

CHAPTER II
A GENERAL FRAMEWORK TO ANALYZE THE ORGANIZATION AND
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II.1 Introduction

The approach to social protection programs proposed in this Report requires a conceptual framework to allow a systematic analysis across programs. It is necessary to allow comparisons for measuring development and administrative costs. It is also essential to find elements that contribute to the advantages and disadvantages of integration or separation of the combined processes that allow national systems to provide social insurance.

The objective of this chapter is to define such a framework, and set a platform for the analysis of special programs designed to attend specific risks. Thus, this common structure will set up the organization of the following chapters of the Report. The overall framework is commonly used in the management literature. It will be familiar to those who have analyzed organizations and operating systems. The details of the framework are somehow arbitrary, but this arrangement is innocuous for the objective of the Report.

II.2 Conceptual Framework

Public and private agencies that have improved their productivity have resorted to one of the following strategies: operational redesign, organizational redesign, or strategic procurement. Strategic procurement can be thought of as a process, but given its importance for fostering productivity, it will

not be analyzed in this Report. Organizational and operational designs basically support strategy. The organizational design should be the enabler or facilitator of the operating model, which in turn is justified by the performance requirements of the strategy. First, operational requirements should be determined to achieve the performance levels set in the strategy. Then, the suitable organizational design can follow (Hagel 1994). This is the approach we try to follow in this Report.

II.2.1 Operating Model

A process "is a collection of tasks connected by flows of goods and information that transform various inputs into more valuable output" (Leonard & Gray 1995). People, technology, and procedures are involved in the process. In the service sector, technology is mainly IT. Process can refer to a subset of the organization, in which case, "process" refers to a single process. Alternatively, the term can refer to a set of processes of the whole organization, which is sometimes called the *operating model*.

Because it is common in this type of analysis, we will use the tool of *process diagrams* to help our understanding. This tool ideally shows procedures organized chronologically. In order to do so, almost every task is described. The diagrams used in this Report highlight the main activities or tasks that should be performed. Thus, even though they follow

a chronological order, in some cases it is not possible at the level of aggregation we are using. By not focusing on the details, we have the advantage of providing a panoramic overview of the programs. Process diagrams, as can be seen in the following sections, include, at most, five basic core processes for social protection programs: 1) product development, 2) funding, 3) management, 4) delivery of benefits, and 5) provision. Although in some programs only four processes (not including provision) are relevant, in other programs, provision is probably the most important process.

In this Report, the back-office processes that are indispensable in any firm or organization are not analyzed. These include the management of human resources, accounting, and others.

Product development refers to the design and evaluation of the financial viability of the program and its benefits, based on information about social conditions (including the labor, financial, and other markets; the state of medical knowledge; and the behavior of communities) and expectations of users and the whole society. In social programs, a key lies in the design to warrant that the well being of beneficiaries is met. Because the benefits developed in social security do not involve the voluntary decision of purchase at some price, the design should be carefully made. Users of social programs are not clients, in the sense that they can choose the service or the provider. Not only are actuarial projections needed, but behavioral responses of beneficiaries should also be taken into account—such as the response of labor supply to taxation, or the potential at the community level to provide care at low cost. Understanding the incentives of beneficiaries is at the core of product design.

The costs of benefits and revenues should be projected. In addition, the administrative cost and dead weight loss of taxation should be taken into consideration when a program is designed. Although financial considerations are often viewed as the leading causes of problems, and the main challenges

to solve, it is often the case that reforms based on them end up showing limited results. A leading example is the point of view that retirement ages must be modified to achieve actuarial balance of a pension system. In fact, the dominant event seems to be that, regardless of the official retirement age, workers prefer to retire earlier in life as they become wealthier, or even when they only reach certainty of future income, especially when marginal taxes from earnings are high. Thus, it seems necessary not to focus on official retirement ages to solve the problem of early retirement, but upon the whole design of social insurance programs. The terms of these programs include: 1) marginal taxes on labor and pensions, 2) definition of the transition between work and retirement in terms of health care, 3) ability of labor regulations to facilitate partial and gradual retirement, and 4) cyclical return of the elderly to the labor force, among other elements. Similarly, it is well known that the intensity of use of health services and the growth in expenditures can be associated, in a significant way, with the organization of health plans. Thus, actuarial studies can turn out to be highly inaccurate in an environment of individuals' rapidly changing participation in health programs.

The complexity of behavioral interactions poses a challenge to the design of programs. A fair and consistent understanding of the administrative processes that make up the final services of social protection against each risk promises to be a useful tool. This understanding can help disentangle such complexity and facilitate the definition of administrative solutions, independently of the policy debates that otherwise may unduly interfere.

Funding encompasses the enrollment, collection, and allocation of registries and monies. Enrollment deals with social security-based programs and those funded by general revenues. Collection mirrors enrollment, and for social security programs, it is based on the payroll. Collection for programs funded by general revenues requires only the transfer of funds from the government to the entity in charge of the program; increasingly, government transfers are based

upon information about individuals. Programs sometimes accept additional contributions from families.

Definition of individual records should be made in either programs with global funds or those with individual accounts, because in any case, a control is placed on benefits at the individual level. Allocation of monies is highly dependent upon basic regulations of a program. In some cases, statutes define the allocation in a very detailed way, as is the case of individual account systems for old age insurance. In a pay-as-you-go (PAYGO) pension system, allocation may be made to a collective fund, and only decades later (on average) gradually transferred to individuals. Similarly, statutes may define detailed budgetary formulas to allocate health tax proceeds to specific funds. However, in other cases, the money may go to a national fund that redistributes it across hospitals and physicians under an internal decision process, without recourse to explicit statutory formulas. Allocation also applies to budget-based programs, when monies should be allocated to different groups of the population and/or regions.

These examples begin to show an advantage from disentangling the different activities that, when combined, result in service provision. Sharing costs across different insurance programs can bring about large economies of scale, as in the case of the affiliation and collection processes. Yet, for the allocation process, programs for health, old age, disability, childcare, and other covered risks typically require *ad hoc* solutions. Thus, a decision to vertically integrate all the processes for a specific program means that significant gains in efficiency may be lost, due to the inability to pool resources with agencies that manage other social risks.

Management encompasses the processes between enrollment and delivery of benefits, meaning those processes for managing the monies and the relationships with beneficiaries and potential providers. As will be seen in the next chapters, the relationship with beneficiaries, known as account maintenance and customer care (AM&CC), is too often

ignored when beneficiaries cannot choose their insurers. However, this relationship represents an important tool for increasing the loyalty of affiliates in programs where beneficiaries can select their insurers, and when a large informal economy means that in practice, workers often decide between covered and not-covered jobs. Actions in this area can significantly improve client satisfaction and general citizen support for the programs.

Delivery of benefits includes two basic processes: request of benefits, and payment or disbursement. This area includes claims processing, i.e., evaluating the eligibility criteria in terms of years of contribution to or registration in the program, and administrative eligibility. Eligibility can also depend on the statement of need, such as earning an income below a certain level or being unemployed. We will refer to this as conditioned eligibility. In some programs, such as disability and long term care (LTC), an additional process consists of the assessment of mental and physical conditions. Finally, all programs include a process of complaints management, which can help agencies overcome those particular difficulties and improve their services. Payment or reimbursement refers to the process of paying monetary benefits once the claim has been authorized. For some types of insurance, such as health or childcare, benefits are not directly paid or reimbursed in cash, but authorized in order to receive a service.

Provision, for the purpose of this Report, refers to clinical services provided under health and work risk insurance, the caring programs, and in-kind benefits under LTC insurance and care centers in childcare programs. Providers across unemployment and supplementary programs can range from traditional schools to job training. Similarly, providers of health and childcare services are usually heterogeneous across societies, challenging agencies to create flexible processes, from funding to payment. Given the differences in these programs, we will not analyze the provision process in unemployment, LTC, childcare, and supplementary programs.

II.2.2 Organizational Design

By organizational design, we mean whether the services should be vertically integrated, (i.e., from enrollment to provision); and whether different programs should be managed by the same organization (i.e., the same agency in charge of unemployment and retirement insurance). Moreover, we want to investigate whether some processes of a specific program should be managed jointly, but other processes should be managed separately. Organizational design also refers to the internal map of the agencies—for example, whether organizations are designed around programs, clients, or regions; the role of the shared service centers, and so on.

In past decades, when agencies were assumed to need vertical integration, horizontal integration was necessarily the merger of large and complex sets of procedures. Currently, the trend towards vertical separation (e.g., funding and provision of services performed by different agencies) has opened the door for more complex and effective organizational blueprints, wherein strong horizontal cooperation at some levels becomes compatible with similarly dynamic decentralization, at others.

While so-called political constraints are often seen to be the cause of an obsolete organizational design, the development of a clear map of goals and strategies, and a clear organizational design, should provide incentives to reform social security procedures and organizational structures. Furthermore, the design should avoid self-inflicted limitations that come from investing in formulas that reduce the options for synergies (for example, those that make it more difficult to integrate data management processes across agencies).

II.3 An Overview of the Operating Systems of Social Security Programs

II.3.1 The Programs

This section shows the overview of the different processes across social security programs. Through this survey, we will be able to recognize common processes across programs, as well as processes

that are specific to each one of them. The identification of common and specific processes is done with two purposes in mind. The first is to organize the discussion within the Report. The next chapter describes the common processes among social security programs. The subsequent chapters discuss specific processes in each of the programs. The second purpose of understanding common processes is to provide the relevant information needed to assess the organizational design.

For all risks, the same final output—payment of benefits or provision—can be achieved under different approaches. The following examples illustrate this idea. In healthcare insurance, for example, benefits can be provided under either social security insurance programs or non-entitlement programs. However, in all cases, funding and management have to end up facilitating the operation of hospitals, whose medical structure is largely independent of previous approaches. A second example relates to pension benefits that can be provided under contributory and welfare/non-contributory programs. Each program involves its own particular affiliation and collection processes, but may possibly have the same allocation and payment process. In order to organize the discussion, the next paragraphs describe the general map of processes in each one of the social security programs treated in this Report.

We will see that any social security program comes with a set of "mandatory" or "natural" activities to be performed. Yet, processes can be organized in very different ways across nations, and also within a country. For example, all disability cases have to be evaluated and defined as such before a benefit can be paid, regardless of the source of funding. This condition holds true regardless of whether the funding comes from individual savings accounts, public insurance, private insurance markets, or a centralized government ministry. Thus, even though prior or subsequent steps to the adjudication process can be organized differently, the issue of determination tends to be common across disability systems. This sort of commonality poses an interesting question:

Is it possible to define common elements not only at the level of specific processes, but also at a comprehensive level? Generally, the answer is yes. However, while academic research provides useful clues on the general structure of programs, these advances are not uniform across social risks. Significant debates on the definition of the "best map" for each social insurance program may still take place.

In a sense, the maps of all programs may seem very similar. Each map includes the processes of affiliation, collection, and allocation of funds, risk management, and delivery of benefits; some others also include the provision process. However, the type of risk and the administrative costs associated with each process vary widely. In some programs, much of the solution to the social risk management problem can be made at the level of affiliation, collection, and allocation. For example, an old age insurance program—which is a monetary pension scheme—that accurately solves those steps at the initial level is left with a set of processes that may not be very different from those employed by a private savings market. That design would include investment of funds with an adequate yield-risk combination, account management, and delivery of benefits in a timely and cost-effective fashion. On the contrary, for a health insurance program, the "next" step in the process, i.e., management, still defines substantial challenges for social risk management. These challenges could include allocation of patients across health plans, continuous reevaluation and measurement of risk at the individual and community levels, and redistribution of public resources in hard-to-predict ways over the years. Moreover, in other cases, the "final" process—provision of services—may define the essence of the program. This is the case with public employment programs that operate through improving the incentives and information available to employers and job searchers, or LTC programs that look for community participation. In summary, to draw more useful maps, it is necessary to identify the behavioral problems and cost structures that affect the management of each risk.

The rest of this chapter summarizes some of the issues that will be further developed in the next chapters.

Pensions. The diagram for pension programs is composed of the first four processes. Here, provision plays no role. To a large extent, the issues of affiliation and collection solve the administrative challenges to these programs.

General Disability. For disability insurance, one of the most important processes refers to the assessment of the disabling condition. This program faces the challenge of adapting to the changing societal views about disability. It also looks to achieve the objective of reintegration of the disabled to a normal life, including their return to the labor force.

Health. Arguably, social health insurance poses the most complex administrative problems found today. The three main processes in health insurance, according to Chernichovsky (1995), are: funding, management (labeled as "organization and management of care consumption," OMCC), and provision. The OMCC process has to deal mainly with budget holding and payment to providers; this process is often identified as the "purchasing" function of health funds. Risk management, account maintenance, customer care, and provision management are important issues. In some countries, health insurance includes cash benefits associated with the inability to work, linking health insurance to the full range of monetary benefits programs: disability, workers' compensation, unemployment, and others.

When health services are not provided under an insurance mechanism, some of the processes simply do not exist, or are integrated with another process. When general revenues fund these programs and providers are directly budgeted, the enrollment and collection processes may not be performed. Typically, then, the OMCC function collapses to the management of an itemized budget. Still, some functions are (or should be) performed, such as allocation, risk management, and customer care. Provision is

performed in almost equal terms as insurance programs from a medical point of view, but the incentives to providers can be very different.

Workers' Compensation Insurance. The benefits under workers' compensation insurance vary significantly across countries. In some countries, they include health care (including medical devices), payment of economic benefits (which, in turn has different modalities), retraining, and prevention services for firms and workers. Two of the varieties relate to whether workers' compensation consists of lump sum or periodical reimbursements. Two very important processes manage this risk: the implementation of preventive measures to reduce work risk (thus, the processes under AM&CC are very important here), and the assessment of mental and physical disability.

Unemployment Insurance and Employment Services. Broadly speaking, unemployment insurance can take two modalities. The first, which was the usual solution until the '80s, is based on the provision of economic benefits (replacement income) to the unemployed. The second modality, which seemingly defines the long-term trend, relates the payment of benefits to beneficiaries participating in training courses and job search activities. Distinctive issues here are the management of claims, and the way these programs link those to the organization of job search and training activities.

Childcare. This program primarily refers to working mothers' care of their children, until they enter the school system. Because programs across nations vary greatly, product design, as well as account management and customer care, are the basic processes to analyze. It seems that, to a large extent, a successful childcare program is defined by its ability to match the diverse needs of families with the heterogeneous supply, and provide that match with the financing flows that sustain a social insurance program in this area.

Long-Term Care. This program refers to the series of services designated for persons who are

not fully capable of self-care on a long-term basis. It includes services aimed to minimize, restore, or compensate for the loss of independent physical or mental functioning. As part of social insurance, this program has two very important tasks to accomplish. First, the assessment of need is vital, due to the fact that *ex post* moral hazard problems exist (i.e., because the need itself is not observed by the insurer, but rather some measure of it, once the individual has claimed the benefit, he/she might try to influence the assessment process to get as much out of the insurance as possible). Secondly, the service, either directly provided or subrogated, should be the object of careful monitoring and evaluation.

Supplementary Programs. Supplementary programs, especially cash transfer programs, are designed to benefit low-income or vulnerable populations such as single mothers, the elderly, persons with disabilities, or poor farmers. At the same time, some of these programs may have the second objective of increasing the human capital of low-income groups, through modifying the demand for health care and school attendance. For this purpose, the benefits of the programs can be conditioned on the co-responsibility of beneficiaries. Although these programs have been growing as part of anti-poverty strategies, they have sometimes been defined as supplementary to social insurance. However, in other instances they have become concurrent and competitive (i.e., for money from public budgets). Often, they include health insurance or a supplementary pension benefit. Thus, they should be designed jointly with the general social insurance mechanism. Certainly, some of these programs are similar to the traditional family allowance programs of social security.

These programs have three important processes: 1) product design, because it must be consistent with the objective of inducing formalization of labor and other activities; 2) enrollment, because mean-tested programs require an ability to identify beneficiaries individually, before a negative event occurs; and 3) the assessment of

eligibility for the payment of benefits is also critical. A natural question refers to the degree to which these programs should be managed by social security agencies. For example, social security agencies are likely to have the largest databases of citizens and their identification (ID) numbers, and can also have advantages as payers of benefits to the whole population.

II.3.2 Identification of Common and Specific Processes

This section will discuss all programs globally. This treatment will allow us to identify the common and specific processes among social security programs. In turn, Figure II.1 structures the detailed discussions found in the following chapters.

Product development. Out of the four activities included in the product development process, we can identify two as very similar across programs, and two that deserve separate treatment for each program. Market research and financial assessment follow practices that apply not only for all programs, but for all benefits that are going to be introduced or modified in the market or society. These processes will not be analyzed in this Report. Product development and implementation, as well as life cycle management, deserve to be discussed in detail for each program. Each of the programs serves different purposes, has multiple alternatives, and is offered to different groups of the population.

Funding. In the funding process, which includes enrollment, collection, and allocation, we can identify two archetypal cases: 1) social security programs, and 2) programs funded by general revenues.

Management. Although different programs should invest the reserve funds differently in terms of risk-return strategies—due to the temporal scope and the risk they cover—the same risk management and accounting principles should apply to all. These principles will be discussed in Chapter III. Account maintenance, on the other hand, is similar in all processes. Indeed, it can be the base for building information systems across (and between) social

security organizations. Although customer care should be present in all programs, the actions within each one can be specific and vary substantially. Customer care will first be generally analyzed in Chapter III, and then for each program. Provision management is important when benefits are provided in-kind, either directly or indirectly. These benefits include health (and the benefits covered by work risk insurance), childcare, LTC, and conditioned cash transfer programs.

Delivery of benefits. Because the administration of eligibility and the management of complaints are similar in all programs, the general aspects will be discussed in Chapter III. Conditioned eligibility in both unemployment insurance and non-contributory programs will be discussed in Chapters VIII and XI, respectively. Physical and mental assessment in disability and LTC will be treated in Chapters V and VII. Cash payments to beneficiaries in all programs will be discussed in Chapter III.

Provision. So far we have identified four programs in which this process is of special relevance: health (including the benefits covered by work risk insurance), unemployment insurance, childcare, and LTC. Nevertheless, given that the provision process is highly fragmented and diverse in unemployment, childcare, and LTC, provision will be described only in the healthcare chapter.

Figure II.1
Index of Processes by Program

	Product development	Funding			Management				Delivery of benefits			Provision
		Enrollment	Collection	Allocation	Invest. and risk mgmt.	AM & CC AM	AM & CC CC	Provision mgmt.	Request of benefits	Payment of benefits		
Pensions	IV					IV			III, IV	III		
Disability	V					V			III, V	III		
Health	VI					VI		VI	III, VI	III	VI	
Workers' compensation insurance	VII					VII			III	III		
Unemployment and employment programs	VIII					VIII	III IV		III, VIII	III		
Childcare	IX					IX			III	IX		
Long-term care	X					X			III, V	X		
Non-contributory programs	XI					XI			XI	XI		