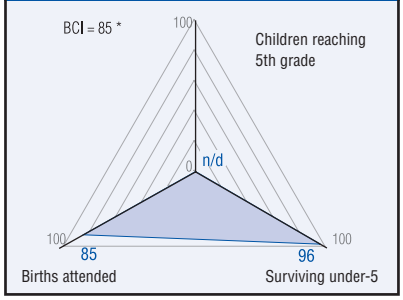
SURINAME

Stifled in development and scared of getting old

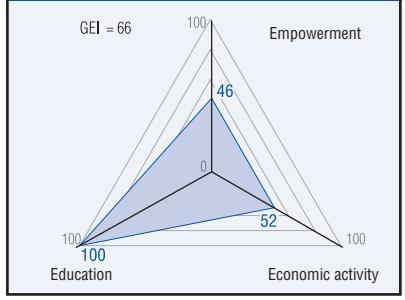
The Social Safety Net intended to provide the population with the social protection measures guaranteed by the Constitution is currently riddled with holes. The benefits paid out are so minimal as to be ineffectual, while services such as free health care are used by many individuals who do not need them, but are unavailable to some who do. Meanwhile, low employment rates lead to concern about the sustainability of social security programmes in the future.

Stichting Ultimate Purpose
Maggie Schmeitz

Basic Capabilities Index (BCI)



Gender Equity Index (GEI)



The Constitution of the Republic of Suriname mentions a just distribution of national income as a means of extending well-being and prosperity over all segments of the population as one of the social goals of the state (Article 6). It instructs the state to create the necessary conditions to meet such basic needs as work, food, health, education, energy, clothing and communication (Article 24). The state is also obliged to protect workers, with special attention for women during and after pregnancy, minors, the less able, and people working in straining, unhealthy or dangerous circumstances (Article 29). It recognizes work as the most important means for human development (Article 25), while instructing the state to define social security policies for widows, orphans, the elderly, people living with a handicap and people who cannot work anymore (Article 50).

Holes in the 'Social Safety Net'

The principles set out in the Constitution are translated primarily through the policies of the Ministry for Social Affairs and Housing (MSAH). This ministry is responsible for the Social Safety Net (SSN), targeted at groups considered unable to work for a living, such as the elderly, children (aged 0 to 18), and people living with a handicap, as well as (poor) female-headed households and other households living in poverty (MSAH, 2007, p. 1).

The material assistance offered through the SSN includes general services provided to any household meeting the obvious criteria (households with minor children, persons aged 60 and over or living with a handicap), regardless of income, such as child support, old age pension, and financial assistance for the disabled. There are also services specifically aimed at households living in poverty, such as financial assistance, free medical aid, the child food programme and the school necessities programme (MSAH, 2007, p. 2).

The first thing to be observed about the different forms of material assistance to households and people living in institutions is that the actual amount of money distributed is so low that it renders the service almost obsolete. For example, in the event of unemployment, a household composed of two adults and two children would receive as financial assistance USD 3.27 per month (MSAH, 2007, p. 4).[1] In comparison, the poverty line for such a household varied between USD 365 and USD 429 over the years 2005 to 2006 (GBS, 2006).[2] It is sad to see that people actually do still apply for this kind of assistance, because the bus fare to get there in most cases will be 50% of the benefit received.

Other things to be observed in the functioning of the SSN in recent decades are a lack of adequate cooperation and coordination between different services, a lack of standard criteria and a central data bank, and high administration costs (MSAH, 2007, p. 3).

Free Medical Aid for whom?

The provision of Free Medical Aid (FMA) cards helps to illustrate some of the social security system's current shortcomings. Persons who are eligible for FMA are divided into households with a monthly income up to USD 14.55 (so-called indigents) and the slightly better off with a monthly income between USD 14.55 and USD 29.09 (insolvents). These criteria have not been linked to inflation over the last five years, despite significant rates of inflation.

In his report on health sector reform, Hindori (2003, p. 10) maintains that FMA cards should only be available to 5% of the population, but they have in fact been issued to 30%. It was calculated that 36% of households receiving this card could not be considered poor, while 23% of the households that *were* considered poor did not receive it, nor any other form of health insurance.

The number of FMA card users rose from 111,814 in 2002 to 165,510 in 2006, which demonstrates that an increasing number of households continue to be issued this card, while in fact no one in Suriname could be expected to still be breathing on an income below USD 30 a month. When compared to the total population – 492,829 according to the 2005 Census Report – we find that one third of all Surinamese people are using a Free Medical Aid card meant for the poorest of the poor! The figures seem to prove what everybody already knew from experience: people who are not covered by the state health insurance fund and are not willing or able to pay for private insurance opt instead to buy or 'lie' themselves an FMA card.

According to the results of the last census (shown in Table 1), the National Health Insurance Fund (SZF) covers only 21.3% of the population, and the overwhelming majority of this group consists of civil servants. Being insured is the reason for many people to stay with the civil service, even if they are engaged in much more profitable entrepreneurial activities outside (GCAP Action Group, 2005). The tradition of political parties 'rewarding' supporters after elections with a civil service job puts extra strain on the already small financial base of the SZF. As a result, poor availability of drugs, poor service, forced extra charges, long waiting times and inconvenient clinic operating hours are frequent complaints of SZF clients (Hindori, 2003, p. 7-8). Such complaints are even more common among FMA card holders.

It is interesting to note that in self-reporting, the percentage of FMA card-holding households (23.3%) is much lower than in accordance with

* One of the BCI components was imputed based on data from countries of a similar level.

1 Amounts in Surinamese Dollars have been transformed in US dollars using the exchange rate of SRD 2.75 = USD 1.

2 The poverty line used is based on a food basket with 28 items (GBS, 2001).

TABLE 1. Coverage of health care costs

Payment of health care	Absolute figures	As % of population
SZF (civil servants)	96,248	19.5%
SZF (self-employed)	8,826	1.8%
MM (covering interior)*	30,657	6.2%
Free Medical Aid	114,740	23.3%
Employer	49,396	10.0%
Private insurance	17,070	3.5%
No insurance (self-paying)	93,342	18.9%
Other/don't know/no answer	82,550	16.8%
Total	492,829	100.0%

* The Medical Mission (MM) is an NGO delegated by the government to provide primary health care services to people in the interior of Suriname.

Source: General Bureau of Statistics (2004). *Seventh General Population and Housing Census of Suriname.* Edited version of Table 13, p. 54, in Census Report 2005.

MSAH registration records (32%). This could be due to a relatively high mobility between the group without insurance and the FMA-covered group (Hindori, 2003, p. 22). That being said, the percentage of people with no insurance (18.9%) and people who do not know whether they are insured (16.8%) is alarmingly high. Both groups combined add up to a total of 35.7% of the population. These people with no access to insurance are typically informal sector workers, people who are (temporarily) unemployed, people working for businesses without health insurance as part of their labour agreement, or undocumented immigrants.

A blessed old age?

Suriname has had a General Old Age Pension scheme (AOV) since 1973.[3] To qualify for this pension, one must live in Suriname, have reached the age of 60, and have Surinamese nationality. Statistics show a steady rise in the number of pensioners from 30,000 in 1990 to over 40,000 in 2005 (Jubithana, 2007a). In 2004, the number of pensioners was equivalent to 25% of the active working-age population. Assuming that all working people pay their AOV premiums, this would mean that there are four active working people to cover the costs of one pensioner. In fact, however, people working in the informal sector do not contribute to the scheme (Jubithana, 2007a).

AOV was originally intended to complement pensions received from former employment, but in fact, many senior citizens depend on it for survival. This can be explained, first of all, by the large segment of senior citizens who were not formally employed and so did not build a pension, and also by the fact that pensions are neither index linked (with inflation) nor welfare linked (with actual salaries). Employment-based pensions therefore do not guarantee social security for the majority of senior citizens. Jubithana (2007c) suggests that social justice should be served better by creating a ceiling for senior citizens with a good pension. It is indeed ironic that the beneficiaries of AOV in the current system include former government directors, parliamentarians and ministers.[4] A small proportion of senior citizens (7.39%) do not receive any AOV benefits. This group most likely includes immigrants who never obtained Surinamese nationality.

As of January 2006, the AOV monthly benefit payment was raised to USD 81 (GBS, 2006). The raises implemented over a period of 15 years (1990 to 2005) have not kept track with inflation, which means senior citizens nowadays often face a significantly lower living standard than before (Jubithana, 2007c). This is even more striking in light of the fact that 59% of senior citizens aged 60 to 64 and 47% of senior citizens aged 65 and older are still the heads of households containing three or more persons. Jubithana (2007a) cautiously suggests that in these cases, AOV benefits probably need to sustain more people than the individual beneficiary. This is not at all unlikely: welfare organizations often report on grandparents being left with grandchildren when a daughter or son migrates (usually to the Netherlands, but also from rural areas to the capital or to French Guiana) to make a better life for themselves. Unfortunately, the promises of "coming to get the children after they have settled in" are frequently not fulfilled. Contact becomes increasingly sporadic and after a while simply stops. This phenomenon has also been reported upon by regional women's organizations such as the Caribbean Association for Feminist Research and Action (CAFRA). More research is needed to determine to what extent this plays a multiplying role in the problem of senior citizens living in poverty and extreme poverty.

Steps towards greater social justice and security

The government, acknowledging the non-impact of the social protection system, declared the strengthening and modernizing of the SSN as a priority in its Multi-Annual Development Plan 2006-2010. With support from the Inter-American Development Bank (IDB) a technical cooperation programme was started up, resulting in an Institutional Strengthening Assessment and a Social Safety Net Reform Strategy. The main elements in the strategy are improvements in *efficiency* (improvement of coordination, selection procedures, monitoring and evaluation), *capacity building* (within both the MSAH and civil society) and *stimulation of human development* (education and access to the labour market) (Blank and Terborg, 2007). One important improvement so far is the computerizing of client files by the MSAH. However, it is the stimulation of human development that is especially crucial in attaining sustainable social security and positive prospects for the future.

Half of working age population unemployed

Statistics show that only 50.7% of the total working age population is employed, with an unemployment rate of 14.7% (GBS, 2005c, p. 36). The fact that only 17.7% of women report being employed is a particular source for concern. In the non-economically active group (a total of 36.5%), women account for the majority with 25.2%. People reporting to be non-economically active homemakers (37,247 women versus 605 men) are dependent on someone else's salary and pension (if any) and are therefore extremely vulnerable. Without being a clairvoyant, it is possible to foresee that those in this category who are not married (17,209) are likely to be in a client file of the MSAH their entire lives.

Civil service employment makes up approximately 44% of total employment today, with women holding the majority of lower echelon civil service jobs. When the salaries of civil servants are compared to the poverty line for the years 2005 to 2006 for a household with two adults and two children (USD 365 to USD 429) (GBS, 2006), we find that 65% of them (24,292 out of a total of 37,303) earn an income that places them below that poverty line. The massive hiring of lower level civil servants, especially after elections, is the way in which successive governments hide the real unemployment and the fact that little to nothing is done to boost production and entrepreneurship (Schmeitz, 2006).

The Constitution of Suriname recognizes work as the most important means for human development (Article 25). The state has ratified all the main international conventions regarding equal opportunities and access to employment. We need all the skill, talent and labour that we have to create a socially just society for all of us. If the trend of rising numbers of clients of social services continues, beneficiaries might very well outnumber working people in less than 50 years. Then we will all be stifled in development, and scared of getting old. ■

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3 The system was set up by the Dutch before Independence in 1975.

4 In the current system, a person who has served as a government minister for *at least one year* is eligible for a pension equalling 40% of the highest salary of a permanent secretary (Jubithana, 2007b).

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According to Article 28 of the UN Convention on the Rights of Persons with Disabilities, adopted 6 December 2006, "States Parties recognize the right of persons with disabilities."[12] The government has not yet ratified this important convention, making it difficult for persons with disabilities to enjoy the right to social security that it guarantees.

Encouraging signs

The Governor of the Bank of Tanzania, Daudi T. Balali, acknowledged in March 2007 that the greater part of the country's population is still dependent on the traditional social security system, now getting weaker every day as a result of the corrosive effects engendered by urbanization and threatening diseases like HIV/AIDS. According to him, "Because of the difficult economic environment and diseases like HIV/AIDS which have torn apart the traditional fabric and economic might, … accessibility to social welfare services by disadvantaged groups is limited." Governor Balali underlined that "this trend calls for a rethink on the way people are organized in the provision of social security by, among other things, exploring new ways of improving coverage as well as benefits in order to fulfil obligations as stipulated in Article 22 of the Universal Declaration of Human Rights of 1948."[13] We are all happy with this observation and urge the government to work on it. ■

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12 <www.un.org/esa/socdev/enable/rights/convtexte.htm>

13 Daudi T. Balali, the Governor of the Bank of Tanzania (BoT) addressing a gathering of International Social Security Associations (ISSA) in Dar es Salaam. Attended by stakeholders from within and outside the country, March 2007. Quoted by Michael Haonga in local newspaper *The Guardian* "BoT Governor calls for enhanced public access to social security" of 26 March 2007.

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