A comparative analysis of public social assistance systems in Belgium and Health Equity Funds in Cambodia: an overview of lessons learned

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Abstract

Belgium has a solidly implemented multi-purposed public social assistance system that is the result of a long social and political history characterised by an evolution from charitable privately funded systems in the 19th century to a publicly funded and operated social assistance system in the last quarter of the 20th century. In a first part of this paper we describe the decision-making structures and processes concerning the delivery of social assistance benefits in Belgium. The main strengths and weaknesses of the Belgian social assistance system are analysed. In a second part, the paper discusses this specific experience of social assistance in relation with the emerging movement in low- and middle-income countries of single-purposed social assistance systems put in place for the payment of health care for the poorest in society. The Cambodian experience with health equity funds is central in this description. Finally, in a third part of the paper, a number of possible lessons from the specific Belgian experience are presented for the design and operation of social assistance systems in low- and middle-income countries. They pertain to the use of social assistants as front-line staff in the delivery of social assistance; to the need for health equity funds to extend their services beyond destitute households; to the importance of stigma as a barrier in the utilisation of social assistance services; to the stewardship role of public administrations of social assistance; and last but not least, it cautions policy-makers for reducing social assistance to a technical issue; they should instead also address its political dimensions.

Introduction

Public social assistance programmes, broadly defined as any public action designed to transfer resources on a non-contributory basis to individuals deemed eligible due to poverty, are solidly implemented in most high-income countries, although important variations exist (Alesina and Glaeser 2004). These systems are the provisional and un-finished result and product of a long social and political history that goes far back in time. Samuel Johnson already wrote at the end of the 18th century that "a decent provision for the poor is the true test of civilisation". Today, these systems are quite comprehensive in their assistance. Modes of operation can be diverse. Public programmes sometimes directly provide goods or services, but they may also subsidise the costs, partially or totally, of good and services available on the market. Operators can be public or private. In the specific case of Belgium, private organizations have been at the forefront of social assistance systems for a long time. But in the 20th century public authorities have gradually taken over the funding and operation of these systems. Social assistance in Belgium today is characterised by a multi-purpose functioning - it aims to ensure people's right to a minimum income and to access basic social services. The mission of these social assistance systems is to guarantee each citizen a 'dignified' life. The first article of the 1976 law on Public Centres of Social Welfare states that "each person has the right to social assistance". "This assistance aims to enable each and everyone to live a life that responds to human dignity" (Belgisch Staatsblad 1976).

In Belgium social assistance operates in parallel with a well-performing and universal system of social health insurance covering (most of) the costs of health care for the Belgian citizens even if not all do pay the contribution themselves (e.g. people living on unemployment benefits are automatically covered). Two other pillars in the Belgian social security system are the provision of a replacement income for unemployed and for pensioners. The Belgian social assistance system targets people who fall through these different safety nets. This clarifies why social assistance in Belgium today only marginally addresses issues pertaining to health care. Indeed, as will be illustrated later in this paper, the bulk of the assistance is provided for other purposes than health care.

In low- and middle-income countries, there is today an increasing interest in the development of social assistance systems and safety nets more generally (Holzmann and Jørgensen 2001; Coady *et al.* 2004; Rawlings 2005). It results from a conjunction of factors. First, at global level, there is the paradigmatic shift from 'development' to 'poverty reduction'. This strong attention to the poorest is today very present in the international health policy debate (Gwatkin 2005). Second, in many countries, there is the growing awareness that a substantial part of the populations is excluded from basic social rights - be it health care or other services like education, housing, work, etc. Third, there is the recognition that safety nets could in fact contribute to economic growth thanks to the protection against shocks that is offered to households (Dercon 2002; Ravaillon 2003). Last but not least, some recent successes with schemes targeting the poorest - e.g. conditional cash transfers - have confirmed that targeting policies are possible outside OECD countries (Gertler 2004; Rawlings 2005). Social assistance, as a policy, is gradually being rehabilitated in low- and middle-income countries.

The concept of publicly organised multi-purpose social assistance in many low- and middle-income countries is however not new: such systems have existed for decades - at least in theory. They are generally located within the administration of Ministries of Social Affairs. In Africa for example, these systems of public social assistance have often been 'copied' from the former colonial masters. But today these systems do not work properly. People hardly know of their existence. Anecdotal evidence indicates that the functioning and performance of these systems are highly problematic: they are under-funded and under-staffed; they sometimes face excessive bureaucracy and may be fraught with problems of ill-management, corruption and political patronage. There is similar evidence from other parts of the world. The paper by Yuebin Xu *et al.* on Medical Financial Assistance (MFA) in rural China in this issue points to important design problems and to the need for additional institutional funding if MFA schemes are to be more effective.

Social assistance and health care in low- and middle-income countries

In the case of health care delivery, there is a strong interest today in social assistance systems covering the cost of health care for the poorest in society. There is a wealth of evidence pointing to the exclusion of households in low- and middle-income countries from basic health care. The reasons for this are multiple, but paramount in the explanation is the issue of health care financing. Today, the bulk of the expenditure for health care in many developing countries takes place on an out-of-pocket basis and patients who attend a health facility thus have to pay user fees (Ahrin-Tenkorang 2001; Gilson 1997). Policy-makers in low- and middle-income countries increasingly recognize the limitations of systems of exemption of user fees: they were supposed to protect the poor but empirical evidence indicates that they do not serve the purpose they were meant for (Gilson *et al* 1995; Willis and Leighton 1995; Stierle *et al.* 1999). Exemption policies indeed are fraught with ill-management, corruption and patronage relationships (Kivumbi and Kintu 2002). Similar patterns have been identified in China (Qingyue *et al.* 2002). Not in the least, exemption policies meant a loss of income for the health services, and thus also for the health personnel. The latter thus face strong disincentives to apply exemptions of payments for poor patients presenting at their facilities. This poor state of affairs of exemption policies has contributed to the current exploration and increasing testing of alternative models of financing health care for the poorest.

The World Health Organization (2000) has clearly argued in its World Health Report for the need of pooling arrangements in the field of health care financing so as to arrive at risk-sharing between healthy and sick people and between the rich and the poor, rather than leaving the burden of the payment for health care on the shoulders of individual patients and households. Insurance arrangements nicely fit that purpose and health insurance arrangements currently attract a lot of interest from policy-makers, be it under the form of Community Health Insurance (CHI) or statutory Social Health Insurance (SHI) systems. The rapid development in rural China of the New Cooperative Medical Schemes (NCMS), an insurance-based arrangement implemented at county level, is a spectacular development in that respect (see the paper by Wang Yunping *et al.* in this

special issue). CHI is also booming in sub-Saharan Africa, albeit at a much more modest pace: a survey carried out in 2003 indicated that in West-Africa alone more than 600 CHI initiatives operate today (La Concertation 2004). It generally takes a lot of time to develop CHI in a bottom-up fashion - as is the dominant *modus operandi* in Africa. In the case of China, with the considerable top-down support the NCMS policy receives from the government, the development of health insurance has been much faster. However, these systems, be it in Africa or rural China, are not a solution for the poorest in society unless subsidy mechanisms exist - which very often is not the case (Waelkens and Criel 2004). There is evidence today indicating that CHI does not reach the poorest and the destitute - even if CHI can play a significant role in actually *preventing* poverty caused by illness and by excessive, or catastrophic, health care expenditure (Waelkens *et al.* 2005). Social health insurance on the other hand is today only poorly developed in low- and middle-income countries, especially in sub-Saharan Africa. These systems, when they exist, often have a small coverage, limited to households in the formal sector (Normand and Weber 1996). If the poorest in society are to access health care, then other complementary financial arrangements need to be conceived. It is in that perspective that an emerging dynamic of "Health Equity Funds" currently takes place. The operating principle of equity funds (for health care) is simple: since the poorest cannot pay for health care, be it under the form of user fees or insurance premiums, and since exemption policies do not work, somebody else needs to pay for them (Hardeman *et al.* 2004; Jacobs and Price 2005; Noirhomme *et al.* 2007). Health Equity Funds fit the concept and definition of social assistance for health care: i.e. a strategy that aims to enhance access to health care through a transfer in cash or in kind to eligible individuals. Increasingly, the option to combine Community Health Insurance and Health Equity Funds is being explored: the latter then serve to fund the insurance premium in the former for those households who do not have the means to pay the premium themselves (Jacobs *et al.* 2008). Also in China, as pointed out in the paper by Yuebin *et al.* in this issue, priority for MFA funds in many counties is given to supporting the poor households' participation in the New Cooperative Medical Schemes.

The purpose of this paper is threefold: first, briefly present some insight in the way versatile social assistance in Belgium is organized and

decided at the local government level; second, present the experience of Health Equity Funds in Cambodia and compare it along the lines of the analysis made for Belgian social assistance systems; and third, identify and discuss possible lessons from the rich and longstanding Belgian experience for the design and operation of social assistance for health care in developing countries.

Methodology

The first author (BC) combines the academic function of researcher at the Institute of Tropical Medicine Antwerp, Belgium, with the chairmanship of the Public Centre of Social Welfare (PCSW) of the semi-rural commune of Kruibeke (15,000 inhabitants) in the province of East Flanders in the north of Belgium. This chairmanship is a political function and BC has been in charge of the Kruibeke PCSW since early 2001. The combination of both assignments provides a unique opportunity to link insights in the complex reality of social assistance in an industrialized country with the recent developments but also growing pains of the emerging trend of equity funds designed to cope with the cost of health care in health systems in low income countries. The three other authors have been among the architects of the health equity funds dynamic in Cambodia that has grown from a small-sized experiment (Hardeman *et al.* 2004) to a nation-wide policy measure (HEF Forum 2006). They are currently involved in EU-funded research in South-East Asia on the study of the performance of safety nets for health care - 'Poverty and Illness' (PovIll). This study aims at a better understanding of whether and how poor households cope with the cost of illness and what the performance is of collective arrangements designed to overcome these problems (for more details, see the paper by Lucas *et al.* in this special issue).

This paper is divided in three parts. In a first part, the focus is on Belgium with a description of the functioning of Public Centres of Social Welfare (PCSW). Most of the elements highlighted hold for any PCSW in Belgium. Some aspects however are particular to the Kruibeke situation. The paper will largely draw on insight experience in and data of the day-to-day running of social assistance. This first part will more specifically deal with the following aspects: (1) an overview of the main decision-making structures within the PCSW; (2) a short review of the current offer of social assistance services; (3) a presentation of the main milestones in the evolving legal

framework for social assistance in Belgium; (4) a presentation of the operational decision-making process concerning the delivery of social assistance for individual clients; and (5) a strengths-weaknesses-opportunities-threats (SWOT) analysis of Belgian social assistance.

In a second part, a more detailed description of the health equity funds is provided. This presentation will be based mainly on the Cambodia experience, the overseas experience with social assistance for health the authors are most familiar with. Eventually a comparative analysis of Belgian social assistance systems and Health Equity Funds in low- and middle-income countries will be presented. We believe this is relevant for policy makers and researchers in low- and middle-income countries because of the longstanding experience Belgium has with public systems of social assistance in general, and with the rights-based approach to such assistance in particular.

In a third and final part of the paper, possible lessons from the Belgian experience for developing countries will be discussed. Such a comparison is far from obvious: the metaphor of comparing apples and oranges would not be entirely incorrect. The Belgian multi-purpose public social assistance system covers a wide variety of social services and the content of the assistance starts from the felt needs of individual clients. Cambodian health equity funds are structured along the lines of a programmatic logic: they cover costs related to the utilisation of (only) health care services and the content of the assistance is decided by the 'programme' managers - not by the users. Moreover, the social, economical and political environment of the two countries is obviously very different. We nevertheless believe that some general lessons can be drawn.

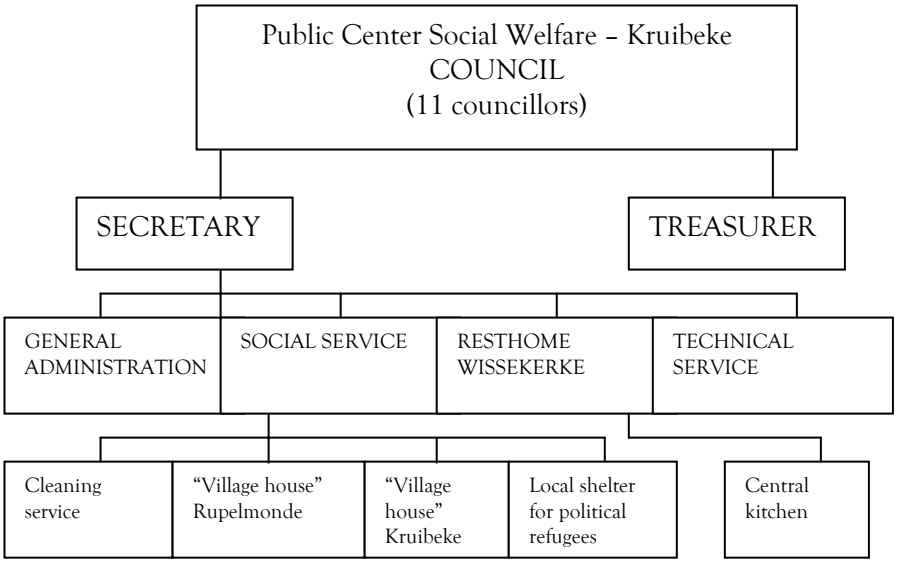
Social assistance in Belgium: the case of the Kruibeke Public Centre of Social Welfare

DECISION-MAKING STRUCTURES WITHIN PCSW

In Belgium, communal elections are held every 6 years. The communal council is established on the basis of direct representation and the majority then elects one of its members as mayor. In a second stage, each political family in the new council proposes and elects candidates for the PCSW council. The latter is a distinct political body that is in charge of the social welfare policies for 6 years. The number of members in the PCSW council is

dependent on the population size of the commune: in Kruibeke there are 11 PCSW councillors. The newly appointed PCSW council then elects a chairman and a bureau composed of the chairman and two other councillors. The PCSW administration is directed by a university-trained civil servant - the PSCW secretary - who is head of personnel and who is closely involved in policy preparation and implementation. Article 1 of the 1976 PSCW law defines the core mission of the Public Centres as follows: "each person has a right to social assistance. This assistance aims to enable everyone to lead a life that responds to human dignity" (Belgisch Staatsblad 1976). The priority target population groups of the PSCW's action of social care are the elderly, the destitute, and those excluded from mainstream society. The services created for that purpose include a "rest home" for elderly people that provide residential care and a central social service with several peripheral services like decentralised community centres ("village houses") offering a wide range of social and cultural services, home-care services like cleaning services, shelter and support for political refugees (Figure 1).

Figure 1. PCSW structure



The PCSW council meets once per month and addresses major policy issues in the local design, organisation and financing of local social services. The council meetings are open to the public except for matters pertaining to personnel that are treated confidentially. The council can decide on its policies on a relatively autonomous basis, except for those decisions that have major financial implications. In those cases, the explicit approval of the communal council is to be sought in the frame of the coordination committee Commune-PCSW that is chaired by the PCSW chairman and that meets 4 to 6 times a year. The largest part of the PCSW budget in Kruibeke (approximately 63%) goes towards institutional care of the elderly; about 21% goes to various forms of social assistance (Table 1). The total PCSW expenditure for social care was 606 Euro per inhabitant in 2003: at national level this assistance represents approximately 2.5% of Belgian GDP. This expenditure is financed by revenue coming from federal and local communal taxes: residential care for elderly in 'rest homes', by far the most costly item in the PCSW's activity portfolio, is mainly funded with federal money; the bulk of the social assistance benefits listed in table 1 is mainly paid for with local taxpayer money.

Table 1. Expenditure of the Kruibeke PCSW, data for 2003

Activity centres	Expenditure 2003 (euro)	Relative proportion	Average expenditure per inhabitant of Kruibeke (euro)
Central administration	882,000	10%	59
Various forms of social assistance	1,900,000	21%	127
Various other social services	600,000	7%	40
Elderly house	4,700,000	63%	380
Total	9,082,000	100%	606

The Special Committee Social Service is the structure that handles all decision-making concerning individual social assistance. The composition of this committee is decided in the PCSW council. In the case of Kruibeke, this Committee is made up of a representation of the council, the PCSW secretary, the head of the Social Service - a senior social assistant - and her

team of 4 social assistants. Other personnel are included on *ad hoc* basis: e.g. nursing staff in charge of the elderly houses and the social workers in charge of the different community centres. The Committee meets on a monthly basis and processes each time some 50 to 75 different demands in its monthly meeting that lasts about 2 to 3 hours. The Committee meetings are always closed to the public but the client who has demanded support may be heard by the Committee if she/he wishes so. This happens on average once per month.

OFFER OF SOCIAL ASSISTANCE SERVICES

This social assistance includes a wide range of services - that may slightly vary from one PCSW to another - going from the delivery of financial and material support, guiding and subsidising individual clients in their search for affordable housing, coaching of households in the management of their personal household budget, provision of free legal assistance, etc. A list of the most common types of financial assistance provided in 2004 is presented in Table 2. This list does not include the provision of support in kind (food, clothes, furniture), the offer of shelter and support offered to political asylum seekers under the care of the Kruibeke PCSW (92 individuals in 2004), nor does it mention the wide range of services provided in the frame of the Kruibeke PCSW's considerable support to the promotion of home care for elderly people. The latter includes the provision at home of warm meals and housing cleaning services at subsidised prices, the offer of alarm devices to be used in case of personal accidents at home, the offer of individualised transport at subsidised prices for poorly mobile elders and the payment of a monthly financial bonus to relatives or neighbours who care for elderly or handicapped in their home situation. The eligibility scope of this social assistance is very large: all people with a legal residence in the commune, including foreigners engaged in an administrative process of asylum quest that have been temporarily assigned to a designed commune[1]. Emergency assistance (shelter, food, financial aid) is also offered to homeless people while structural solutions are being explored. It is left to the discretion of individual PCSWs to offer humanitarian assistance to refugees

[1] The Belgian federal government has opted for a 'spreading' policy of asylum seekers over the entire territory of the country. In practise this does not always work because many political refugees prefer to live in large cities.

whose request to stay and live in Belgium has eventually been overruled by the federal government (Note: they have then become 'illegal'). In principle, these 'illegal' people are supposed to leave the Belgian territory but in practise this measure is hardly enforced. Many of them rely upon private help.

It is important to highlight that in many instances the person in need of social assistance - who may not be (fully) aware of his rights, or who is ill-informed on what social assistance services actually can offer, or who simply is reluctant to take himself the initiative to consult a social assistant - is referred to the PCSW through the intermediation of one of the actors (public or private) operating in the complex network of the pluralistic Belgian local social system. This 'mediator' may be a general practitioner (self-employed private health worker in Belgium) or nurses, a staff member of one of the several non for profit home care services that operate at communal level, the local schoolmaster or police officer, local politicians, the parish priest,... The referral most often takes place along informal channels: not with a formal referral note, but through a telephone call or an occasional personal contact or with a small informal handwritten note.

Table 2. Provision of social assistance in Kruibeke, data for 2004

Type of support	Number of times support was granted in 2004
Versatile financial support*	110
Living wage (includes social health insurance contributions)	80
Support of cost of medicines and medical care	32
Support of cost of hospital care	31
Support of schooling costs	28
Participation to cost of social and cultural activities for individual clients (e.g. sport activities, leisure activities)	23
Provision of social employment in PCSW facilities	19
Provision of subsidies for house rent	18
Advances on partner allowances in case of divorce	17
Payment of allowances for minor children	16
Payment of taxes for domestic waste disposal bags	8
Payment of house rent guarantee	7
Support for heating services (fuel)	3

Type of support	Number of times support was granted in 2004
Provision of social housing in PCSW housing infrastructure	3
Support of cost of stay in elderly homes	2
Support of funeral costs	1
Support of travel expenses	1

* Urgent allocation of money in about half of cases; to be refunded in instalments in a third of cases

A very important item of this social support is the *living wage* - formerly called subsistence *minimum.* End 2005, the living wage consisted of 626 Euro per month for a person living alone. A one-parent household with minor children received 834 Euro per month excluding child allowances. People above 18 years old and living together received 417 Euro per month per person in 2005. It is to be noted that 50% of these amounts are paid by the Belgian federal government and 50% by the local budget. The latter is financed with the revenue coming from local taxes collected by the commune. This policy of co-funding of the living wage illustrates the articulation that exists in Belgium between the central and the local level. In the case of the living wage, central funds complement local funds in order to alleviate the financial burden on local budgets.

People on a living wage automatically benefit from the full package of services offered in the frame of the Belgian Social Health Insurance system. The PCSW may in addition decide to help them to pay the various co-payments due when they consult a general practitioner, in case of a hospital admission and/or in case of purchase of medicines at a pharmacy. Routine data from the Kruibeke PCSW concerning people allocated a 'living wage' in the period 1998-2002, show that 254 individuals have benefited at least once from this type of financial support in this 5-year period. The average duration of the time during which these people received the living wage was 9.6 months. It is only for 10 out of 254 people (i.e. 4%) that financial support was provided for the *entire* 5-year period. This indicates that the need for a living wage is only for a minority of households a quasi-permanent situation. The corollary is that the need for social assistance, and more specifically for financial support, is in the majority of cases relatively limited

in terms of time. Interestingly, this fact contradicts the current popular perception in the mind of many Belgian citizens that 'there would be too many people (ab)using social assistance services on a permanent basis…'

In 2003, some 80,000 people received a living wage in the total of Belgium. With 10.5 million inhabitants, the incidence of the allocation of a living wage in the country is close to 1%. Recent research has indicated that this coverage is very probably well below the volume of true need; this aspect of unmet need will be discussed further in the paper. In the specific case of Kruibeke, the average yearly incidence rate for a living wage in the period 1998-2002 was 0.34%.

LEGAL FRAMEWORK

The framework regulating social assistance policies in Belgium has dramatically evolved over the last 150 years. The principal evolution over time has been a movement from a privately funded charity service in the 19th century to a publicly funded service in the 20th century aiming at societal reintegration of individual clients of social assistance services. In 1925 the autonomous Charity Offices that existed in each municipality were transformed into Commissions of Public Assistance (CPA). The most significant legal breakthrough however took place in the 1970s. The concept of 'subsistence minimum' was instituted in 1974. Two years later, in 1976, the law on the Public Centres of Social Welfare (PCSW) was passed: CPAs were transformed into PCSWs and social assistance became a right. More recently, in May 2002, the law on the right for societal integration was voted in the federal parliament. A legal framework was established whereby every citizen was given the right 'to participate in societal life'. The concept of 'subsistence minimum' that existed for half a century was turned into the concept of 'living wage'. The 2002 law strongly emphasised paid work as the main means to achieve integration in society (although a job is not a guarantee to earn a sufficient income[2]) and implied a well-defined responsibility of the PCSW vis-à-vis people below the age of 25. This is illustrative for the progressive shift from a purely compensatory to a more enabling and activating approach (von Maydell *et al.* 2006).

[2] The Belgian 2005 poverty report indicates that 5% of people with a job have an income below the poverty line (Armoede en sociale uitsluiting. Jaarboek 2005).

DECISION-MAKING CONCERNING INDIVIDUAL SOCIAL ASSISTANCE

The sequence in the decision-making process in Kruibeke, and in most Belgian PCSWs for that matter, concerning individual demands for social assistance is presented in Box 1. There is a clear distinction between the technical process handled by the social assistant on the one hand, and the subsequent political process whereby the Special Committee Social services approves or rejects the proposal formulated by the social assistant. In practise in Kruibeke, the Special Committee objects in less than 5% of cases to the social assistant's proposal. When it does so, the Special Committee may overrule the social assistant's proposal in two ways: either disagree with the proposed allocation of benefits, or disregard the negative advice given by the social assistant in charge and give the green light to the delivery of a benefit. In practice, both types of overruling are roughly equally frequent.

In cases of urgency, the Chairman of the PCSW decides the same day on the basis of an urgent written request formulated by the social assistant in charge of the client's file. The social assistant eventually informs the Special Committee at its first coming plenary meeting. Such urgent demands occur in Kruibeke, on average, once or twice a week.

Box 1. The decision-making process concerning individual social assistance

First a *technical* process : preparation by the social worker of an argued advice	**Second a *political* process: the Special Committee Social Service validates the proposed advice**
Contact (generally demand-driven) between a potential client and the PCSW ↓	The social worker presents the case and the advice to the Special Committee in its session closed to the public ↓
Private discussion between client and social worker ↓	The Special Committee agrees or not with the advice given by the social worker ↓
Social worker establishes an individual file and a provisional advice is formulated ↓	The social worker then briefs the client on the outcome of the Special Committee's decision.
The individual case is discussed in the team of social workers and a final advice is formulated ↓	
A summary of the case, with its advice, is prepared for the Special Committee Social Service	

The criteria used in the social assistant's decision-making process on the allocation of individual social assistance benefits to clients are based on a set of objective and standardised criteria like income, family status and age. There is however room for a more subjective appreciation of the case by the social assistant on the basis of elements generated by a short review of the client's past history, on the basis of home-visits carried out by the social assistant, and, eventually, on the basis of her/his 'gut-feeling' and personal appreciation of the client's situation. *This person has really been doing his best* or *that person is really not cooperative* or *this other person has been consistently lying to me…* are examples of personal experiences social assistants face and that play a role in their overall assessment.

The mechanisms in place to balance objective and subjective assessments in the delivery of social assistance are the peer control from the other social assistants in the team (in the Kruibeke PCSW there are 5 full-time social assistants - four female and one male), the need for final clearance from the senior social assistant who heads the team, and finally, the need for approval by the Special Committee composed of local politicians.

The latter may be a subject of controversy: why indeed should local politicians have the final word in the decision to allocate (or refuse) benefits to clients demanding for social assistance? The senior social assistant in the Kruibeke PSCW, who has more than 25 years of experience, when asked how she felt about this, estimated the advantages to outweigh the disadvantages. The same question was put to senior social assistants of 3 neighbouring PSCW in the cities and communes of Lokeren, Sint Gillis-Waas and Sint Niklaas. In Table 3 a synthesis of their arguments is presented.

Table 3. A political body as final authority in the decision on allocation of social assistance benefits

Pro's	Con's
• Need to thoroughly prepare the client's case for understanding and approval by non-professionals • Protection of the personal relationship between social worker and client in case of negative judgment by the Special Committee • Allows for control on possible power abuse by social workers • Politicians, and their constituencies, are informed on how local tax money is being used • Politicians are informed on local elements (structural and others) that contribute to poverty and social exclusion: this information is helpful in policy design	• Risk of patronage relationships • Expertise of councillors in deciding on allocation of benefits is not guaranteed • May cause delays in allocating the benefits • Social worker may be entrusted with tasks that are either not feasible or not backed up personally • The composition of the PCSW council may change after the 6-yearly local elections: this can contribute to limited continuity in local social assistance policies*

* One senior social worker considered this also to be a possible advantage: ill-designed policies can be reshuffled by a newly constituted PCSW council.

Apart from the *technical* and *political* decision-making processes concerning the delivery of social assistance described in box 1, a third possible process exists, albeit relatively rarely used: i.e. a *legal* process. If a client disagrees with the outcome of the Special Committee's decision, she/he can make an appeal to the labour court which can then overrule the Committee's decision. In Kruibeke, such appeals occur only a few times per year.

SWOT ANALYSIS

A Strengths-Weaknesses-Opportunities-Threats (SWOT) analysis of the Belgian system of social assistance was performed on the basis of the first author's experience as Chairman of the Kruibeke PCSW (Table 4).

Strengths: a major strength of the system lies in its strong legal framework and more specifically in the rights-based approach to social assistance formalised in the 2002 law on societal integration. Another important strength lies in the specific and earmarked human and financial resources allocated by both federal and local governments to social assistance - even now that it becomes increasingly clear that these resources are insufficient to cope with poverty alleviation.

Weaknesses: among the weaknesses is the fragmentation of information and service delivery in the field of social care: a variety of players, both public and private, are involved in social assistance of some kind. The complexity of the Belgian institutional situation - both federal government and regional governments play a role in the design and financing of social policies - certainly contributes to this state of affairs. An overview on who is doing what is often lacking, with a risk of duplications and inefficiencies. But probably the main weakness of the system is the insufficient coverage of the current social assistance system - in terms of both depth and width. Despite the many efforts made over the years and despite the good intentions of many hardworking PSCWs, a variety of barriers remain in the use of social assistance services. The lack and/or inadequacy of the information potential clients possess on the existence of social assistance services and the strong stigma that is still attached to the use of social assistance services are prominent among the barriers in place (Nicaise and Groenez 2001; Groenez and Nicaise 2002; Van Meerbeeck and Criel 2006). Data for the year 2005 on poverty in Belgium suggest that about 15% of the Belgian households would live below the poverty line (Armoede en sociale uitsluiting, Jaarboek 2005). There is however controversy on the validity of

the (monetary) cut-off point used: the criterion used is a level of income < 60% of the national median income[3]. It is nevertheless reasonable to state that today only part of the population in need is being reached by social assistance services. A possible indicator of this situation is the recent trend in Belgium whereby non-governmental organisations, Church-related organisations, civil society groups and private households increasingly take care of people falling through the formal safety net (e.g. the NGO *Médecins Sans Frontières* offering health care to people without any residence or that are illegally in Belgium or the organisation *Welzijnsschakels* offering help in cash and kind to the same people). Many of these people are political refugees that, after a relatively long administrative screening process handled by the federal government, were eventually not granted authorisation to legally take residence in Belgium - and who can therefore not claim (anymore) a minimum living wage.

Private forms of social assistance, organized on a discretionary basis, have always existed and will probably always exist. What may however change over time is the relative importance of this type of assistance in relation to more 'rules-based' forms of publicly delivered social benefits. Today in Belgium, private charitable initiatives seem to be again on the rise even if the bulk of social assistance still is delivered through public channels, i.e. via the administration of Public Centres of Social Welfare.

Opportunities: a major opportunity is the recent pressure from the Flemish regional government to coordinate social policies at local government level. This regional authority forces the local players, both public and private, active in the domain of social care, to coordinate and optimise their action. The PCSW is supposed to steer and coordinate this process and to create the conditions for local actors to communicate and to collaborate. Eventually, the PCSW is asked to come up with a comprehensive social policy plan that integrates the action of the various local players. Another opportunity ahead is the increasing interest to involve "experience-experts" in the design and delivery of social assistance policies[4].

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[3] For a person living alone this means less than 772 Euro/month - implying that the living wage in Belgium for a single person (626 Euro) is well below the poverty line thus defined.

[4] The non-governmental association "The Link", that is committed to increasing the involvement of the poor themselves in policy-making for the poor, nicely conceptualised the different gaps that exist today between policy-makers, public social assistance services and social assistants on the one hand, and the poor on the other hand (De Link 2005). The

Threats: among the threats, two seem prominent. One is the increasing workload social workers face. There is more and more paperwork and less and less time for these professionals to leave their offices and visit clients in the community. This situation creates frustration and goes at the expense of the client-centred character of the social care provided. Another threat is the increasing bureaucratisation and progressive 'toughening' of the sector of public social assistance with, concomitantly, a creeping resurgence of an attitude whereby individual cases are being held largely responsible themselves for the situation in which they live. This is an attitude Vranken and De Boyser (2004) refer to as the 'individual guilt model' consistent with the prevailing social and political mainstream state of mind that focuses on individual responsibilities of clients.

Table 4. Strengths-Weaknesses-Opportunities-Threats (SWOT) analysis of the Belgian system of Social Assistance

Strengths	**Weaknesses**
- Legal framework and rights-based approach - Funding available - Skilled human resources available	- Insufficient coverage - Fragmentation of information and service delivery in the domain of social care
Opportunities	**Threats**
- Regional government pressure to streamline social policies at communal level - Use of experience experts	- Overworked and understaffed departments of social assistance in PCSW - Increasing bureaucratisation of PCSW?

picture established by association "The Link" is straightforward: policy-makers do not speak nor do they understand the language and the reference frame of the poor, hence the existence of a quite fundamental mismatch. One of the strategies proposed by the association is to train people who themselves have experienced (and sometimes still do) a situation of long-lasting poverty that transmits from generation to generation. They then become formal "experience-experts" in the fight against poverty and are used as consultants in the design and implementation of public anti-poverty policies in federal, regional and local governments (Spiesschaert 2005).

Health Equity Funds in low- and middle-income countries: the case of Cambodia

In this section, we intend to present the Cambodia experience with a particular form of social assistance designed to cover health care-related expenditure. We will discuss this specific experience along the same lines as the ones we handled when describing the Belgian experience.

In Cambodia, Health Equity Funds (HEFs) have emerged over the past years as the preferred option for national and international stakeholders alike for health-care related social assistance to the poorest. HEFs have been piloted since 2000, mainly by international non-governmental organizations (NGOs) as a third-party payment mechanism on behalf of the poor for the cost of health care in government hospitals (Hardeman *et al.* 2004). HEFs are usually established inside the hospital, and are implemented by local NGOs that are contracted for that purpose by the funding agency. By 2007 more than one third of the government hospitals had an HEF operational.

PURPOSE OF HEFS

HEFs are single-purposed: they focus exclusively on reducing barriers, especially the financial barriers to health care for people in the lower-income groups. Besides user charges, most HEFs pay transport costs and some subsistence costs for the patient and relatives during hospital admission. Most HEFs cover only hospital costs; some cover also the fees in government health centres. There is consistent evidence that HEFs indeed reduce barriers to health care for the poorest. Hospital utilization by the lowest income groups increased in most health districts with an established HEF (Annear *et al.* 2006; Ministry of Health 2006). It is hoped that HEFs will protect the poor financially, and decrease catastrophic health expenditure, but this has not yet been proven unequivocally. Indeed, studies have shown that most out-of-pocket health expenditure serves to purchase health care from unregulated private health care providers (Van Damme *et al.* 2004). It is hoped that HEFs can modify health seeking behaviour away from private to public providers: the paper by Annear *et al.* in this book presents some evidence on this.

A recent evolution is that some HEFs give increasing attention to the protection of the rights of the users: HEF operators carry out regular hospital

ward rounds to check with their clients whether they need further help, whether they are properly taken care of, or, more generally, to provide them with information and psychosocial support. From time to time, home visits are made for similar purposes, additional to the purpose of confirming eligibility.

ELIGIBILITY FOR SOCIAL ASSISTANCE

In Cambodia, there are two ways of identifying those eligible for HEF benefits: pre-identification, or 'active' identification; and post-identification, or 'passive' identification. "Passive identification" refers to a process whereby patients are interviewed at the time when they arrive at the hospital. They are screened on a series of items like family composition, food security, income and assets, on the basis of which a score is calculated that determines whether a person is eligible for HEF benefits. "Active identification" on the other hand is a process whereby the entire population of a district is screened before any utilization of hospital services, and those falling below a certain level of poverty-rating receive a HEF card, establishing their entitlement, which they can use when in need of health care.

Both modes are presently used, depending on the HEF. A strength of the active identification mode is that it promotes the awareness in the community on the very existence and availability of the scheme, whereas passive identification provides the necessary flexibility to include in the programme those that were not identified by active identification. These issues of identification are discussed in more detail in the papers by Jacobs and Price and by Chean Rithy Men in this book.

Sometimes both modes are used in conjunction, where it is thought that active identification, although relatively costly, will empower eligible people to use their entitlement to free health care and reduce their feeling of vulnerability against illness; as a matter of fact, households with a HEF card are insured against hospital admission costs. Yet, passive identification may remain needed for people falling into poverty because of illness. The people eligible for HEF benefits are estimated at between 10% and 40% of the population, depending on the region and the inclusion criteria and procedures.

Currently, a working group led by the Cambodia Ministry of Planning has developed national standard criteria and procedures to identify poor households and these criteria and procedures are increasingly being applied

on the field. It is the intention of policymakers to entitle eligible households not only to health care, but also to other forms of social assistance.

LEGAL FRAMEWORK

HEFs have started since 2000 and have evolved in the absence of an explicit legal framework. They result from a combination of a civil society and donor-driven initiative and initially had little relation with government bodies or legal frameworks. But after several years, and under the impulse of the Asian Development Bank, the Ministry of Health has developed a national HEF framework, given guidance to operational actors and funding agencies, and established itself as the government agency dealing with HEFs. The framework also stipulates reporting channels and governance structures, which will depend on the primary source of funding. These recent developments are discussed in more depth in the paper by Annear *et al.* in this book.

FUNDING OF HEFS

Till 2006, all HEF funding originated from donors, mostly from international NGOs and from bilateral donor agencies. Cambodia receives considerable amounts of donor aid, and the donor community sees HEFs as a convenient demand-side vehicle to target resources directly to the poorest. Today nine HEFs are funded by USAID and eight by the Belgian Technical Cooperation (BTC). The World Bank currently funds two HEFs and plans to extend its support to ten others. Asian Development Bank has announced a grant for funding 11 HEFs over several years. Since late 2006 the Cambodian government also allocates a budget to subsidize health care cost for the poor in the form of reimbursement of user fee exemptions in settings where no HEF is operating. In 2007 fifteen hospitals without an operational HEF have benefited from such funding. Negotiation is underway to channel these public funds through HEFs to cover the user fees, while the donor funding would be used to cover the administrative costs of HEFs and the transportation and other subsistence costs of patients and their relatives.

DECISION-MAKING

Programmatic decisions on funding, benefit packages, and choice of HEF implementer, have largely been taken by the donor agency that funds the HEF, but the role of the Cambodian Ministry of Health is increasing. Decisions on individual eligibility and benefits lay with the operational staff of the HEF implementer, mostly local NGOs, which are monitored by the HEF funder and the Ministry of Health. Two of the existing HEFs are community-based, with local pagoda committees or mixed committees between local authorities and community representatives playing a key role in operating the HEF (Noirhomme *et al.* 2007). The national HEF framework established by the Ministry of Health specifies different oversight mechanisms depending on the source of funding. The above-described mechanisms are valid for the current 27 donor-funded HEFs. The 15 schemes that receive public subsidy, and which are also labelled HEFs in many instances, are managed by local public health authorities, and report through MoH channels.

In Table 5, a comparative analysis is made of the main features of social assistance in Belgium and the characteristics of health equity funds as they are increasingly being established in low- and middle-income countries.

Table 5. Comparison between social assistance in Belgium and health equity funds in Cambodia

	Social assistance in Belgium	**Health equity funds in Cambodia**
What? Benefits	Multi-purpose. Cornerstone: cash transfer: life wage.	Single-purpose: only health care in public facilities
To Whom? Target population	People who are socially excluded	People who are excluded from health care
What criteria for eligibility?	Beyond only income and/or material assets, other criteria address the lack of access to social networks, to training opportunities, to social and cultural activities, etc.	Lack of financial means and material assets

	Social assistance in Belgium	Health equity funds in Cambodia
Process of selection /deciding on eligibility	Civil servant social workers play a central role in the operations	Variety of actors involved in the operations: mainly staff of local and international non-governmental organisations, sometimes community members.
Political decision-making	Important democratic control by local politicians and jurisdictional authorities	Politicians not involved
Legal framework	Solid legal framework	Legal framework in development
Funding	Federal and local government tax-revenue	Different sources of funding: mainly donors and non-governmental organisations (possibly government funding in the future)

The comparison is tricky indeed because of the important differences in context. We nevertheless believe it enables us to capture the key differences between the two types of systems.

Possible lessons from the Belgian experience with multi-purpose public social assistance

Despite huge differences in context and history between social assistance in Belgium and Cambodia, or in other low- and middle income countries, we think the Belgian multi-purpose experience of social assistance raises a number of issues that are relevant for the emerging policy option of 'health equity funds' in low- and middle-income countries, more in particular in South East Asia and sub-Saharan Africa. The paper by Chean Rithy Men (on the organisation of pre-identification of Health Equity Funds beneficiaries in Cambodia) clearly illustrates that the principles and procedures that guide the identification processes of beneficiaries in Cambodia sometimes strongly differ from current practice in a country like Belgium.

The issues we intend to discuss in this section are more specifically

situated at five levels: i) the nature of the manpower and the specificity of the professionals that need to be involved in the delivery of social assistance; ii) the dynamic situation of 'destitution'; iii) the importance of stigma as a barrier in the utilisation of social assistance; iv) the stewardship role of public services of social assistance; and last but not least, v) the necessary political dimension of the social assistance debate.

THE NATURE OF THE MANPOWER IN THE PROVISION OF SOCIAL ASSISTANCE

Social assistance requires specific skills and attitudes that health workers or volunteers do not possess. One does not ask nor expect social assistants to decide on the medical treatment sick people would need; the corollary is that health professionals do not have the necessary competencies to decide whether people are eligible for social assistance nor have they the training to organise this social assistance. The very specificity of the work of social assistants lies in their capacity to balance standard criteria for the identification and management of poverty (like for instance income level) with more qualitative elements (the personal history of the client) and even the social assistant's personal impression (the gut-feeling): this client-centred approach - each client being seen as a unique individual with a unique history - fits better the complex and multi-dimensional nature of poverty (Sen 1995). The task of the social assistant is not only to *identify* the poor, but also to personally counsel and *accompany* them. This implies provision of psychological and emotional support to the client and an attitude where the social assistant acts as an independent agent on behalf of the client for the provision of financial and material support, social services and benefits. There is need for somebody to defend the interests of the social assistance client.

When necessary, a long-term (possibly even a lifelong) follow-up must be provided in the frame of a personalised relationship in which the client's privacy is protected as much as possible. This contrasts with the trend in Cambodia and other developing countries that emphasises and relies upon a system of identification of the poor mainly via means testing or proxy means testing - with little or no room for a more subjective assessment by a professional social worker. Eventually, people receive a poverty card (or not) which entitles them to a certain number of benefits, and which makes redundant the judgement of social assistants... However, the recent trend observed in some HEFs in Cambodia to give attention to the general welfare

of the clients (e.g. provision of information and psychological support to hospitalised clients) and to give more room to non standard elements in the clients' situation, especially in the interviews conducted in the course of the passive identification process, indicates a shift in the direction of the client-centred role social assistants play in the Belgian system.

The overall availability of social assistants in low- and middle-income countries is however limited. It is necessary to train more of these cadres. But most importantly, there is a need for more collaboration between the sectors of social assistance and health. The 'walls' between the two sectors should be torn down and bridges between social assistants and health workers should be built so that these two cadres can collaborate in designing and operating systems of social assistance for health care. Such collaboration could contribute to strengthening under-developed departments of Social Affairs in low- and middle-income countries.

THE DYNAMIC SITUATION OF DESTITUTION

A second lesson from the Belgian experience is related to the definition of the population in need of social assistance services. The Kruibeke data on the number of clients receiving a living wage, and on the duration of the allocation of these benefits, illustrate that many households are confronted, somewhere in the course of their life, with an acute need for social assistance, sometimes more than once over the course of several years, that is *time-limited*. These individual clients or households are however not in a situation of chronic poverty *unlimited* in time. Destitution is not to be seen as something that is necessarily of a permanent status - for many it only is a temporary situation. *Destitution is a situation, not a status* (personal communication from Pierre Fournier).

Research carried out in Guinea-Conakry in the 90's indicated that about 5% of the population are in a situation of total economic *and* social exclusion, but also that half of the remaining population lives in an 'unstable' situation of transient poverty with important periods of temporary, often season-bound, exclusion from health care (Criel *et al.* 1999). This fuels the idea that social assistance should not limit itself to the targeting of the group of chronically (extreme) poor with little or no social capital. It should also target the much larger group of poor people who are not excluded on a permanent basis, but who face a temporary shock or crisis (often related to the need for health care). The resource implications of the

latter option are of course substantial.

In Cambodia, the dominant practice is that the poor are pre-identified and are provided with a poor card for a period of 3 years. This procedure is non consistent with the fact that illness can trigger the need for assistance irrespective of the poverty status defined a year or two earlier. On the other hand, pre-identification of the poor may be an acceptable trade-off in a context where social assistants hardly exist and where the financial resources required to cover *all* the needs in terms of assistance for health care lack.

THE IMPORTANCE OF STIGMA

A third lesson deals with the issue of stigma. Anecdotal evidence from the Kruibeke PCSW suggests that stigma, next to information gaps, constitutes one of the barriers in accessing social assistance services. This situation has of course positively evolved over the decades and today an increasing number of 'non-chronic poor' households make use of social assistance services. This evolution certainly contributed to reducing the negative perceptions on social assistance. There is no comparison with the situation 50 years ago when the use of social assistance services was the ultimate dishonour. In addition, PCSWs today increasingly develop services that are also used by middle-class households (e.g. home-care services, institutional care for the elderly). But stigma remains and the numerous informal and formal contacts the first author had with potential clients indicate that many still have strong feelings of shame when the option of using PCSW services is mentioned. It is seen as a personal failure not to be in a position to take care of one's own situation and to cope with the problems that occur in life. Stigma is of course not the only barrier to social assistance, but it definitely is one that is difficult and time-consuming to properly address. In the case of the Cambodia HEF experience, stigma does not seem to be a major issue, but anecdotal evidence from sub-Saharan Africa indicates that being labelled 'destitute' is perceived as a humiliation. The relationship between social assistance and stigma would however need to be investigated much more thoroughly in a variety of settings in low- and middle-income countries. This is an important research priority.

Anyway, the operational implications of stigma-reducing policies are plenty. One would need to have a respectful and empathic attitude vis-à-vis social assistance clients, and maintain a minimum of confidentiality and privacy in identifying social assistance clients, in managing their case and in

following-up their situation. We therefore caution for the use of poverty lists or poverty cards - although we understand the managerial rationale underlying their use in the context of low- and middle-income countries and are aware of the fact that the perception of stigma may strongly differ between cultures. More often than not, such lists are not confidential but are made public: for instance, they circulate between different services and/or are even attached at the notice boards in the health centre nurses' offices where routine outpatient consultations take place...

THE LOCAL STEWARDSHIP ROLE OF PUBLIC ADMINISTRATIONS OF SOCIAL ASSISTANCE

A fourth lesson has to do with the specificity of the local institutional context in which Belgian social assistance operates. The Belgian social system is characterised by an important diversity and plurality of actors. A mix of private and public actors offers social care at the operational level. The PCSW is the (public) body that occupies the central role in the provision of publicly funded financial social assistance. On an *extra-muros* basis it also provides a range of home care support services. General practitioners, pharmacists and nurses are the key players in the local health care delivery system: in the majority of cases they are private self-employed health workers whose activities are regulated by the federal government. Social workers of different qualifications provide a wide range of home care services; they are generally employees of big private non profit organisations that operate on a regional basis.

Increasingly, PCSWs recognise the need to coordinate these different actors and their interventions in this complex local web of the social care delivery system. The legal and regulatory frameworks in which PCSWs function are gradually formalising and institutionalising this coordination and steering role. PCSWs are increasingly investing in the promotion of networking among these actors. In the commune of Kruibeke different initiatives have been taken in that respect: quarterly meetings are organised between PCSW and the local general practitioners; the Kruibeke *Welfare Forum* was instituted a few years ago as a platform for all the players in the local social system to meet, to exchange information and to build collaborative links.

This experience illustrates that the role of a professional social assistance administration cannot not limit itself to the provision of assistance

to clients, but should also extend to a 'stewardship' role in the local social system. If the different actors are to contribute to the identification and follow-up of people at the margin of society in need of social assistance, then the social assistance administration needs to actively liaise with them - beyond the traditional sector borders.

THE NEED FOR POLITICAL ACTION

A fifth and final lesson is the need to keep a 'political' perspective on the social assistance debate. Social assistance definitely should not be confined to the purely technical sphere: there is a need to try and address structural determinants of poverty next to the careful analysis of individual responsibilities of clients themselves.

In that respect, the Belgian situation presents some comparative advantage given the close linkage between the design and operation of social assistance services and local policy-making by PCSW Councils composed of local politicians. The Council has some level of local leverage on issues that have to do with work opportunities, housing, schooling, etc. The multi-purpose nature of Belgian social assistance services also makes it easier to handle the multi-dimensional web that shapes poverty and exclusion. Hence the relevance to try and overcome in developing countries the traditional administrative and bureaucratic barriers between social assistance services and other social services like health care. This tends to question the dominating single-purposed health care focus of Cambodian health equity funds.

Conclusion

Social assistance in Belgium today is comprehensive and multi-purposed. It has a long history and covers today a wide range of social services. It functions in a society where a well-performing social health insurance system operates - making the intervention of the PCSW for issues specifically related to health care a rather marginal issue and event. Health equity funds in Cambodia on the other hand are of a very recent origin; at the basis of their creation - by health systems managers - were the problems poor people experience in coping with the cost of health care. Cambodian health equity funds today focus on health care only - although issues that do not directly pertain to the direct expenditure for health care such as transport and food

costs are increasingly taken into account.

The case of Belgium may appear extremely remote from the realities in the South but a study of its history and current functioning is not without relevance for social policy-makers in low- and middle-income countries. The present paper is an attempt to address such a cross-country, even cross-continental, analysis.

The Belgian social assistance experience has gradually evolved from charitable privately funded systems in the 19th century, to a legally enforced and publicly funded social assistance system in the last quarter of the 20th century. Social assistance in Belgium is today underpinned by an extensive legal framework that gradually evolved with the changing values and priorities in Belgian society. Social assistance has become a right and considerable efforts are made today by social workers to tailor assistance to the clients' specific needs in a capability-based approach. Social assistance is obviously also about politics: its development requires active steps by society and by the State. In the case of Belgium, political decision-making has fostered the creation of publicly controlled and pluralistic institutions that carry the defence of the rights of the poor high in their banner and that stand up for the poor. We believe that these political dimensions should be fully part of the scientific attention for the development of social assistance in other parts of the world.

In many low- and middle-income countries today, public multi-purpose social assistance systems exist on paper, but in practice their functionality is limited. Their design needs to be adapted to local circumstances and embedded in local social and cultural values. These systems would benefit from a sound management with the necessary legal, institutional and organisational frameworks and checks and balances for a democratic control by the public on the usage of public and/or donor funds allocated to these systems. The challenge in low-and middle-income countries is to design social assistance systems - for health care and otherwise - that are effective in reaching the poor, that are protected from patronage and favouritism, and that are socially and culturally acceptable to the local society. Each country must find its own way in developing social assistance systems, but an exchange of experiences and more cross-country comparisons of the functioning of such systems could be helpful in a better understanding of generic conceptual and managerial issues.

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