coverage reached its zenith in the early 1980s, when roughly 70 per cent of the labour force was protected. Since then coverage has steadily declined, as have the values of pension benefits and the reported quality of services offered by the health insurance system. This decline reflects an accumulation of long-term institutional and financial weaknesses. It has been exacerbated by a recent shift towards a neo-liberal development model, which has reduced full-time formal sector employment. As such, social protection for older people in Argentina must be understood within a context of welfare retrenchment.

South African social policy cannot be understood without reference to the wider framework of apartheid which prevailed before the Government of National Unity was elected to office in 1994. The resultant racial inequality is evident in basic indicators. In 1991, at 67 per 1,000 live births, infant mortality rates for African children were more than ten times those of their white counterparts (Lund, 1995). Social policy directly contributed to this racial divide in many ways. Many aspects of social responsibility were 'delegated' to Bantustan quasi-states, enabling an extreme degree of geographical inequality between richer and poorer regions. For example, in 1992 per capita health spending in the Western Cape was more than three times the level of Mpulamanga. In 1995 over a third of Africans in former bantustans had to travel an hour or more to reach the nearest health care provider (Hirschowitz and Orkin, 1995). The racial divide can also be seen in demographic terms. The 1996 census found that whites accounted for 24 per cent of over-65s, compared to 11 per cent of the total population. The respective figures for Africans were 67 and 77 per cent (Ramashala, 2000).

The Government of National Unity took immediate steps to redress these inequities, including the establishment of a school nutrition programme and a promise of free basic health care for mothers and children. However, progress in overturning the previous arrangements has been relatively modest to date. Efforts have been hampered by the country's worsening economic performance and the rapid spread of the AIDS epidemic.

Given this context and the country's youthful population, it might be expected that formal social provision for older people would not be prominent. Yet South Africa contains a surprisingly embracing pension scheme which pays relatively generous benefits on a non-contributory basis. In 1993 alone retirement pension funds paid out over 9 billion Rand (Republic of South Africa, 1995). This compares to a total state expendi-

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ture on national AIDS programmes amounting to only 183 million Rand between 1992 and 1997 (Budlender, 2000). While the South African welfare system as a whole cannot be characterised as social democratic, it will become apparent that some aspects of the old age pension programme do fit this model.

PENSIONS AND INCOME SUPPORT FOR OLDER PEOPLE

International debates about formal social protection for older people emphasise the importance of pension programmes, sometimes to the extent that other issues are largely ignored (World Bank, 1994). One criticism of these debates is their tendency to generalise about developing country experiences with pension schemes and their tendency to put forward general solutions. The experiences of the three countries studied here point to a variety of approaches.

Argentina, as with much of Latin America, conforms quite closely to the standard neo-liberal narrative of pension reform. This involves the replacement of inefficient, inequitable and unsustainable public pension programmes with supposedly superior private schemes. There can be no doubting the problems which faced Argentina's pay-as-you-go public programme by the 1980s. These included large financial deficits resulting from *inter alia* low returns on investment, contribution evasion, administrative inefficiency and corruption. This had led to a significant real devaluation of benefits, which came to represent only a fraction of older people's financial needs (Isuani and San Martino, 1993).

A radical reform was implemented in 1994. This obliged all new entrants into the workforce to affiliate with defined contribution private pension schemes, although workers aged over 44 were given the option to stay in the old public system. Private coverage of the labour force had reached 25 per cent by 1997, but its impact on current generations of older people remains minimal. In 1997 private funds paid out fewer than 2,000 retirement pensions, compared to over 3 million benefits from the public system (INDEC, 1998). Various aspects of the reformed pension system have attracted criticism. These include concerns about administrative efficiency and the long-term financial sustainability of the new arrangements (Arenas de Mesa and Bertranou, 1997). Moreover, coverage of the working population has fallen sharply, reaching 42 per cent in 1999 (Bertranou *et al.*, 2000). If this trend is not reversed it will mean that, for future generations of elders, only a minority will be entitled to contributory pensions.

Argentina also has a number of non-contributory pension programmes, which have not been subject to reform. Official data record

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that 280,000 non-contributory pensions were provided in 1994 (INDEC, 1995). If all these benefits were to go to older people, this would constitute roughly 17 per cent of those lacking a contributory pension. However, a high proportion are taken up by Honorary Congressional Pensions, which individual politicians are empowered to bestow upon any person they choose, regardless of age. This system creates considerable opportunities for abuse and clientelism, and many of these pensions go to younger age groups. Responsibility for means-tested old age pensions has been increasingly delegated to local government, and little information is available about their scope or effectiveness. One scheme run by the Province of Buenos Aires provided 4,000 benefits a year in 1994, but had a waiting list of 35,000 elderly applicants (Lloyd-Sherlock, 1997b).

Provision of old age pensions in Thailand provides a sharp contrast with Argentina. Social insurance benefits for public sector workers are well established, but efforts to extend the scheme to private employees only began in 1998. Social insurance coverage of older people currently stands at around 2.5 per cent (Knodel *et al.*, 1999). Private pension plans are virtually unheard of, and were found to have a negligible impact in a recent survey (Chayovan and Knodel, 1997). Since 1993 the Thai Department of Public Welfare has developed a programme of monthly allowances worth 200 *baht* (US$8 at the 1993 exchange rate) for indigent elders in rural areas. By 1997 the scheme had reached 300,000 people. Allowances are applied for by village heads on behalf of poor elders and are vetted by municipal welfare offices. A smaller scheme was later implemented in urban areas, partly with support from the Japanese government. It is claimed that the allowances provide an effective safety net for the most vulnerable elders, but no official evaluations have been made available to date.

South Africa points to a third approach to old age pensions. The country runs a contributory social security programme which rapidly expanded to cover around 70 per cent of the formally employed workforce in 1990, compared to less than 20 per cent in the 1960s (Republic of South Africa, 1995). However, this expansion has occurred too recently to affect most of today's elders, and the formal sector of the economy has contracted significantly over the past decade. Private retirement insurance has grown rapidly in recent years, but mainly serves to supplement formal sector protection, rather than extend overall coverage (Van der Berg, 1998). Instead, the majority of older people (around 70 per cent) receive pensions from a non-contributory scheme.

The origins of the non-contributory programme are deeply rooted in apartheid and its fall. The pension was initially developed to provide a

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basic income in retirement for whites who did not have an occupational pension. In the final stages of apartheid it was extended to Coloureds and Indians to demonstrate the benefits of a three chamber parliament (Case and Deaton, 1998). After the fall of apartheid, the pension was extended to Africans, who are now the main beneficiaries. The scheme is funded through general taxation and provides relatively generous pensions (around US$3 a day). Entitlement for the pension is means tested according to the income and assets of the individual claimant beneficiary, and partner if married, but this does not include other household members. Different surveys have found that coverage of low-income groups, including Africans living in rural areas, is virtually universal (Ardington and Lund, 1995; Van der Berg, 1997). As such, the non-contributory pension produces a significant redistribution of income in a country where the average incomes of Whites are ten times the average incomes of Africans (Barrientos and Lloyd-Sherlock, 2001).

HEALTH CARE PROVISION FOR OLDER PEOPLE[1]

Health policy for older people in developing countries has received less international attention than have pensions (Lloyd-Sherlock, 2000a). Yet access to good quality health services is as important to older people as access to monetary income, and there are many links between health status and economic wellbeing. Moreover, health care accounts for a significant share of state social spending in most developing countries and, given demographic trends, policy is likely to become increasingly focused on elders' needs. Discussions about health sector reform and new public management rarely, if ever, refer to the potential effects of these changes on older people. As with pensions, the three countries studied here have taken very different approaches to meeting the health needs of older people.

In 1994 South Africa's Government of National Unity developed a new set of priorities for the health sector which emphasised the needs of mothers and young children. As part of this, a national network of geriatric clinics was closed down, and its staff were redeployed to child immunisation programmes. Since then, there has been a substantial loss of capacity and expertise in geriatric and psychogeriatric care. There are currently no dedicated state health care services for older people, with the exception of a single geriatric medicine unit in Cape Town. Older people have been found to suffer particularly serious problems of access to primary care clinics and in the system of upwards referral (Mohatle and de Graft Agyarko, 1999). The limitations of state provision have provided an opportunity for the expansion of private health insurance, but this has been confined to high-income groups.

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In Thailand the health needs of civil servants (including retirees) are covered through a social insurance fund, but the great majority of older people are obliged to rely on public provision or private financing. In 1989 the Ministry of Public Health introduced a means-tested free medical care card programme for poor elders, and in 1991 this was extended to the total population aged 60 or more. The card entitles older people to services in public clinics and hospitals, and accounted for 5 per cent of the Ministry's total expenditure between 1995 and 1997. The card programme exists as part of a wider policy framework which emphasises the role of primary health care (PHC) clinics, particularly in rural areas. Card-holders must register at a single primary health care clinic, and are entitled to mostly free hospital care if they are referred on by the clinic. This emphasis on PHC for elders goes against a general and increasingly misguided tendency to see such services as essentially relevant for mother and child health, rather than older age groups (Phillips, 2000).

Evaluations of the health card programme give a mixed picture. A major survey conducted in 1995 found that the scheme was widely used by older people in rural areas, where community clinics are the main source of care. Elders in cities were more likely to buy their own drugs or go to private clinics. This reflected the wider range of services on offer and higher incomes in urban areas (Thailand Health Research Institute, 1996). A separate study identified a number of quality problems in a some rural clinics, where staff had received no training in geriatric care and displayed little awareness of issues of relevance to older people (Lloyd-Sherlock, 2001).

Use of state hospitals by Thai elders fell sharply between 1988 and 1995. This may partly reflect the success of the card programme in promoting appropriate referral mechanisms. It may also reflect a lack of provision in the hospitals themselves. By the late 1990s there was no national inpatient service for older people, although most hospitals with 60 or more beds ran geriatric clinics. None of these provided services for rehabilitation, health visitors or wider links with social services (Jitapunkul and Bunnag, 1998). Reduced utilisation of state hospitals was part of a more general expansion of private financing and provision in the Thai health care system as a whole. Between 1973 and 1995 the private sector's share of hospital beds increased from 7 to 23 per cent (Tangcharoensathien *et al.*, 2000). In 1995, 27 per cent of older people who visited a formal health care provider used a private hospital or clinic.

Argentina has a health insurance fund specifically for pensioners: an unusual feature in Latin America. The fund, known as the Integrated Programme of Medical Assistance (PAMI) was created in 1971, in

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response to fears that existing health care arrangements were failing elderly people (Golbert, 1988). The scheme was funded by a number of sources, the most important of which was a 2 per cent wage tax. PAMI finances health care for pensioners, contracting out to third party providers (mainly from the private sector). Services include hospital care and commonly used drugs, which are provided either free of charge or at a substantial discount.

During the 1980s, while much of the rest of Argentina's formal welfare system suffered financial and administrative crises, PAMI extended its services and appeared financially sustainable. By the early 1990s it provided a wide range of medical and social services to over 4 million beneficiaries, with an annual budget of around US$ 2.5 billion (Lloyd-Sherlock, 1997c). In 1994 it emerged that PAMI had generated a financial deficit of US$1.3 billion. This resulted partly from a decision to halve the wage tax, in keeping with a wider policy of reducing labour costs. However, reports of large-scale corruption, inefficiency and administrative malpractice suggest that the causes of the deficit were more complex (Bonvecchi *et al.*, 1998). Since then, the programme has received financial bale-outs and has undergone a series of largely failed reform efforts.

Given the scale of the programme, information about its capacity to provide appropriate health services to pensioners is scarce. Despite contracting out to a large number of providers, PAMI did not set up an effective system of quality control until 2000, and has been unable to police contracts. A study from the 1980s found a high and rising share of spending went to expensive specialist services, rather than potentially more cost-effective PHC ones. A survey conducted in 2000 found 88 per cent of affiliates who required hospitalisation chose not to use a PAMI provider, indicating serious quality problems (INAP, 2000). This has contributed to a major expansion of private provision and financing.

Around 40 per cent of older people in Argentina lack insurance entitlements and are therefore forced back onto the public health sector. Data about the range and quality of geriatric services are not available, but numerous reports have drawn attention to the historical underfunding of the sector and rapid declines in quality (World Bank, 1997; IADB, 1998). Recent efforts to increase decentralise authority to public hospitals and encourage cost recovery may have a range of impacts on older people which are not taken into account in policy debates.

OTHER SERVICES FOR OLDER PEOPLE

Social protection for older people in developing countries has been dominated by concerns about pensions and, to a lesser extent, health care. Yet

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these do not meet all the needs of elderly populations, such as general care provision and residential services. Such issues can be particularly indicative of a country's welfare state regimes category, as they tend to straddle state and family responsibilities.

In low and middle-income countries, it is widely assumed that residential care is not a policy priority, since traditional household and community structures are still expected to play this role. In most cases the vast majority of older people continue to live with children or other family members (Sokolovsky, 2000). Thais reflect this general trend, as do Africans in South Africa (see Table 2). However, in a small number of cases, living arrangements are closer to those in developed countries. Argentina fits into this exceptional category. Here, the number of people aged 60 or more living alone rose from 12.0 to 17.5 per cent from 1960 to 1991. The case of whites in South Africa is more extreme: 39 per cent lived alone in 1990, while another 41 per cent lived with only their spouse. Some studies have argued that living arrangements in most developing countries are likely to shift towards a Western pattern over the next few decades (Palloni, 2000).

The limited available research suggests that it is misleading to equate co-residence with adequate informal care from family members (Palloni, 2000; Lloyd-Sherlock, 2000b). Increased female participation in the salaried labour force is likely to constrain the supply of informal care, regardless of household structure. However, the patterns of co-residence for Argentines and South African whites probably lead to particularly high levels of demand for residential care services.

More generally, there are indications of a significant and growing unmet demand for residential care in all three countries. Surveys from around the world have found that between 10 and 20 per cent of older people unable to live independently expressed a desire to live in residential care (Wilson, 2000). However, in none of the countries studied here has the state developed significant policy initiatives to meet these needs. In Argentina only 1 per cent of people aged 60 years or older were living in care institutions in 1991 (Castells, 1992). This is surprising since PAMI affiliates are, in theory, entitled to residential care, and points to a supply constraint. PAMI contracts out to the private sector, which runs the great majority of homes in the country, and the past decade has seen a rapid expansion of the private for-profit sector. However, new homes have mainly targeted privately financed elders. PAMI's financial crisis and delays in paying providers have further reduced its ability to meet its care commitments. Thai state residential services for poor elders date back to 1953, but by 1997 they only provided shelter for around 2,500 people.

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TABLE 2. *Living arrangements of older people in Argentina, Thailand and South Africa.*

	Argentina 65+, 1990 %	Thailand 60+, 1994 %	South Africa, Africans 60+, 1990 %	South Africa, Whites 60+, 1990 %
Live alone	18	4	4	39
Nuclear[a]	44	30	45	55
Extended	34	59	51	6
Composite[b]	4	7	NA	NA

[a] including spouse only
[b] included with extended households in South Africa
Note: information for other racial groups in South Africa is not included.
Sources: Chayovan and Knodel, 1997; INDEC (1993); Kinsella and Ferreira (1997).

Older people who are unable to feed, dress or wash themselves are not eligible for these services. Thailand has also seen a rapid growth in private nursing homes, particularly around Bangkok (Jitapunkul and Bunnag, 1998). The 1996 South African census found 48,000 people aged 65 years old or more lived in social service institutions of one kind or another (2.5 per cent of this age group). The great majority (88 per cent) were whites (Ramashala, 2000).

Permanent residence in nursing homes represents just one possible option at an extreme of the spectrum of care services. Developed countries are paying increasing attention to a range of intermediary alternatives, including sheltered housing, day centres, home visitors and support for informal carers (OECD, 1996). The countries studied here have made some efforts in this direction, but their overall commitment has been minimal. Nor had they implemented schemes of state support for informal carers in the home. Nevertheless, their limited experiences provide some clues about what might be possible on a larger scale.

In both Thailand and Argentina there has been a small amount of state support for day care and other intermediate services. The Thai ministry of welfare ran thirteen social service centres for elders by 1997. These provided day care, emergency shelter and a limited amount of outreach care. The country also has a network of around 3,500 senior citizen clubs, which until recently received a limited amount of support from the health and welfare ministries. The main provider of day care in Argentina has been PAMI, which ran a national network of day-care centres, including 300 in Buenos Aires alone. These centres provided a range of services including health promotion, counselling and leisure

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activities. As with other PAMI services, these were only provided to those relatively privileged elders with social insurance entitlements, and their long-term future remains doubtful.

In South Africa no state agency has taken a significant interest in intermediary care services. However, a number of innovative projects have been developed by NGOs. These include a network of eighteen community old age homes in Cape Town, which are administered by elders and financed through their pension benefits (Ferreira, 2000). The network also carries out community development work, and is a teaching site for geriatricians from the local university, who run weekly clinics there. While the scheme has many merits, it mainly serves the white community and older people who are fit and able to care for themselves. Efforts are currently underway to extend it other racial groups (Ferreira and Stolze, 2001). Also, whether the scheme could be applied in countries with less generous provision than South Africa is open to doubt.

SOCIAL EXCLUSION AND OLDER PEOPLE

A key characteristic of social protection systems is the degree to which they promote or alleviate social exclusion of particular groups of elders. This paper now focuses on various aspects of exclusion, comparing the experiences of the three countries.

In Argentina the most obvious form of exclusion occurs through the distribution of entitlements in the social insurance system. Those who are included enjoy rights to contributory pensions, as well as health and other services provided by PAMI. Those excluded are left with an incomplete and arbitrary means-tested pension programme and generally inferior public health services. Given the link between past occupation and entitlement, excluded elders tend to be those with lower lifetime earnings and fewer assets. As such, the system reinforces social exclusion among older people. A survey of shanty towns in Buenos Aires in the early 1990s found levels of pension coverage well below the national average and a virtual absence of PAMI entitlements (Lloyd-Sherlock, 1997b). This form of exclusion is not so apparent in the other two countries. In Thailand social insurance is less prominent and restricted to a very small minority of public sector employees. The non-contributory basis of South Africa's main pension system precludes this form of dualism.

Thailand and Argentina provide a number of services to older people on a targeted or means-tested basis. Advocates of this approach argue it promotes financial sustainability and reduces undesirable incentives for groups such as elders to quit economic activity or to crowd out inter-generational

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exchange (Grosh, 1994). Others question both the effectiveness of targeting and its ethical justification (Russell and Gilson, 1997).

Surveys of older people living in poor communities in Thailand and Argentina found that targeting promotes social exclusion in a number of ways. Thai emergency allowances are distributed equally across all the country's villages, so that destitute elders in villages with high concentrations of poverty are much less likely to receive one. A more geographically targeted approach is deemed politically unfeasible. In areas with large numbers of potential claimants, elders' relations with village heads have a major effect on their inclusion in the allowances programme, leading to fears of favouritism (Lloyd-Sherlock, 2001). In Argentina, non-contributory pensions have sometimes been allocated by lotteries. A survey of Buenos Aires shanty towns found that the bulk of elders who met the means-testing requirements lacked benefits, and identified a number of cases of extreme need which had fallen through the non-contributory net. It found that older people with poor mobility, little education and little family support were less likely to have knowledge about pensions, and were less able to fulfil the complex and onerous bureaucratic application process. As such, there was often a negative relationship between need and access to means-tested benefits (Lloyd-Sherlock, 1997b).

These surveys reveal a number of wider issues relating to access and service provision for elderly people, which do not just relate to targeted schemes. Where elders lack physical mobility and literacy skills, it is essential to take a pro-active approach whereby welfare officers go out into communities to identify needy cases. However, none of the countries studied here had developed significant out-reach services in health or other aspects of welfare.

While insurance and targeted systems create considerable exclusion, more comprehensive programmes were not without problems. The survey of poor elders in Thailand found a higher proportion of the very old (28 per cent of those aged 80 or more) lacked knowledge about the medical card programme than those aged 60 to 69 (11 per cent). The South African pension programme excludes all those aged less than 60, yet for many poor Africans 'old age' to all intents and purposes starts at a much lower chronological threshold. However, the scale of social exclusion caused by these schemes would appear to be much lower than that resulting from contributory ones.

In all three countries there were significant gaps in state provision, particularly for residential care and geriatric hospital services. To some extent this also contributed to social exclusion, as relatively wealthy elders were able to plug these gaps with private provision. With little sign that the state is

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prepared to up-grade its involvement in these areas, this form of exclusion is set to deepen. The increased role of the private health care financing poses particular problems for elders in general, given the reluctance of insurance firms to provide affordable *premia* to groups perceived as high health risks.

One aspect of social exclusion of particular relevance to older people is that based on gender. Numerous studies have testified to the degree of relative deprivation of older women in a wide range of respects. This includes reduced entitlements to social policies, increased burdens of care and domestic responsibility, greater likelihood of living alone, and, in some cultures, entrenched discrimination against widows (Alter Chen, 1998; Ewing, 1999). Consequently, the degree to which social provision for elders influences gender exclusion is a key consideration. In Argentina, several aspects of social protection reinforce these differences. Women are not granted pensions or PAMI entitlements independently from their spouses, and widows' pensions tend to be worth less than the standard one. This is in keeping with Argentina's conservative/corporatist welfare regime credentials. The minimal nature of social provision in Thailand creates fewer opportunities for bias. The author's survey of access to emergency allowances and health cards did not reveal any gender skewing (Lloyd-Sherlock, 2001). By contrast, South Africa's pension programme directly benefits roughly twice as many women as men. This in turn reflects the gender structure of its elderly population. The limited research suggests that the pension has done much to promote the role of older women in households and communities (Ardington and Lund, 1995).

Since the great majority of informal carers are women, it is important to consider the effects of social protection systems on domestic care roles. The failure of governments in all three countries to provide support or alternatives to informal care has as much an impact on carers as it does on elders. It should not be forgotten that sometimes these carers are elderly themselves: particularly when older women outlive their spouses. As elder care is combined with existing domestic roles (child care and chores) as well as female increased participation in salaried activities, the need for the state to mediate these responsibilities will become acute. This has been identified as a key issue of social justice in developed and well as developing countries (Nussbaum, 2001). However, it should not be forgotten that obliging elders to live in sub-standard nursing homes represents an equally reprehensible form of social exclusion.

CONCLUSIONS

The three countries studied here display a variety of approaches to pension and health provision, as well as a general tendency to ignore other

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TABLE 3. *Comparing social protection for elders in South Africa, Argentina and Thailand.*

	South Africa	Argentina	Thailand
Income support			
Occupation-based protection	Limited	Well-developed	Embryonic
Non-contributory protection	Well-developed	Weak	Minimal safety net
Private sector	Small	Emerging	Small
Health			
Occupation-based entitlements	Weak	Well-developed but weakening	Just civil service
Non-contributory protection	Weak	Weak	Health card safety net
Private sector	Small	Emerging	Rapid growth
Care			
Occupation-based entitlements	None	Weak	None
Non-contributory protection	Minimal	Minimal	Minimal
Private sector	Emerging	Emerging	Emerging

forms of social policy for older people. This variety calls into question the 'one-size-fits-all' thinking which sometimes prevails at the level of international debate. If the scope of this paper were extended to other developing countries, further alternatives might well emerge.

Table 3 provides information for the overall articulation of old age social protection for all three countries. This includes the relative importance of occupation-based and non-contributory entitlements, and the role of the private sector. The table does not specify the role of the family and other forms of agency, such as NGOs and the community. Strong empirical data about these elements of the welfare regime are not available for the three countries. To some extent, their role can be inferred, as they are required to fill the gaps in public and private sector provision. However, it would be dangerous to assume that the family automatically fills the breach in elder needs.

Table 3 shows that Argentina conforms closely to a conservative/corporatist regime, with strong occupational entitlements, and a policy emphasis on family responsibility for care-giving. Thailand presents a picture of minimal state involvement and an emerging private sector. As such, it would seem to be moving ever closer to a US-style welfare state regime. South Africa represents a more unusual approach. Its generous pension programme contrasts with a virtual absence of state interest in health or care provision for elders. Each of these cases must be understood with reference to specific historical processes, and to institutional

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path dependency. Argentina remains heavily influenced by a welfare model which has its roots in the early twentieth century. The South African regime is a consequence of apartheid and its aftermath. Thailand's welfare state regime is a more recent creation, giving policy-makers more space to innovate. However, the Thai approach is also very much a reflection of its neo-liberal times and neo-liberal regional context.

Despite their different approaches, these countries have much to learn from each other. Thailand's health card, though flawed in its implementation, hints at a model of affordable primary health care for elders in developing countries. Argentina's health insurance fund for pensioners provides a salutary tale of what can go wrong in social policy for elders. Interestingly, PAMI's design (health care financing based on insurance and contracting out provision to a pluralistic array of theoretically competing providers) conforms quite closely to a model which is strongly advocated by the World Bank and others.

South Africa's non-contributory pension scheme may be written off by some as financially unsustainable, but parallels can be drawn with large-scale non-contributory programmes in other developing countries, including Botswana, Namibia and Brazil (Barrientos and Lloyd-Sherlock, 2001; Charlton and McKinnon, 2001). Numerous studies report that the scheme offers a range of indirect benefits in addition to income support for elders. As has been seen, pension income facilitates the provision of self-help residential care. It has also been demonstrated that receipt of the pension is associated with better health status (Case, 2001). In this way, the pension programme may partly compensate for the shortcomings of old age health policy. Furthermore, pension benefits are often spread across three-generation households, greatly widening their impact (Burman, 1996; Bozalek, 1999). In the context of increasing care of AIDS orphans by grandparents this will become increasingly significant.

Comparing the three countries, Argentina's policies for older people appear to raise the most serious problems. The existing array of pension and health schemes is expensive, inequitable and often ineffective. The rapid expansion of the private sector into these areas is unlikely to benefit the bulk of the country's elders. Thailand has taken a more minimal approach, but existing services could provide the basis for a relatively effective support system if they were extended and up-graded. Sadly, the long-term survival of South Africa's pension programme in its present form is open to doubt. Efforts should be made to retain the programme's most positive aspects and to spur the development of geriatric health care and social services.

The lack of significant state efforts to promote day care, out reach services or residential care for older people is the most worrying finding

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in this survey. This absence is linked to a wider failure to take a 'joined up' approach to meeting elderly needs: pensions and health care are usually seen as separate policy domains with separate institutional structures. Bridging the gap between state provision and family support is particularly relevant in contexts of relative resource scarcity and rapid socio-cultural change, but there are few signs of this happening. Perhaps this is one aspect of policy where these countries might look to the north.

NOTES

1 This section focuses on formal service provision. It does not include traditional or homeopathic medicine, or a discussion of the household production of health. Little information is available about the impact of these sub-sectors in the study countries.

2 A survey conducted in selected parts of the country between 1998 and 2000 found that 61 per cent of homes had been established since 1990, and of these 87 per cent were in the private for-profit sector (Freysselinard et al., 2000).

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