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Health insurance for workers in the informal economy: exploring the potential of micro-insurance schemes

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In most countries of the developing and developed world, workers in the informal economy have become an increasingly important part of the workforce. This is contrary to the received wisdom in development economics which had assumed that with continuing economic growth more and more workers would become part of the modern or formal economy. Moreover, in most developing countries structural adjustment measures over the past 10-15 years have forced many governments to cut down on social services, including access to health services. While formal sector workers often enjoy health protection, such protection has generally not been extended to the large majority of workers in the informal economy.

This context of low provision of health care services in low-income countries has led to the emergence of so-called health micro-insurance schemes, organized for and/or by workers in the informal economy. These schemes generally cover only a small part of the working population. The purpose of this chapter is to explore the value of such schemes as well as their potential for up-scaling.

The chapter will start with giving some characteristics of the market for health services in low-income countries and with examining the reasons why statutory health insurance coverage is so low in these countries. It will also review some key characteristics of micro-insurance schemes, and provide an example of one particular scheme. It then examines the possibilities for up-scaling such schemes as well as the roles that could be played by the government, the private sector and civil society and then it closes with some conclusions.

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Workers in the informal economy and the market for health services

In many developing countries, health-care market institutions are not highly developed. Organizational purchasers are a weak force in the market, the quality of health care provided may be low and consumers may face a bewildering number of health-care choices. The market structures are often complex, particularly because of the fragmentation of health-care systems. In developing-country contexts, patients themselves are often the key decision-makers (Bennett 1997).

This poses new problems to the consumers of health services, and in particular for workers in the informal economy who are not used to dealing with private providers. Such workers need the intermediation of self-organized and self-financed group-based structures that deal and negotiate with private (and public health providers) on their behalf. So table 1 reflects the idea that there are multiple forms of group organizations that cater to health services. It also points to the growing importance and opportunities for group-based schemes and private sector health care provision in a changing market for health services.

Table 1. Effective demand and supply of health services

Type of health service	EFFECTIVE DEMAND (financing)			SUPPLY (production)		
	Individual	Group-based	Public goods	Local Government	Central Government	Private sector
Immunization			x	x	x	
Health education		x	x	x		x
Primary health care	x	x	x	x		x
Secondary health care	x	x		x		x
Tertiary health care	x	x			x	x
Water and sanitation	x	x	x	x		x
Ambient environment			x	x	x	

Many group- and community-based schemes reviewed by Bennett *et al.* (1998) act as intermediaries between the individual and the (public or private) provider of primary, secondary or tertiary care. In some cases the social financing of health care can go in parallel with the provision of health education at work. Another study (Muller and Rijnsburger 1996) shows that water and sanitation can also be financed and managed by informal sector associations.

In general, the table shows that there is a wide variety of options to the financing (effective demand) and delivery (supply) of health care services. While immunization and the provision of a healthy environment is in principle an activity financed by the (central and local) government, primary health care as well as adequate water and sanitation services can be financed by individuals, groups as well as the government. In the case of financing secondary and tertiary health care, there is a tendency for the government to withdraw.

With regard to the delivery of services, the local government can in principle provide all of them, except tertiary health care which – with immunization and the ambient environment – is mainly the responsibility of the Central government. The table shows that the private sector can supply an important array of health services, ranging from health education, curative services to water and sanitation facilities.

Behind this picture of changing market structure is hidden the changed relationship between the consumers and producers of health services. In the case of the health care market, the mix of demand and supply is determined by both quality and price. As is happening in many social security branches, various components in the provision of benefits can be subcontracted to the private sector through the intermediation of group-based structures. In the economic literature this is called the "principal-agency" relationship, where the "principal" is the group-based structure and the "agency" the (private) health providers. The "principal" attempts to steer the "agency" into the desired direction by means of "contracts", such as conditions for access, fee for service, flat rate and capitation fee (Normand and Weber 1994).

Reasons for low statutory health insurance coverage

In low-income countries, workers in the informal economy are generally excluded from health insurance provided by statutory national social security schemes. In most of these countries, structural adjustment policies have contributed to a decline in the – often small – percentage of the working

population in the formal economy. The successive waves of structural adjustment programmes have also led to wage cuts in the public and private sectors, thereby eroding the financial base of statutory social insurance schemes. Simultaneously, many such schemes in developing countries have suffered from bad management, partly because of too much government interference, which has often strongly reduced the trust of members in the scheme. In addition, structural adjustment programmes have often resulted in severe cuts in social budgets, leading to the virtual dismantling of public primary health care services in most low-income developing countries. The ideal solution is to publicly finance access to basic health care, but since this is not likely to happen in the foreseeable future, there is inevitably a strong demand for group arrangements to finance and organize these social services. In this situation of second-best solutions, it is often more efficient to be part of a group insurance scheme than to have to face health expenditures individually (van Ginneken, 1999a).

Generally speaking, the principal social protection priorities for informal sector workers are related to more immediate needs and to some possible catastrophic events, such as (van Ginneken 1999b):

- improving the effectiveness of health care expenditure;
- death, survivor and disability benefits;
- regularizing expenditure on basic education;
- maternity and childcare benefits.

The total contribution rate for statutory social insurance is often 20 % or more of the total payroll. Formal sector wage workers share these contributions with their employers. However, self-employed workers are often not prepared to pay the full (workers' and employers') contribution by themselves, and they have various ways to escape compliance. In addition, they have irregular income patterns, since their earnings are often dependent on the business cycle and various product and services markets. Other informal sector workers, such as casual and seasonal wage earners are also excluded from statutory social insurance schemes, since they tend to have low and irregular earning patterns. Their employment depends on the availability of jobs in specific periods. When there is no work, employment is immediately terminated, and hence incomes are lost.

The fundamental reason for low social security coverage in developing countries is therefore that many workers outside the formal economy are not able or willing to contribute a relatively high percentage of their incomes to finance social security benefits that do not meet their immediate priority needs. Since statutory social insurance schemes are compulsory and do not generally allow workers (or their employers) to insure for some benefits and not others, they perpetuate a situation in which the majority of workers remain excluded. Moreover, given the extent of exclusion, it is understandable that workers within such schemes are not

willing to extend coverage to workers outside the scheme who – even if they were interested in joining – have lower contributory capacity and would have to be supported with cross-subsidies. As far as self-employed persons are concerned, this suggests that compulsory coverage may be feasible only through special schemes.

The role of micro-insurance schemes

Various self-employed and informal sector workers have set up their own schemes in order to meet their priority social protection needs. The mechanism used in these schemes is generally the provision of mutual support through the pooling of resources based on the principles of insurance, help being extended to those in need within the overall framework of certain basic regulatory conditions. In this system, it is the group itself that decides on the size and the source of contributions that group members are meant to make. The collection and management of contributions – as well as the disbursement of benefits – are again matters for the group to consider and arrange.

In a recent article, Dror and Jacquier (1999) set out the concept of micro-insurance and its basic tenets: (i) the insurance is autonomously managed by groups and units at the local level; and – ideally – (ii) the local unit is structured in such a way as to link up with multiple small area- and occupation-based units into larger structures that can enhance both the insurance function and the support structures needed for improved governance. Such local micro-insurance structures have the advantages of cohesion, direct participation and low administrative costs.

As noted earlier, health insurance is often felt to be the most urgent social protection priority by informal sector workers (see for example Kamuzora 1999). As shown in some of the recent literature (Atim 1998; Bennett et al. 1998; ILO 2000), informal sector health insurance schemes often cover either high-cost, low-frequency events (hospital care), or low-cost, high-frequency events (primary health care), and in some case a mix between them. They are designated as Type I and Type II schemes respectively in table 2. The frequency of service utilization and possibilities for cost control are different in the two types of scheme.

Table 2. Two ends of the health cost risk-sharing spectrum

Type of scheme	Type I	Type II
Costs insured	Hospital care	Primary health care
Cost per intervention	High	Low
Frequency of utilization	Low	High
Ownership	Hospital	Community or association
Coverage	District	Community or association
Basis for premium setting	Actuarial study	Ability to pay

Source: Adapted from Bennett et al., 1998, p. 10.

Hospital-based insurance schemes covering hospital costs have been proposed (see, for example, Shaw and Griffin 1995) as one of the strategies for generating additional revenues for health financing. These schemes have generally been set up in a context of reduced government or donor financing, and are basically aimed at putting hospital financing on a sound footing. Some of these schemes face high and rising costs because they suffer from adverse selection, and patients tend to enrol when they know that they will need hospital care. In addition, hospital-based schemes often lead to overprescription and overprovision of services. Finally, they provide relatively high-cost primary and secondary health care services.

Governments in many developing countries claim to provide free or subsidized access to basic health care for low-income families. But in practice, many workers – even those with incomes under the poverty line – can spend between 5 and 10 % of their income on health services (Jain 1999), so that they are potential candidates for participating in health insurance schemes. As a result, informal sector workers tend to contribute to micro-insurance health schemes focused on the provision of primary and some secondary health care services for which they face relatively small but periodical expenses. These schemes usually have low population coverage.

The main advantage of micro-health insurance schemes is that they improve health expenditure efficiency or the relation between quality and cost of health services. There are basically three reasons why participants in such schemes would prefer group schemes to individual spending and financing (van Ginneken 1998):

(i) by regular contributions, the problem of indebtedness brought about by high medical bills can be alleviated;

(ii) the financial power of the group may enable administrators to negotiate services of better quality or better value for money from private health care providers; and

(iii) the group may be willing to spend on preventive and health promotion activities so as to keep down the cost of medical services.

An example: the UMASIDA scheme in Dar es Salaam

Micro-insurance is a relatively new event for workers in the informal economy of Dar es Salaam (Kiwara, 1999). In 1995 an ILO project facilitated the establishment of an umbrella organization of informal sector associations, called UMASIDA (an acronym for Mutual Society for Health Care in the Informal Sector). UMASIDA has now a written constitution and is led by an executive committee chosen from the member associations and consisting of a chairperson, a secretary and a treasurer. At the beginning of 1999 the organization counted 1,800 contributing members from about ten different associations, most of whom are involved in trading or in manufacturing. New groups are waiting to be included in the scheme.

Members contribute Tsh.1,000-1,200 (less than US$2) a month, which is deposited in a centralized UMASIDA account. The exact amount contributed varies from group to group depending on the benefiting dependants (spouses, children and parents) as well as on the health care package. In general, UMASIDA covers the costs of primary health care, laboratory investigations and treatment. With assistance from the back-stopping local consultant, each group makes an agreement with one specific health care provider in its neighbourhood, who provides the required services at agreed prices.

Beneficiaries are only entitled to treatment upon presentation to the health care provider of a special identity card and the so-called sick sheet which needs to be endorsed by the group leader. This procedure insures that only UMASIDA members (workers and their families) have access to health care. Group bills are paid to each health care provider by the UMASIDA central office on a monthly basis; appropriate deductions are then made from the group's total contribution. With the assistance of the local consultant, the UMASIDA central office then checks the costs and appropriateness of treatment, before effecting the payment. Other information, such as the disease pattern and cost trends, is analysed on a quarterly basis and feedback is provided to the providers and the groups. While UMASIDA maintains an account for each group, the same maintains a mirror account showing contributions and expenditures.

In the course of 1998 five new groups joined the scheme, and in 1999 three more were awaiting admission. As a requirement, a group has to

mobilize at least 25 contributing members, and make a one-month collection before access to services is granted. The whole process of sensitization to accessing services takes about three months. UMASIDA now has a permanent office and recruited an administrative assistant/accountant; the ILO has agreed to pay her salary for one year. It is estimated that with the extension of the scheme to more groups, UMASIDA can finance its own overhead costs.

The great advantage of the scheme is that it provides access to quality health care at an affordable cost. This is achieved through negotiation with carefully screened private sector health care providers on price and quality, the result of which is then reflected in contracts. In various groups UMASIDA's intervention has also resulted in health promotion activities at work and at home, for example on work-related accidents and preventable diseases, such as diarrhoea and venereal diseases. Shortcomings of the scheme are that providers occasionally prescribe drugs other than those in the WHO list of essential drugs. A general problem is that contributions are dependent on season or business activity and are often irregularly paid, especially by the smaller groups that have weak managerial structures. In addition, some providers cannot dispense all of the needed drugs, and beneficiaries are still forced to pay for them out of their own pockets.

The Ministry of Health is now conducting feasibility studies in 14 other cities in Tanzania, to investigate whether some elements of the UMASIDA scheme can be replicated. It would like to install a pre-payment scheme that would finance part of the public health care services in these cities.

Replicating micro-insurance schemes on a wider scale

In their review of rural risk-sharing strategies in health, Bennett, Creese and Monash (1998) note that there are several threats to the scope for raising revenues through health micro-insurance schemes. The threats include:

– the small scale of the majority of schemes examined;

– adverse selection leading to progressively smaller risk pools and higher costs;

– heavy administrative structures and costs in some schemes.

These three threats are clearly interrelated, because the heavy administrative structure and costs are often the result of the scheme's small scale. In addition, the small scale of most of the schemes is reinforced by the

problem of adverse selection. So one key issue is to define under what conditions health insurance schemes can be sustainable and/or replicable.

There are various characteristics on the basis of which work- and residence-based groups can organize themselves for the provision of health protection. People can organize themselves because they share the same occupation, live in the same area or belong to the same gender, cultural or religious group, for example. Each of these characteristics has its own advantages and disadvantages with regard to group factors such as trust, leadership, as well as financial and organizational capacity. These characteristics also have a major impact on the extent and speed with which self-financed health insurance schemes can be replicated.

In most countries, work-based organizations have been at the origin of statutory social insurance programmes. Informal sector workers – to the extent that they are organized at all – are principally organized in occupation- or sector-based associations and cooperatives. Their first priority is to improve their economic base in terms of credit, marketing and production technology. Once that is ensured, their organizations can often constitute a foundation for the establishment of contributory social and health protection schemes. This is also frequently true for women's organizations, whose purpose often includes raising consciousness with regard to the position of women in the family, work and society. Some of these organizations have set up savings and/or credit bodies which significantly improve the chances of successfully organizing social and health protection schemes.

It seems likely that women are generally more interested in and committed to the provision of health care and education to their family, rather than in occupation-based (and often male-dominated) schemes, which tend to consider disability and survivor pensions as a greater priority. Most work-based schemes are characterized by a high level of group cohesion, but they take a long time to mature. As a result, they are not easily replicable.

Organizations based on the place of residence are usually less cohesive, since they may not be interested in the participation of poor people, given their weak financial base (Weinberger and Jütting 1999). This may be different in the case of rural areas, where communities are often close-knit, and people have similar financial resources. At the area (district) level the social cohesion is likely to be even lower, but the quality of local government strongly influences whether some form of consensus, incentives and accountability can be established. The area-based approach is very suitable for social health care financing, since it can take into account the provision of not only curative but also preventive and promotional activities. In addition, participation by local government can also increase the extent and speed of replication of pilot experiences.

Moreover, local health insurance schemes can help to relieve some of the pressures on the budget of the Ministry of Health. This idea was worked out in India by Hsiao and Sen (1995) who proposed to manage and finance some primary and secondary health care services through local communities, particularly in the rural areas.

Partnerships for promoting micro-insurance

As noted before, in most low-income countries the extension of statutory health insurance can only be a partial answer to the problem of non-coverage. The question is therefore how the government and social actors can ensure that protection is extended to workers in the informal economy. One way to extend this protection will be through the promotion of micro-insurance schemes.

The extent to which micro-insurance schemes have been successful has depended on the characteristics of the bodies that set up the scheme, on their design and on the context in which they operate. The association should be based on trust among its members, which is enhanced by factors, such as strong and stable leadership, its economic base, the existence of participative structures and a reliable financial and administrative structure (Kiwara and Heijnis 1997). Good design features include measures to control fraud and abuse, to promote some form of mandatory participation, to contain costs and to foster preventive and promotive health services (Atim, 1998). Important context variables concern the availability of quality and affordable health care services (public of private) and a favourable climate for the development of micro-insurance schemes.

As noted above, most of these schemes remain fairly small, and it is therefore important to know under what forms of partnership the coverage of these schemes can be expanded. One option is that such schemes form organizations among themselves, which will enable them to achieve various objectives, such as a stronger negotiating power towards the goverment as well as (public and private) health providers, sharing of knowledge and greater financial stabilization through mechanisms, such as re-insurance (Dror 2000). Such inter-group associations could grow into a professional organization with a "beehive" structure, that would enable individual associations to affiliate rapidly (van Ginneken 1999b). In addition to the expansion of micro-insurance schemes, the impact of such schemes can also be enhanced through multiplication and mainstreaming (Uvin and Jain 2000). This means that small schemes can be seen as catalysts of innovations, the creators of strategic and programmatic knowledge

that can be spun off and/or integrated into the three mainstreams of society: governments, civil society and markets. The success of such experiments can then be judged, not only in terms of their size, but also in terms of the spin-offs they created, the number of projects that have been taken over by other actors, and the degree to which it contributed to the social and intellectual diversity of civil society.

However, with the growth of micro-insurance schemes, other forms of partnerships may also be necessary. Such schemes may team up with, and/or receive support from, larger organizations in civil society (cooperatives and trade unions for instance). They may also seek to involve private companies and social security agencies which already have a well-functioning administration. Experience with successful scaling-up efforts shows that two sorts of changes are needed; i.e. in the culture and organization of participating organizations as well as in linkages and forms of collaboration between organizations (Gaventa 1997).

The role of the government is critical for the successful up-scaling of these schemes. Local governments can play an important role in setting up area-based social protection schemes – in partnership with local groups of civil society. At the national level, governments are in the best position to ensure that isolated experiences can be replicated to other occupations, sectors and areas. Moreover, it can create an enabling environment for the development of micro-insurance schemes. In the case of health insurance four functions can be distinguished (Carrin, Desmet and Basaza, forthcoming).

(i) Promote health insurance through recommendations on design (benefits package, affiliation and administration) and the setting up of a management information system;

(ii) Monitoring the performance of micro-insurance possibly within the context of legislation on the efficient and transparent administration of schemes;

(iii) Undertake and organize training, based amongst others on the promotion and monitoring activities mentioned under (i) and (ii);

(iv) (Co)finance the access of low-income groups to health insurance, possibly through subsidies or matching contributions.

It is in particular this last option that has not been investigated in this chapter, but it requires further research in the future.

Conclusion

This chapter argues that the satisfaction of health care needs should not be considered an affair between governments and individual workers alone. Intermediate, group-based structures, such as micro-insurance schemes, are also necessary to ensure that workers in the informal economy and their families have access to health services provided by the private sector.

We identified some of the key characteristics of successful micro-insurance schemes, such as the characteristics of bodies that set up the scheme (good economic base, stable leadership and a reliable financial and administrative organization), good design features (measures to control abuse and costs and to foster promotive and preventive services) and context (availability of quality and affordable health care services).

It then reviews some of the factors that could lead to the up-scaling of micro-insurance schemes. It examines the potential for collaboration between schemes, but concludes that this is not sufficient. Schemes would also have interest in teaming up with larger organizations in civil society (such as trade-unions and cooperatives) as well as with private sector companies or social security institutions. It also sees a new role for the national government for promoting micro-insurance schemes, through monitoring as well as training and recommendations on design and administration. At the local level, governments could play a crucial role in so-called area-based schemes.

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