

Adequacy Pensions and Access to Healthcare

Maintaining human capital during old age

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INTRODUCTION

Maintaining human capital during old age requires both an adequate pension (cash component) as well as access to affordable quality healthcare (healthcare component). Lack of universal/affordable healthcare and long-term care services for the elderly means governments may need to provide sufficiently higher old age financial assistance to poor elderly to compensate for high out-of-pocket health expenses. While countries with universal¹ quality healthcare may be able to ensure a minimum standard of living for the elderly at a lower benefit level, in countries where the elderly face high out of pocket health expenses – pensions may need to be higher to achieve that same minimum living standard.²

Governments should aim to provide a “minimum level of protection” for the disabled and elderly poor that fall outside the reach of contributory social insurance. Given the prevalence of informal jobs in developing countries, *Bismarkian* formal sector social insurance programs (pensions, health insurance, and unemployment benefits) have failed to provide sufficient coverage and protection. As a result, many countries, including low-income countries, have introduced non-contributory mechanisms to cover the informal sector and the self-employed. Some countries have chosen to cover all elderly, regardless of their income level at a substantially higher cost, while others have opted for means-tested pensions. Constrained fiscal space, multiple competing development objectives, and a growing number of older people due to demographic ageing generally means that developing countries could either afford to provide a lower benefit to a larger share of the elderly population, or a higher benefit to a more limited share of the elderly population.

Determining what level of pensions is “adequate”, what constitutes a “minimum level of protection” and who should be eligible are the biggest design challenges today, for several well-documented reasons (high costs, incentives to formalize, etc.). A recent study for the South Asia Region (SAR) region (Demarco et al. 2022) presents the challenges to expand social pensions in a region where most population in the informal sector is poor and needs to rely on non-contributory programs to provide financial support to the elderly. A similar framework was used in studies for the Latin America and the Caribbean (LAC) region discussing the trade-off between the expansion of non-contributory pensions and the fiscal costs, even

with benefits defined at poverty line level (Rofman, Apella, and Vezza 2015). This chapter adopts the conclusion from these studies, that expanding non-contributory pensions to provide all informal workers with retirement and coverage of other long-term social insurance risks would require enormous fiscal efforts and is not recommended. Although non-contributory pensions play a necessary role in providing income security in old age for the poorer informal workers, fiscal constraints will limit both the size of this kind of pensions and the income and age to be eligible to receive the old age benefit. The study also highlights that even if noncontributory pensions are devised to be affordable now, a major challenge is ensuring that the program remains affordable over time, given the population aging and the potential for discretionary increases in the benefit amounts.

In designing non-contributory pensions, policy makers should consider questions such as the following: (i) what percentage of the elderly are poor?; (ii) are elderly poorer (or more vulnerable) than other age groups?; (iii) what are the living arrangements of the elderly – do they live with other family members or alone?; (iv) what is their per capita consumption relative to the per capita consumption of non-elderly populations; (v) do they spend more on healthcare than other age groups?; (vi) do they spend more on healthcare out of pocket (and if not, could it be because there are other barriers in the way to seeking and obtaining healthcare altogether); (vii) what benefit level could be considered “adequate”; (viii) what would be the available fiscal space to expand benefits – both now and into the future – vis-à-vis competing development needs.

1 It is worthwhile to note that universal contributory health insurance programs, even when they exist, do not always provide sufficient elderly coverage, for instance, health insurance does not always cover long-term care.

2 While the chapter aims to underscore the need for both adequate pension as well as quality healthcare in order to support human capital in old age, it does not explicitly advocate for any single one approach to achieving this goal; it merely posits that in cases where the elderly lack healthcare, non-contributory old age pensions may need to be correspondingly adjusted to ensure the same level of wellbeing as in cases where sufficient/quality/high coverage healthcare is available to the elderly population. The chapter does not argue against broader initiatives that would provide increased affordable quality healthcare to the elderly through funds and risk pooling mechanisms.

Including the costs of access to quality health care in the definition of “adequate” pensions, does not necessarily imply that increased pensions are preferable to addressing the deficiencies of the health system; it may just reflect the additional financial needs pensioners will face if access to universal health of good quality is not granted. Improving this access is, no doubt, a more efficient and permanent

solution, but it may take longer to implement.

This chapter is organized as follows: (i) a review of current global patterns of non-contributory pension provision (design, coverage, eligibility criteria, benefit levels, costs) complimented by a discussion around adequacy, equity, and fiscal sustainability (ii) a review of healthcare provisions for the elderly without access to social insurance, (iii) recommendations.

FINANCIAL PROTECTION

The difficulties to expand contributory Social Insurance in developing countries has driven a growing number of governments to conclude that non-contributory programs are necessary to ensure minimum income protection at older ages. Several countries have moved in that direction in the past decade, notably in response to the impact of the COVID-19 crisis on vulnerable groups such as elderly and persons with disabilities. In the last two decades, around 30 countries have introduced some form of a non-contributory benefit targeted to the elderly. Analytical work and policy dialogue supported by development agencies has been consistent with this approach and provided analytical framework to support the policy shift and respond to the fiscal challenge of expanding tax-based pensions (Palacios and Robalino 2019). This chapter sets out to present a general framework to understand the rationale and objectives of the different models.

The design and scope of non-contributory programs targeted to the elderly varies considerably across the developing world, both in terms of eligibility criteria and the level of the benefits (Table 14.1). Some countries have chosen to provide a universal pension to all individuals above a certain age, while others limit access to those below a certain income level. For

example, Egypt’s Karama program, provides cash transfers to poorer elderly and persons with disabilities in a targeted manner, while Mexico³ launched a universal program for all above age 65, regardless of their income. Argentina has adopted more complex modalities combining untargeted and targeted benefits on a contributory and non-contributory basis.

TABLE 14.1 Design and scope of non-contributory programs targeted to the elderly

Program Name	Targeting	Age
Albania: <i>Social Pensions</i>	pension tested	70
Argentina: <i>Universal Pension for the Elderly</i>	pension tested	70
Armenia: <i>State Social Pension</i>	pension tested	65
Bangladesh: <i>Old Age allowance</i>	means tested	65m/62f
Belarus: <i>Social pensions (disability and old age)</i>	pension tested	60m/55f
Bolivia: <i>Dignity Pension</i>	universal	60
Botswana: <i>Old-Age Pension</i>	universal	65
Brazil: <i>Benefício de Prestacao Continuada (BPC / Continuous Cash Benefit)</i>	means tested	65
Bulgaria: <i>Old age pension - not related to labor activities</i>	means tested	70
Cabo Verde: <i>National Center for Social Pensions</i>	means tested	60
Canada: <i>Old Age Security Pension</i>	universal, residency	65
Chile: <i>Basic Solidarity Old Age Pension (PBS)</i>	pension tested	65
Colombia: <i>Social protection program for the elderly</i>	means tested	59m/54f

3 México universal pension: *Programa Pensión para el Bienestar de las Personas Adultas Mayores*

Program Name	Targeting	Age
Costa Rica: <i>Régimen no contributivo de pensiones por monto básico</i>	means tested	65
Ecuador: <i>Pension para Adultos Mayores</i>	means tested	65
Egypt: <i>Karama elderly assistance</i>	means tested	65
Eswatini: <i>Old Age Grant</i>	universal	60
Fiji: <i>Social Pension Scheme</i>	pension tested	68
Georgia: <i>Universal old age pension</i>	universal	65m/60f
Greece: <i>Social solidarity allowance for uninsured elders</i>	means tested	67
India: <i>Indira Gandhi National Old Age Pension Scheme</i>	means tested	60
Indonesia: <i>Elderly Social Assistance Programme</i>	means tested	70/60*
Kazakhstan: <i>Basic state pension</i>	pension tested	63m/58f
Kenya: <i>Older Persons Cash Transfer OPCT</i>	means tested	65
Kiribati: <i>Elderly Fund Pension</i>	universal	65
Kosovo: <i>Basic Pension (social pension, non-contributory)</i>	universal	65
Lesotho: <i>Old age pension</i>	pension tested	70
Malaysia: <i>Financial Assistance for Older Person</i>	means tested	60
Maldives: <i>Old Age Basic Pensions Scheme</i>	pension tested	65
Mauritius: <i>BRP - zero pillar</i>	universal-residency test	60
Mexico: <i>Programa Pensión para el Bienestar de las Personas Adultas Mayores</i>	universal	65
Mongolia: <i>Social Welfare Pension</i>	means tested	60m/55f
Namibia: <i>Old Age Pension</i>	universal	60
Nepal: <i>Senior Citizens Allowance</i>	pension tested	68
New Zealand: <i>Superannuation</i>	universal, residency	65
Panama: <i>120 to the 65</i>	pension tested	65
Papua New Guinea: <i>New Ireland Social Pension</i>	universal regional	60
Paraguay: <i>Pensión Alimentaria para Adultos Mayores</i>	means tested	65
Peru: <i>Pension 65</i>	means tested	65
Philippines: <i>Social Pension for the elderly</i>	means tested	60
Samoa: <i>Senior Citizens Benefit</i>	universal	65
Seychelles: <i>Retirement Pension</i>	universal	63
South Africa: <i>Old-age grant</i>	means tested	60
Sri Lanka: <i>New Elders Assistance Program</i>	means tested	70
Tajikistan: <i>Social pensions</i>	pension tested	65m/60f
Tanzania: <i>Zanzibar's Universal Social Pension</i>	universal	70
Thailand: <i>Old Age Allowance</i>	pension tested	60
Timor-Leste: <i>Elderly support allowance</i>	universal	60
Tonga: <i>Social Welfare Scheme for the Elderly</i>	means tested	70
Uruguay: <i>Non-contributory pensions for old age and disability</i>	means tested	70
Viet Nam: <i>Monthly subsidy for elderly</i>	means tested	60

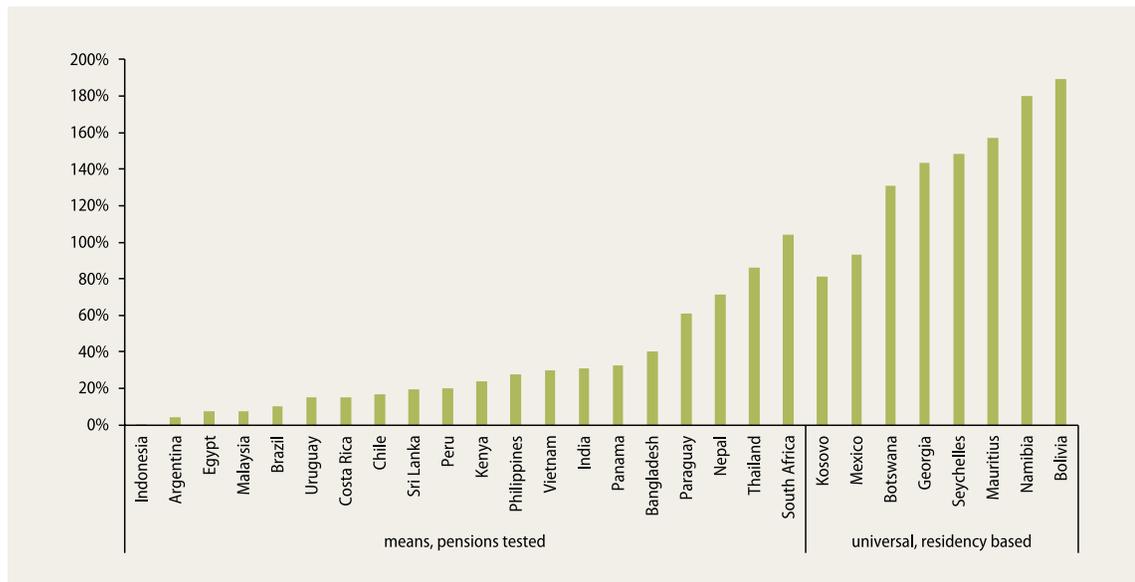
Source: World Bank Atlas of Social Protection Indicators of Resilience and Equity (ASPIRE).

*Indonesia: Elderly Social Assistance Programme 70/60 if chronically ill

Lower ages of eligibility and/or a lower income threshold for means-testing unsurprisingly results in a higher count of beneficiaries. Figure 14.1 below shows non-contributory pensioners as a share of the population above age 65. Coverage is highest in Bolivia, Namibia, and Mauritius where the age of eligibility is 60 and the benefit is universal, meaning there isn't a means test and everyone above the

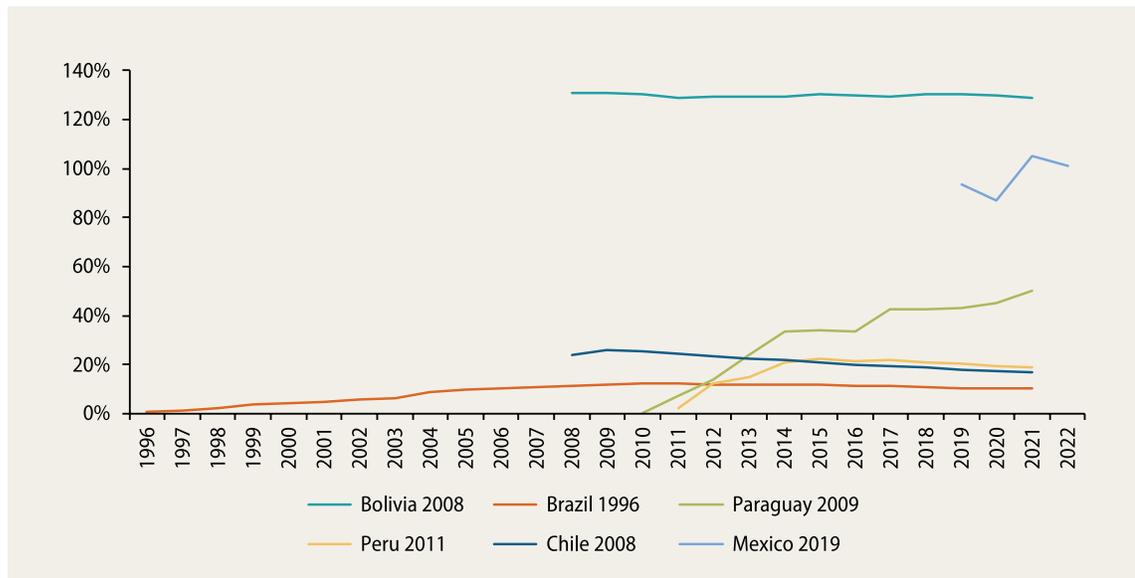
age of 60 is eligible (percentages in the graph exceed 100 percent because the denominator is population ages 65+ whereas the retirement age is 60). Conversely, coverage in Uruguay, where the age for eligibility is 70 and benefits are means tested, stands at 15 percent of the population above age 65. Figure 14.2 presents the data on beneficiaries of social programs in LAC countries over time.

FIGURE 14.1 Coverage of non-contributory pensions, % population 65+



Source: World Bank ASPIRE dataset

FIGURE 14.2 Old age social pension beneficiaries, % population 65+



Source: World Bank ASPIRE dataset

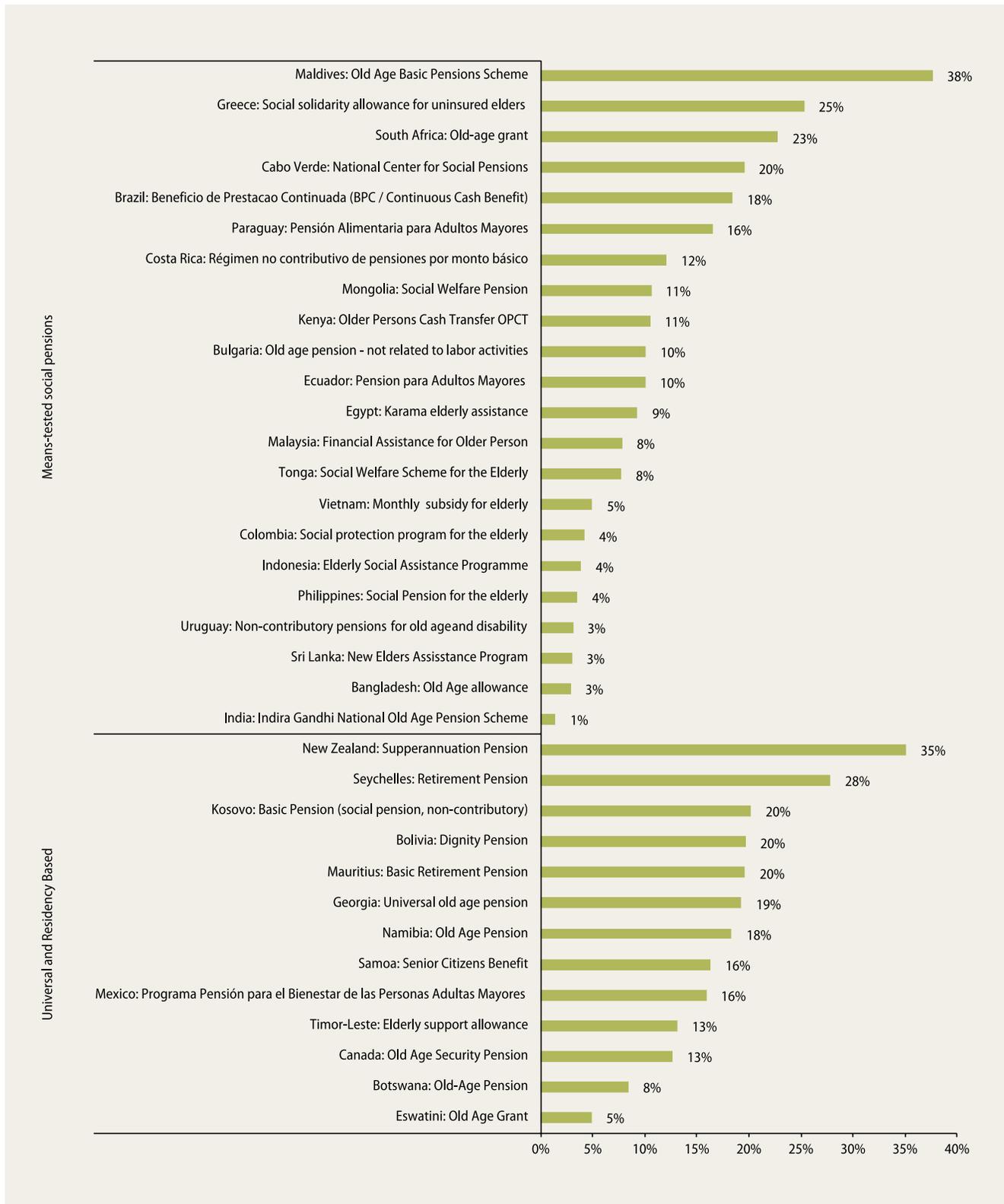
All these models have two main objectives in common – to ensure a minimum level of income support to the largest possible number of (poor or vulnerable) elderly. What that “minimum level” of income support needed is, and who is “poor”, can vary from country to country. Some countries have assigned greater importance on expanding coverage at the expense of a lower level of pensions, while others have set more strict eligibility conditions (including higher eligibility ages or income threshold levels for means testing) – opting to provide higher benefits to fewer beneficiaries. Governments are faced with the need to balance the potential disincentives to formalization and higher costs that a high level of non-contributory pensions spell with the potential regressivity and limited impact on poverty of a low level of benefits (Figure 14.3).

While the overall objective of non-contributory pensions is to ensure a minimum standard of living in old age, some countries provide benefits that exceed the poverty line, while others only provide a fraction of the poverty line. Across the Organization for Economic Cooperation and Development (OECD) countries, means-tested non-contributory pensions average around 19 percent of gross average earnings. It is interesting to note however that some countries, including Australia, New Zealand, and the US have pension amounts for elderly eligible couples that are less than twice the benefit amount a single elderly person receives. In Australia, an eligible couple receives 1.5 times the benefit an elderly person living alone receives. In the developing countries where data is available, universal, and residency-based pensions average 18 percent of GDP per capita, whereas means-tested pensions average around 10 percent of GDP per capita. The current poverty line is approximately at 20 percent of GDP per capita in lower-income countries, and a little lower in middle- and higher-income countries. However, in only 8 of the countries where data is available (n=34), non-contributory old age pensions equal or exceed 20 percent of GDP per capita (Figure 14.4). Benefits below the poverty line alongside high

out of pocket healthcare expenditures suggest that poor and vulnerable elderly in lower income countries may be inadequately positioned to maintain a decent⁴ and healthy life at older ages. Out-of-pocket expenditure accounts for 48 and 43 percent of total health expenditure in lower middle income and low-income countries respectively, whereas it accounts for 32 percent in upper middle-income countries and only 14 percent in high income countries.

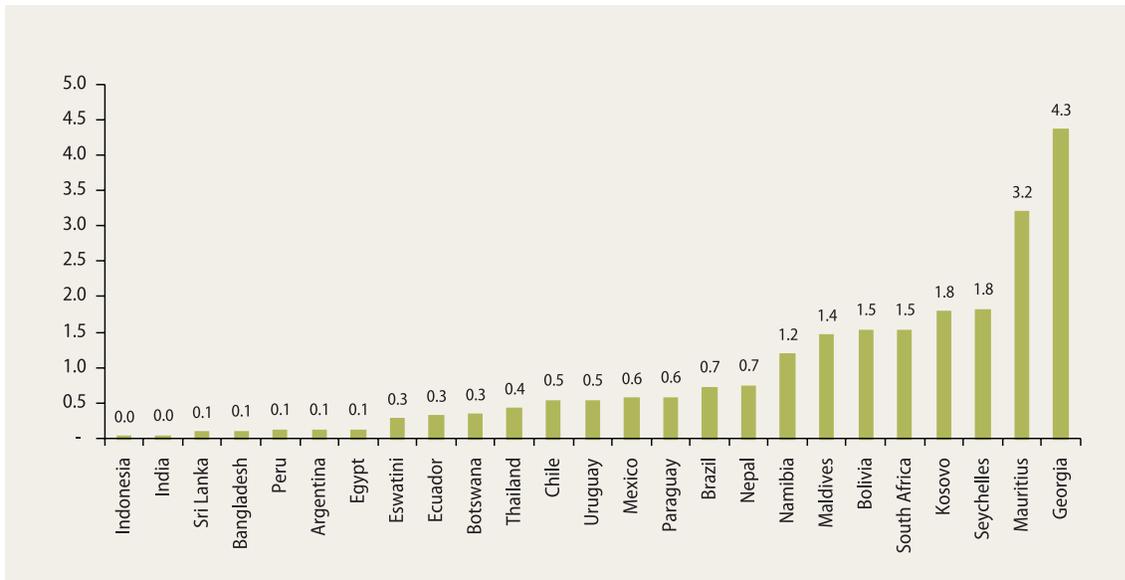
However, increasing the benefit level without carefully defining the pool of potential beneficiaries may lead to programs quickly becoming fiscally unaffordable. A recent study for the SAR region (Demarco et al. 2022) presents the challenges to expand social pensions in a region where most population in the informal sector is poor and needs to rely on non-contributory programs to provide financial support to the elderly. The study concludes that expanding noncontributory pensions to provide all informal workers with retirement and coverage of other long-term social insurance risks would require enormous fiscal efforts and is not recommended. Although noncontributory pensions play a necessary role in providing income security in old age for the poorer informal, fiscal constraints will limit both the size of this kind of pensions and the income and age to be eligible to receive the old age benefit. The study also highlights that even if noncontributory pensions are devised to be affordable now, a major challenge is ensuring that the program remains affordable over time, given the population aging and the potential for discretionary increases in the benefit amounts. Figure 14.5 shows the current and projected share of 60+ individuals in total population in South Asia region – most countries are projected to see their elderly populations double or more as a share of total population. The figure shows expenditure on non-contributory pensions – expenditure is highest in countries with universal coverage and high benefits as a share of GDP per capita. Fastest ageing countries with universal pensions will likely need to budget a growing, potentially unsustainable, fiscal allocation to their income support for the elderly.

4 The ILO Convention No. 102 recommends that non-contributory pensions, including means-tested old-age pensions, should guarantee that the provision offered is at least sufficient to maintain the family of the beneficiary in health and decency (Convention No. 102, Art. 67(c)).

FIGURE 14.3 Benefit amount, % GDP per capita

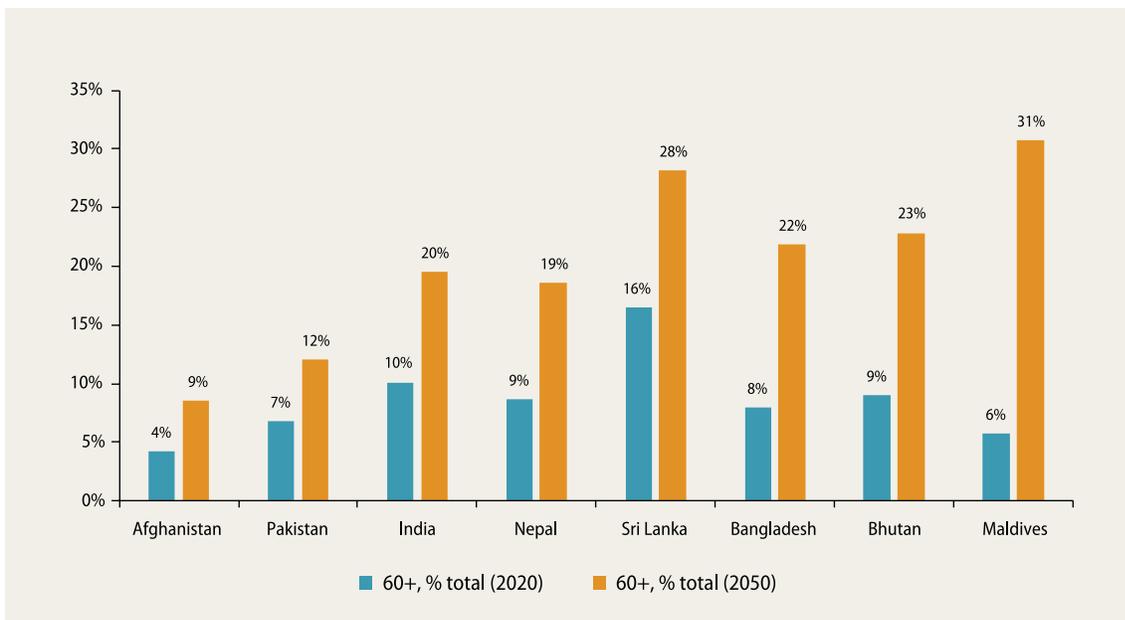
Source: Original calculations for this publication based on World Development Indicators and World Bank ASPIRE dataset

FIGURE 14.4 Expenditure on non-contributory pensions, % GDP (latest year)



Source: World Bank ASPIRE dataset

FIGURE 14.5 Projected share of 60+ in total population in SAR



Source: Original calculations for this publication based on data from World Bank ASPIRE

ACCESS TO HEALTH AND LONG-TERM CARE SERVICES

While rapid progress in medical science and treatments explain the important extension in life expectancy and aging worldwide, health and long-term care costs can quickly become overwhelming. These costs are higher in the last years of life, so older people face a much higher risk of encountering such catastrophic costs that would not only eat up their pension and other social benefits, but also their savings and other assets. So, to fulfill the financial protection mandate, countries not only need to provide pensions but also access to affordable health and long-term care.

In many countries, pension systems link to health care, and in a few countries even long-term care. Again, this seems to work well in the *Bismarckian* systems when the economy is highly formalized and coverage—both in terms of beneficiaries and contributors—is broad. In these countries, typically social insurance type pension systems are linked with social health insurance so that beneficiaries of pensions are also covered by—and contributing to—health insurance. There are some exceptions, notably the US, which has a separate health program for the elderly (Medicare) and the UK, which

has a universal national health system.

There is large consensus on the motivation and need to provide healthcare for the elderly, but the concept of adequacy pensions usually misses the *implications of out-of-pocket healthcare expenditures*, which is in turn dependent on *the health care financing model* and *the quality of health service delivery*.

The table below, using the categories proposed by Scheil-Adlung (2013), includes some additional dimensions which may help us identify additional factors to incorporate in the concept of adequacy pensions.

TABLE 14.2 Additional dimensions to identify factors to incorporate in the concept of adequacy pensions

	Social Health Insurance				
	National Health Services	Traditional (Bismarckian)	National Health Insurance	Community-based Health Insurance	Private Health Insurance
Coverage	All	Formal sector	All	Selective (community members)	Selective (voluntary members)
Financing	Public budget	Contributions (group or national risk pooling)	Public budget and contributions	Local governments and NGOs	Individual contributions (low or no risk-pooling)
Sufficiency	Yes, if all health services are provided efficiently	Yes	Yes, if all health services are provided efficiently	Yes, if all health services are provided efficiently	Yes
	No, if some services are excluded or the quality is poor		No, if some services are excluded or the quality is poor	No, if some services are excluded or the quality is poor	
Out of pocket costs	Low	Low	Low	Low	High

Source: Adapted from Scheil-Adlung (2013)

The table shows five basic models to provide health coverage for the elderly, with different financial implications: (i) National Health Services (also known as “Public Health”); (ii) Health Insurance (under three possible variants: contributory, national or community based), and (iii) private health insurance.

The green shadow means that the probability of the members to incur in costs is null or low, while red means they must incur in costs, or they may need to do so. This may happen because the costs are on the members (by design), because the original sources of funding may result insufficient, or because the population covered may need to seek alternatives at their

expense when quality of services is low.

National Health Services provided in many countries are the main mechanism of health coverage for the poorer (elderly and non-elderly). Countries with strong public health systems will provide health care at null or low cost. This would be the only case in which **adequacy pensions** can be defined at a level equivalent to the poverty line (*p*):

$$AP = p \quad [1]$$

However, if public health does not cover some treatments, or the services are of poor quality, some

health services, treatments, and medicines may need to be paid out of pocket, and the level of adequate pension would change to:

$$AP = p + \alpha nc + \beta q \quad [2]$$

Where α and β are coefficients to increase the level of adequacy pension in the cases of non-covered services (nc) or to compensate for quality deficits (q , with $\beta \leq 0$). Both parameters are dependent on the probability of occurring and the costs incurred.

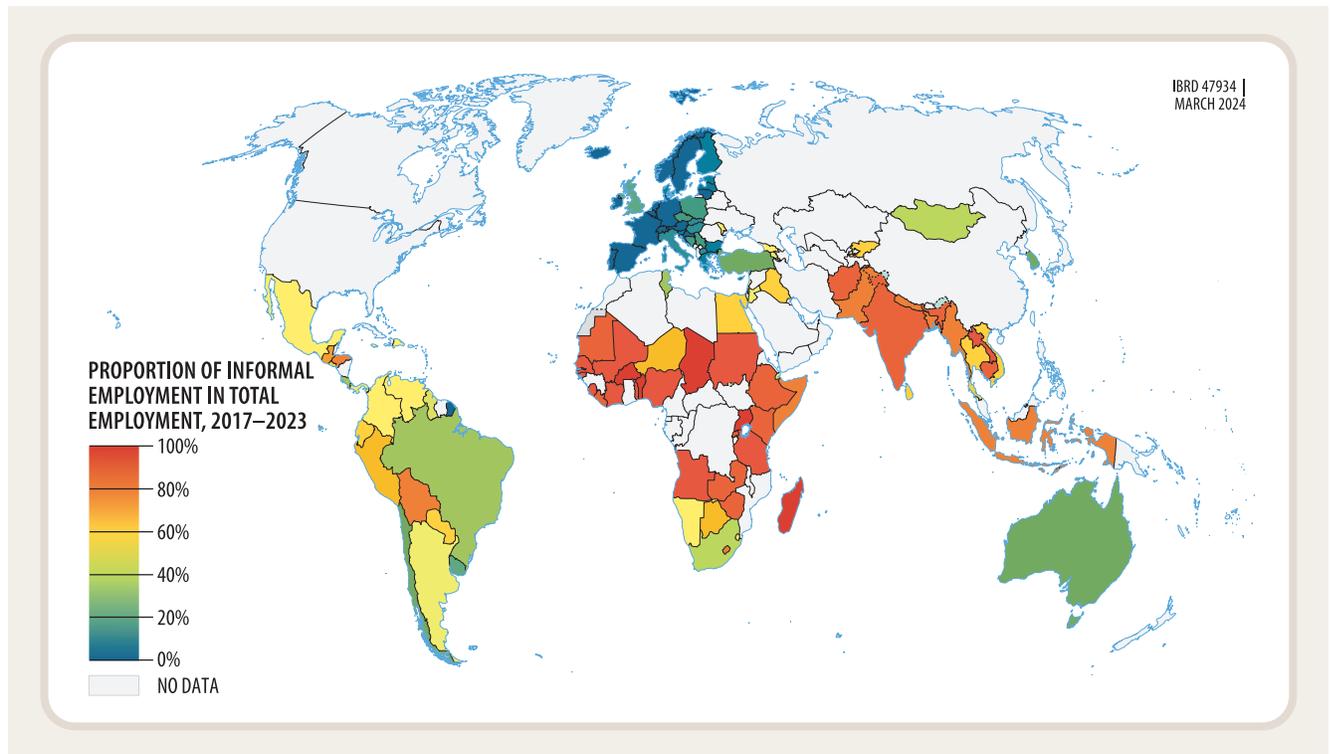
The source of financing appears in yellow in the table, to reflect the risk of a potential limitation of financing sources in the future (unsustainable social expenditure), resulting in the need for further adjustments in the level of pensions to be considered “adequate”.

Similar situations can be observed in the cases of National Health Insurance and Community Based Insurance, except that these programs were developed in some countries to complement the Public

Health programs and overcome some of their limitations and challenges. In several countries, NHI and CBHI coexist with NHS, but they usually provide additional services and more expedited treatment, especially for targeted groups such as children, elderly, and persons with disabilities. One of such examples is Egypt, where a National Health Insurance program was launched to provided poorer groups with better access to the services provided by the pre-existing Public Health hospitals and facilities.

The case of traditional Health Insurance is different because the health services provided are usually wider and, in general, of higher quality than in the case of public hospitals. However, these services are usually available to workers in the formal sector, which in developing countries represent a small percentage of the total labor force and usually excludes the growing group of self-employed, migrant workers, and other forms of work which are becoming prominent in the world, such as platform workers.

MAP 14.1 High shares of informality in developing countries

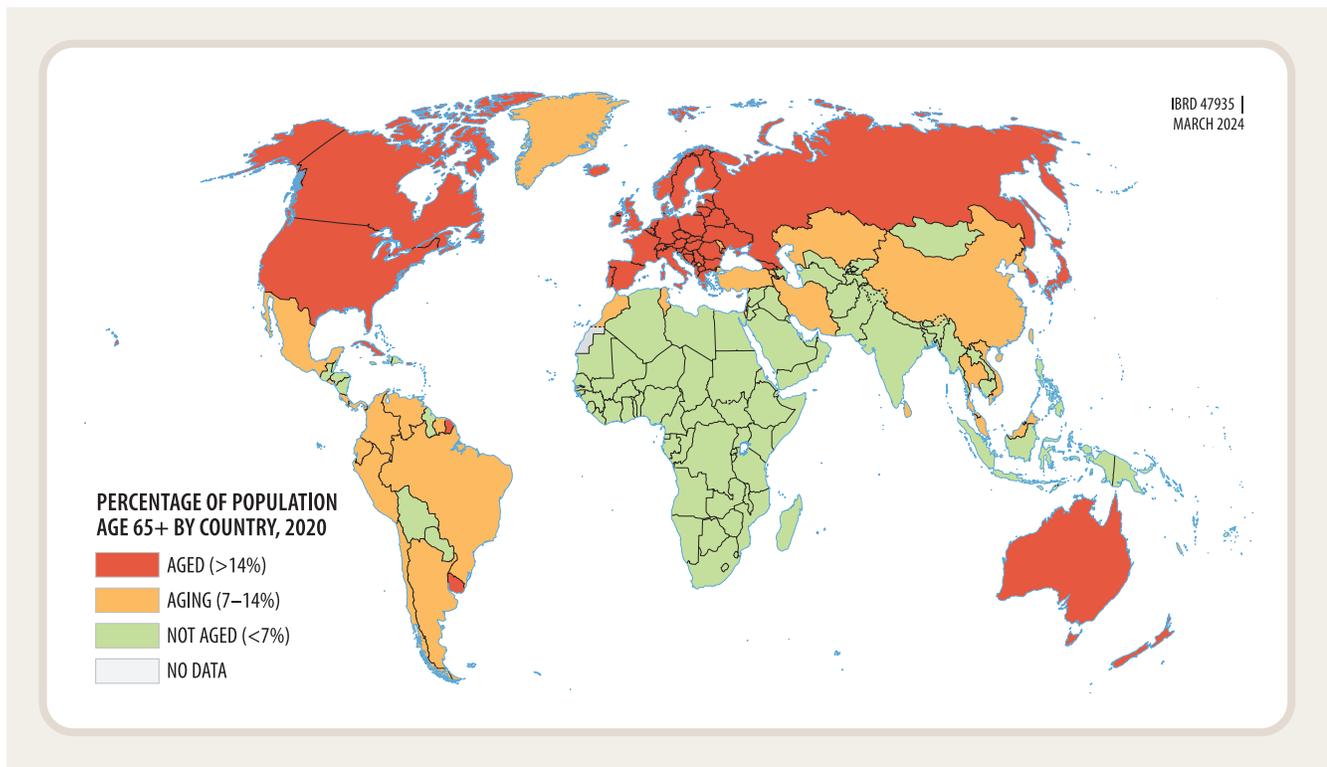


Source: ILOSTAT

However, formal sector workers’ health insurance is at risk of becoming unsustainable due to the increasing costs of health and pensions associated with demographic change. As shown in the following figures

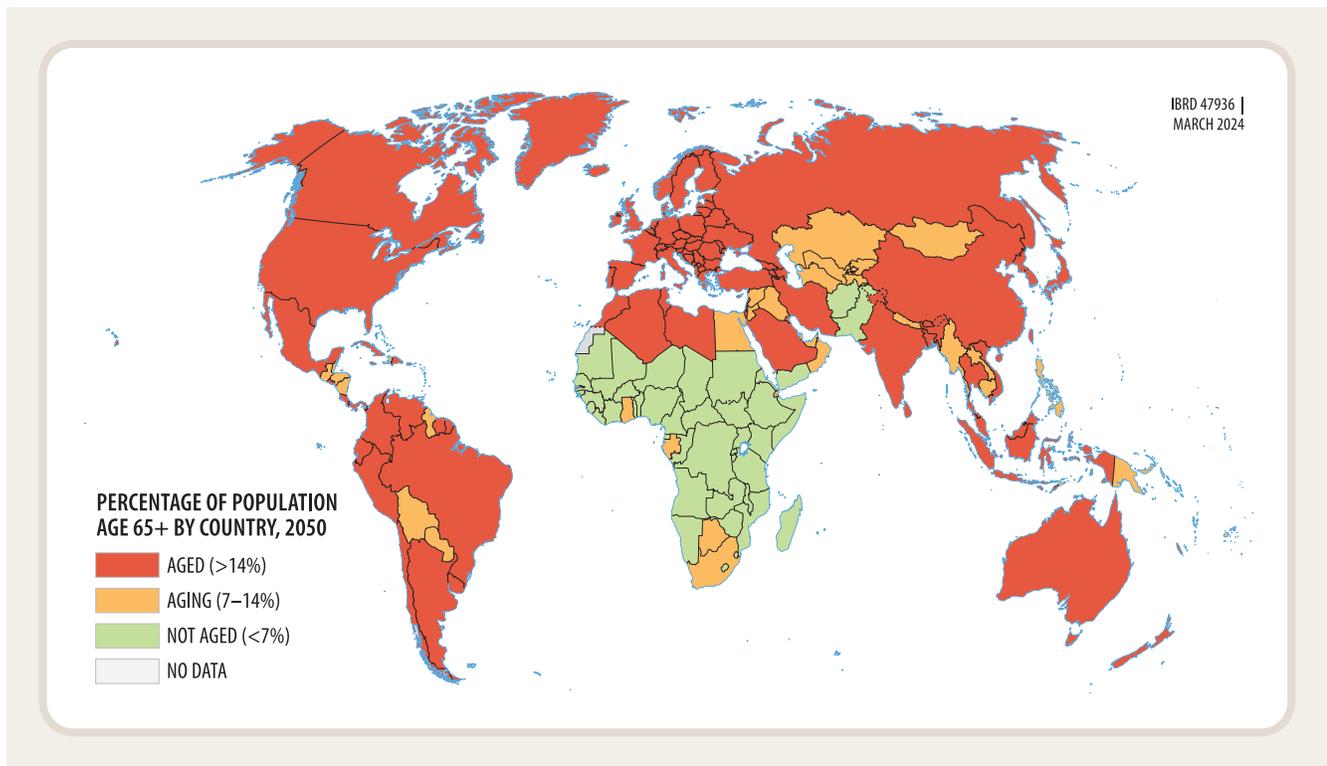
(Maps 14.1 - 14.3) and highlighted in multiple publications, aging population is happening at a high speed, even in young countries, many of which will have large number of the elderly in the coming decades.

MAP 14.2 Global Aging in 2020



Source: Adapted from Harasty and Ostemeier (2020)

MAP 14.3 Global Aging in 2050



Source: Adapted from Harasty and Ostemeier (2020)

The case of the voluntary private health insurance is beyond the scope of this chapter. It is limited to a small number of higher income groups of the population, so they have no implications on the analysis of “adequacy pensions”.

In summary, minimum, or social pensions should be defined as “adequate” if they are able to provide income protection to prevent poverty and some minimum level of income to provide for health expenses at older ages, as shown in equation (2). Ideally, access to good quality health services would be a better solution, but we will assume that this would require more structural reforms of the health system, which could not be achieved in the shorter term.

The main problem with that formula is that most of the variables (notably nc , q and the parameters α and β) are difficult to observe or measure.

The Elder Economic Security Standard Index (Elder Index), developed by the Gerontology Institute at the University of Massachusetts, Boston (Elder Index 2022), provides a measure of the income that older adults in the United States need to meet their basic needs and age in place with dignity. This includes not only housing and food but also the cost of healthcare. The Elder Index is one example of a methodology that facilitates tailoring the adequacy measure to the elderly while still providing a relatively simple way to evaluate retirement security. Even so, the extension of such methodologies faces important data challenges, particularly in developing countries.

In the absence of detailed data required for an accurate measurement of “adequate pensions”, we propose the use of a proxy variable. Out-of-pocket health expenditures (OOP) have frequently been suggested to increase the needs of poor, above the poverty level. There is abundant information on OOP, although the data not always discriminates the expenditures by income level and age. If that information was available, then the proper definition of adequacy pensions could simply be reduced to:

$$AP = p + OOP \quad [3]$$

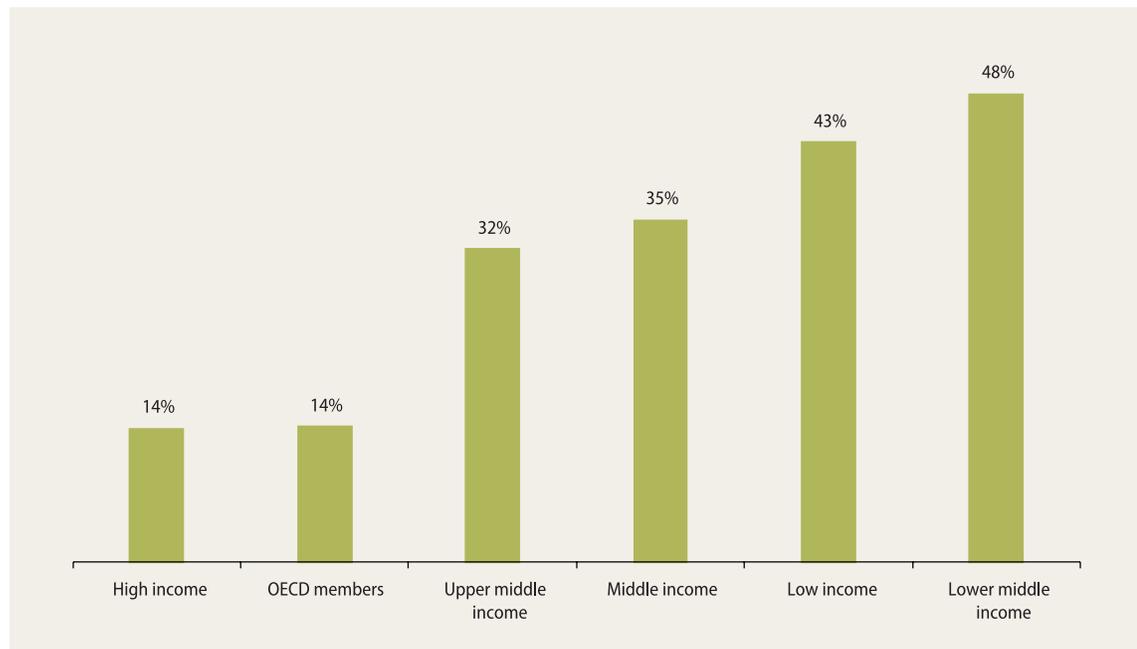
The caveat of this approach is that “OOP” may underestimate the needs of health coverage, especially for poorer population, who may not be able to incur so much OOP as their health needs would require, precisely because of their limited income, and they may just not attend medical consultations or stop

treatments. A possible solution would be to use the OOP variable corresponding to a higher income group (for example, the lowest income quintile instead of the lowest decile households). It may be useful to incorporate this indicator (or estimate its level) in the definition of adequacy pensions.

Impoverishment⁵ due to out-of-pocket spending occurs even in countries where the entire population is officially covered by a health insurance scheme or by national or subnational health services (Wagstaff et al. 2018). Out-of-pocket spending on health can add to the poverty head count and the depth of poverty by diverting household spending from non-health budget items. Data from WHO and World Bank shows that the size of out-of-pocket expenditures is highest among low and lower middle-income countries, followed by middle and upper middle-income countries and is lowest among high income countries (Figure 14.6). OOP spending on health care tends to be higher across countries where the share of total public health spending channeled through social security funds is lower. While high OOP spending can add to poverty, low OOP spending doesn’t necessarily mean a good thing, especially if public health spending is lower and the country is low-income. Countries with low levels of public spending on healthcare that also report lower OOP costs suggests that the lower OOP expenditure levels may, to a degree, be resulting from people forgoing healthcare altogether at higher rates – lower OOP costs among low-income countries with lower levels of health spending channeled through social security funds may signal inadequate financial resources resulting in healthcare done without.

Analysis of household survey data also shows that having any OOP health costs is widespread among low and lower-middle income countries with around 8 out of 10 households reporting OOP health costs across all income quintiles. A deeper look at the household composition by age shows that a higher percentage of households with elderly vs households without elderly report having OOP health expenditures. Further analysis using the income distribution shows that the largest percentage of households reporting OOP costs fall in the richest quintile (Q5), while the lowest percentage of households reporting OOP costs are in the lowest income quintile (Q1): only 75 percent of households with elderly in the Q1 report having OOP costs while 87 percent of households with elderly in

5 Impoverishing out-of-pocket metrics include indicators to identify both people impoverished and further impoverished by out-of-pocket health spending, using various poverty lines (e.g., the global extreme poverty line, a relative poverty line).

FIGURE 14.6 Out-of-pocket expenditure (% of current health expenditure)

Source: WHO Data Portal.

Q5 report having OOP costs. These findings align with both the thinking that healthcare needs increase with age and that lower income individuals may forgo care at higher rates for financial reasons.

Household survey analysis shows that households with elderly have 1.3 percentage points higher OOP health expenditure relative to households without elderly (Table 14.3). Households with elderly in the lowest income quintile spend 1.29

percentage points more than households without elderly in the same income quintile. In the richest income quintile, households with elderly spend 1.5 percentage points more than households without elderly in the same income quintile.

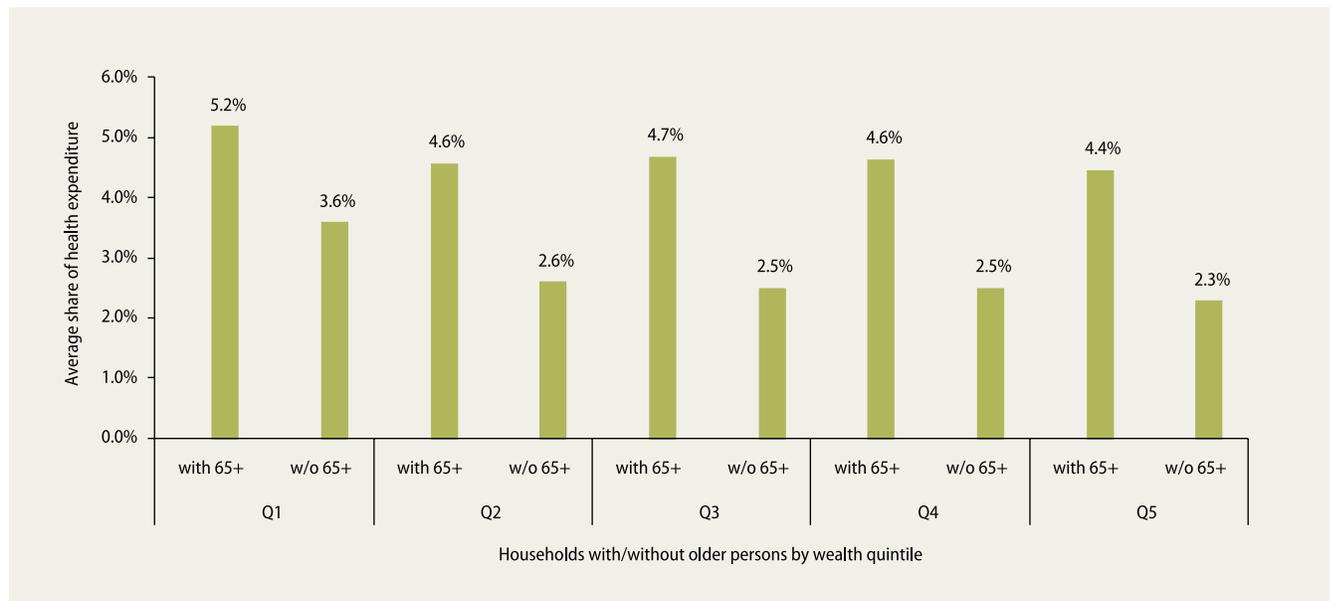
On average, a household with elderly that belongs to the bottom 20 percent spends 5.17 percent of welfare (based on household expenditure), whereas households in Q5 spend only 4.4 percent

TABLE 14.3 Comparison of average shares of OOP health expenditure between households with elderly in the poorest quintile versus households with elderly in the richer quintiles

	(1)	(2)	(3)	(4)	(5)
VARIABLES	sh_hexp_1	sh_hexp_1	sh_hexp_1	sh_hexp_1	sh_hexp_1
hh_older_65	0.0129*** (0.0029)	0.0121*** (0.0017)	0.0149*** (0.0019)	0.0119*** (0.0011)	0.0149*** (0.0010)
hh_size	-0.0007*** (0.0002)	-0.0001 (0.0002)	-0.0005*** (0.0001)	-0.0004** (0.0001)	-0.0008*** (0.0002)
Constant	0.0379*** (0.0015)	0.0274*** (0.0014)	0.0288*** (0.0009)	0.0277*** (0.0009)	0.0267*** (0.0007)
Observations	50,191	58,894	64,584	71,737	88,508
R-squared	0.0048	0.0072	0.0127	0.0082	0.0143

Note: Robust standard errors in parentheses; *** p<0.01, ** p<0.05, * p<0.1

FIGURE 14.7 Average share of out of pocket health expenditure by quintile and presence of persons age 65+



Source: Original calculations for this publication based on household survey data from World Bank ASPIRE.

of welfare – representing a 16 percent higher burden on poor households with elderly. Comparing average shares of OOP health expenditure between households with elderly in the poorest quintile versus households with elderly in the richer quintiles also shows that elderly poor devote a larger share of their income to OOP health costs relative to richer households with elderly (Figure 14.7).

Households with elderly in the poorest income quintile are more likely by 0.40 percentage points to be pushed below the poverty line (\$3.2 per day) whereas richer households with elderly report no impact on their welfare due to OOP health spending. In addition, households with elderly and households without elderly have a 4 percentage points and 1.5 percentage points higher likelihood of incurring at least 10 or 25 percent of OOP expenditure on health respectively as a share of their welfare.

Welfare is calculated on a per capita basis at the household level, which means analysis assumes

each family member receives an equal share of the overall household welfare. However, elderly members may not always receive an equal share, exposing elderly individuals to an even greater vulnerability than household survey results suggest.

In summary, households with elderly face higher healthcare costs in general across all income groups relative households without elderly. Poor households with elderly spend a larger share of their welfare on OOP health expenditures. As such, elderly in the bottom 40 percent of the income distribution face increased vulnerability as their healthcare needs – along with higher OOP health costs increase as they become older. Findings from this household survey analysis of low and lower middle-income countries suggest that elderly poor among these countries may choose to forgo healthcare at lower rates if they receive an adequate non-contributory pension that not only covers their basic living expenses but also provides for access to adequate healthcare.

CONCLUSIONS

To define a level of pensions as “adequate”, we need to include considerations on access to health care. Well-designed programs can either offer a package of pensions plus health coverage or invest in improved public health and long-term care for the elderly. Not doing so exposes many of the programs launched in recent years to the risk of failure. This may be the case both of programs to provide universal pensions (without provisions for healthcare), and of the universal national health care system that is de-linked from any social protection benefits.

In the case of social insurance, the link between pensions and social health insurance for the elderly exists in many cases but is concerningly missing in others. In the cases where health insurance exists, it sometimes only covers the workers during the active life, but not after retiring. The link between pensions and health programs may prevent the lower income pensioners from falling in poverty. But, as explained in the main text, this can only apply to formal sector workers, and these are a minority of the workforce in most low- and middle-income countries.

The *Bismarckian* social insurance model has many advantages and is very effective in highly formalized economies, although even among those, societal ageing and the changing nature of work pose considerable challenges for the pay-as-you go financing model going forward. In recent years, an alternative to the Bismarckian social insurance model has been gaining popularity in the form of basic pensions, old age allowances, or simply an increased re-

liance on the general safety net. A separate program to provide healthcare for elderly has been adopted in several countries. The US Medicare program is one such example of a program is delinked from pensions, while extended programs for elderly such as the “*Programa de Atención Médica Integral*” (PAMI) – the Integrated Medical Assistance Program – adopted in Argentina in the early 1970s only apply to pension beneficiaries (in a fairly lax manner).

Programs designed to expand social pensions or non-contributory programs should explicitly provide enough resources to cover the minimum expenses at poverty level, plus the projected out of pocket health expenses. However, the fiscal implications of providing adequacy pensions are stark and require careful analysis and projections to ensure fiscal sustainability. The approach proposed in this chapter may provide further evidence to support targeting fiscal support to non-contributory pension programs, as opposed to universal benefits.

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