

PART IV. MICRO-INSURANCE: A COMPONENT OF SOCIAL PROTECTION

Some micro-insurance schemes (certain types of organizations covering certain types of risks or contingencies) are not only risk management instruments, but have the potential to actively contribute to the extension of social protection to excluded groups and furthermore to facilitate and improve the governance of the social protection sector and raise supplementary resources (financial means, human resources, etc.) that benefit to the social protection sector as a whole. This is particularly the case in contexts of low financial and institutional capacity of the State (low income countries).

Considering micro-insurance schemes as components of the national social protection systems has several implications, among which:

✓ Micro-insurance schemes may take over some of the social protection functions such as redistribution, with internal cross-subsidies or through the channeling of external subsidies to their members (public subsidies).

✓ Micro-insurance schemes should not only be evaluated on technical aspects (financial viability, etc.) but also on their capacity to reach social protection expected outcomes (financial protection in case of a shock, access to a minimum, efficient and relevant health package, etc.); more generally the socio-economic impact of these schemes on their members and on the non-members should be taken into consideration. A non-regulated market may fail in providing an efficient benefit package to the poor.

✓ Micro-insurance schemes have an important role to play in the promotion of empowerment and participation of their members, which has implications in terms of the design of the products, the choice of the most appropriate benefit / premium combinations, the organization of the schemes (participative decision making).

However stand-alone, self-financed micro-insurance schemes have strong limitations to become sustainable and efficient social protection mechanisms able to reach large segments of the excluded populations. Their potential as tools to extend social protection is increased when the governments recognize their interest and include them as a key dimension in their national strategies of extension of social protection, linking them to other components of the social protection systems in order to create a progressively more coherent, efficient and equitable system of social protection for all.

In any case, the decision to implement or support micro-insurance schemes is not only driven by a risk analysis but also by political considerations: on priority contingencies to cover, on populations to be targeted, on the relevance of this mechanism as compared to others, on its comparative advantages, on the possibility to link it to other mechanisms and other social protection components, in order to improve each others efficiency, to increase coverage and to progressively create more coherent and equitable systems of social protection.

Because they have a specific role, micro-insurance schemes in the context of social protection should be considered in a different way from other micro-insurance schemes (e.g., property micro-insurance (assets, livestock, housing), or credit life micro-insurance securing the reimbursement of loans) regarding in particular use of public subsidies, design of the benefit package and regulation

1- What is social security? What is social protection?

❖ *Definition, objectives and key functions of social security and social protection*

Social security has always been a core mandate of the ILO since its creation in 1919 and a first series of conventions and recommendations on social security were adopted before 1939. The Declaration of Philadelphia, adopted in 1944, requires the ILO "to further among the nations of the world programmes which will achieve the extension of social security measures to provide a basic income to all in need of such protection and comprehensive medical care". The objective of implementing everywhere in the World social security schemes aiming at universal coverage was established.

According to the ILO [ILO, 2000a], social security is the protection which society provides for its members through a series of public measures:

- To offset the absence or substantial reduction of income from work resulting from various contingencies (notably sickness, maternity, employment injury, unemployment, invalidity, old age and death of the breadwinner);
- To provide people with health care; and
- To provide benefits for families with children.

Social protection is defined to include not only public social security schemes but also private or non-statutory schemes with a similar objective, such as mutual benefit societies and occupational pension schemes, provided that the contributions to these schemes are not wholly determined by market forces.

ILO's approach to social security and to social protection is set out, among other places, in the decent work strategy [ILO, 1999], which states that all men and women must be able "to obtain decent and productive work in conditions of freedom, equity, security and human dignity". One of the aims of decent work is to strengthen and extend social protection for everyone.

ILO's definition of social protection is one among a large range of approaches. Other organizations such as the World Bank and the Asian Development Bank claim more holistic conceptions of social protection, with a larger range of contingencies addressed as long as they affect individuals' income security, with various overlaps with other sector policies such as education or labour market policies (e.g., enforcement of labour standards, elimination of child labour), with not only protecting mechanisms but also promotional interventions aiming at increasing the levels of asset base or economic opportunities for the households (such as microfinance programmes, price supports or commodity subsidies).

GTZ's definition of social protection (to be written by GTZ)

Through the attainment of the core objectives mentioned previously, social protection can have also other functions.

Social protection is an important tool to prevent poverty, and strengthen the capacity to go out of poverty. The absence of social protection leads to greater chances of falling into poverty or remaining stuck in a poverty trap. Some social protection measures consisting of direct transfer of funds to the poorer (e.g., social assistance benefits that are means tested) have a direct and at least temporary effect on the level of poverty.

Social protection also contributes to poverty reduction through its positive impact on economic performance and productivity. It can be seen as a productive factor [ILO, 2005] & [ILO, 2001a], for three main reasons.

- Firstly, social protection helps people to cope with important life risks and loss of income. In doing so, it can enhance and maintain the productivity of workers and creates possibilities for new employment. For instance, health-care systems help to

maintain workers in good health and to cure those who become sick. Other example, work injury schemes are playing an important role in preventing work-related accidents and sickness and in rehabilitating workers who fall victim to these.

- Secondly, social protection can be a critical tool in managing change in the economy and the labour market. For instance unemployment insurance creates a feeling of security among the workforce which facilitates structural and technological changes and encourages individuals to undertake riskier initiatives in the production and labour market spheres, that can result in a higher return for them and for the economy overall.
- Thirdly, social protection can stabilize the economy by providing replacement income that smoothes consumption in recessions and thus prevents a deepening of recessions due to collapsing consumer confidence and its negative effects on domestic demand. For instance, unemployment benefits and old age pensions help to maintain the purchasing power of workers after they lost their job or retired.

Social protection can enhance principles such as solidarity, dignity and equality.

- Solidarity within a social protection scheme arises when every one contributes to a common pot according to its capacity and draws from this pot according to its needs (within the limits fixed by the internal rules of the scheme). Solidarity can materialize through public subsidies and redistribution of funds raised through taxes. The level of solidarity depends on the nature of the financing instruments that are being used: unlike income tax or income-related contributions that are usually progressive, consumption taxes or flat-rate premiums entail the risk of being regressive.
- Social protection is linked with the principle of dignity since it gives people the right to live a decent life whatever the adverse events. Contrary to charity, social protection integrates individuals in a process of exchange where individuals have the right to receive and the obligation to give. Giving people the possibility to give (or contribute) is fully recognizing their dignity.
- Social protection is also linked with the principle of equality (including gender equality) and non-discrimination when equal rights are given to people exposed to the same risks or supporting the same burdens without discrimination of any kind, such as race, colour, sex, ethnicity, etc.

According to the New Consensus [ILO, 2001b], “Social security should promote and be based on the principle of gender equality. However, this implies not only equal treatment for men and women in the same or similar situations, but also measures to ensure equitable outcomes for women. Society derives great benefit from the unpaid care which women in particular provide to children, parents and infirm family members. Women should not be systemically disadvantaged later in life because they made this contribution during their working years.”

The application of the principles of solidarity, dignity and equality within social protection may help to foster social cohesion, social inclusion and social peace, which are in turn prerequisites for stable long-term economic growth.

Social protection can play an ‘integrative’ role and assist in bringing back into the mainstream individuals or groups that have been excluded, by providing support in getting back into employment and becoming an active (and possibly tax-paying) member of society once again. Social protection can be justified on the basis of social inclusion related to equal citizenship. It is also a strategy for responding to social exclusion and a way of promoting greater social cohesion [Piron, 2004].

Social protection can finally be a tool to promote empowerment and participation through the representation of workers (within formal statutory social protection schemes) and that of mutual benefit associations’ members (within community based social protection schemes, mutual benefit associations). This participation is one way of enhancing democracy.

The Declaration of Philadelphia stipulates “the collaboration of workers and employers in the preparation and application of social and economic measures” (§III-e) [ILO, 1944]. The new consensus on social security [ILO,

2001b] stipulates that “In order to be effective, initiatives to establish or extend social security require social dialogue.” (§16) and states that the ILO’s technical cooperation should include a wide range of measures, in particular: “ supporting and training the social partners to participate in policy development and to serve effectively on joint or tripartite governing bodies of social security institutions” (§19).

ILO’s conception of social protection (definition, functions) is shared by many institutions worldwide. Recently, the most important international federations and organizations representing the cooperative and mutual insurance sector and the ILO have formed the International Alliance for the extension of social protection (www.social-protection.org)¹. Their shared vision, values and principles are exposed in the “Geneva consensus”, 2005. This consensus recognizes that “*Social security is a fundamental and universal human right.*” and that “ *The International Labour Standards of the ILO in the area (particularly Convention 102) are the basis of reference.*” This consensus also enumerates basic principles and values regarding social protection, such as: solidarity, redistribution, role in economic and social development, importance of efficiency, relevance, good governance and financial viability, and suggests that values held by the cooperative and mutualist movement be valued (e.g., social justice, absence of exclusion and discrimination, etc.).

❖ *Right to social security*

Several international instruments affirm that every human being has the right to social security. These include: the Universal Declaration of Human Rights², the International Covenant on Economic, Social and Cultural Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, the European Social Charter, the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights.

Universal Declaration of Human Rights: the right to social security

Art 22: Everyone, as a member of society, has the right to social security and is entitled to realization through national effort and international cooperation and in accordance with the organisation and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Art 23 (3) : Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.

Art 25 (1) : Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

¹ ISSA (The International Social Security Association), AIM (The Association Internationale de la Mutualité), ICA (The International Cooperative Alliance), ICMIF (The International Co-operative and Mutual Insurance Federation), IHCO (The International Health Co-operative Organization), WIEGO (Women in Informal Employment: Globalizing and Organizing)

² The Universal Declaration of Human Rights: articles 22 and 25.1

The International Covenant on Economic, Social and Cultural Rights: article 9

The International Convention on the Elimination of All Forms of Racial Discrimination: article 5

The Convention on the Elimination of All Forms of Discrimination against Women: article 11

The Convention on the Rights of the Child: article 26

The European Social Charter: articles 12 and 13

The Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights: article 9.

One of social security areas (provision of health care) is related to a specific human right: the right to health care. Similarly this right is recognized in numerous international and regional human rights instruments. According to the Economic and social council [Economic and social council, 2000], the right to health includes notably the right to a system of health protection, which provides equality of opportunity for people to enjoy the highest attainable level of health.

In line with these international and regional human rights instruments, the Declaration of Philadelphia adopted in 1944 by the International Labour Conference assumes that “all human beings, irrespective of race, creed or sex, have the right to pursue both their material well-being and their spiritual development in conditions of freedom and dignity, of economic security and equal opportunity” (§II-a). This definition of social security as a human right is reasserted by the International Labour Conference in its 89th session, 2001: “Social security is very important for the well-being of workers, their families and the entire community. It is a basic human right (...)” (§2).

ILO’s social security conventions constitute technical extensions dealing with the practical implementation of this right [Reynaud, 2005]. The most important of these conventions is the Social Security (Minimum Standards) Convention, 1952 (No. 102). It defines nine branches of social security and the corresponding contingencies covered: medical care, sickness benefit, unemployment benefit, old-age benefit, employment injury benefit, family benefit, maternity benefit, invalidity benefit and survivors’ benefit. In addition, it introduces the idea of a general social security minimum level that must be achieved by all member States.

Convention No 102 has been subsequently completed by a series of conventions and recommendations:

- Equality of Treatment (Social Security) Convention, 1962 (No. 118)
- Employment Injury Benefits Convention, 1964 (No.121)
- Invalidity, Old-Age and Survivors’ Benefits Convention, 1967 (No.128)
- Medical Care and Sickness Benefits Convention, 1969 (No.130)
- Maintenance of Social Security Rights Convention, 1982 (No. 157)
- Employment Promotion and Protection against Unemployment Convention, 1988 (No.168)
- Maternity Protection Convention, 2000 (No.183)

To take into account the different national situations, most of these norms contain flexibility clauses in terms of the population covered as well as the scope and level of benefits provided. They also give to the States full scope on the organisation of their social security scheme. In other words, these conventions derive from the international instruments that affirm the right of everyone to social security, but at the same time they recognize the major practical difficulties in actually implementing this right in the various social realities that prevail worldwide.

Definition of social security as a human right starts from the principles of universality and equality: every human being is equally entitled to social security, which has two major implications.

First implication: States have some kind of obligation regarding the right to social security / social protection [Maastricht Guidelines, 1997]³. They have the obligation to fulfill this right i.e.

³ Other elements than the conception of social protection as a basic human right may require State’s intervention in the delivery, financing and regulation of social protection mechanisms. Some of these mechanisms are public goods, that cannot be efficiently delivered without State’s intervention. Among social protection areas, State’s intervention is above all required to provide access to health care, since health is being recognized as populations priority need (Source : Millenium poll, United Nations, New York, 2000), is one of the components of Human Development and therefore one of the ultimate goals of development (Source : UNDP Human Development report 2003), and is included in four of the Millenium Development goals (namely MDGs n° 1, 4, 5 and 6) that have been adopted by 189 States in september 2000.

they have to take appropriate legislative, administrative, budgetary, judicial or other measures to ensure the full realization of the right. Social protection schemes to provide minimum social security to all would come under this obligation – though the obligation does not necessarily mean that the State has to directly provide social protection; it can facilitate or encourage actions of third parties.

- Obligation can be of conduct: States have to take the necessary steps to realise a particular right. This would include an obligation to take steps towards ensuring the realization of social security and more broadly developing a social protection strategy. Other actors of society (e.g., local communities, health professionals, intergovernmental organizations, civil society organizations, as well as the private business sector) may also play a part in the progressive implementation of this right or the denunciation of its violation, although they are not ultimately responsible for its realization.
- Obligation can also be of result: States have to achieve specific targets to satisfy a specific standard. In this case, States are obligated to actually ensure social protection in line with the policy and legislative framework they have adopted.

In addition, there is some sort of, but so far unofficially recognized, obligation of the international community to support States with insufficient resources for the realization of human rights standards, including right to social security. This is in line with the idea behind the Global Fund for Malaria, Tuberculosis and HIV.

Second implication: everybody is entitled to a minimum of social protection, without exception or discrimination. This claims for an equitable access to social protection, independently of individuals age, sex, health status, location, type of occupation or level of income. This entitlement to a minimum of social protection is often put forward in order to justify the design and implementation of equity subsidies between the rich and the poor.

❖ *Gaps between right and reality*

In many developing countries, however, social protection coverage is dramatically low: it reaches a very limited proportion of the population and provides protection against only a limited range of risks [Reynaud, 2002]. In sub-Saharan Africa and South Asia it is estimated that only 5 to 10 percent of the active population is covered by a statutory social security scheme, most of these being old-age pension schemes, in some cases providing also access to health care. Although the situation is less dramatic in other parts of the world, it can be taken that worldwide only 20 per cent of workers enjoy adequate social protection. In some cases the percentage of covered population is even shrinking, in particular as a result of structural adjustment policies, privatisation and the development of the informal economy. Although some excluded people work in the formal sector (e.g., in Cape Verde: members of liberal professions, employees in civil engineering firms), the large majority is active in the informal economy: employees in small workplaces, self-employed workers.

Until the last decade, social protection strategies were in fact designed with the idea that the formal economy would progressively gain ground on the traditional economy and therefore that social security systems would progressively cover a larger proportion of the working force. But this trend did not come true since in many developing countries, and particularly in Latin America and Africa, most of the jobs created during the last decade have been in the informal economy [ILO, 2002a]. Today, informal employment comprises one half to three-quarter of non-agricultural employment in developing countries: 48 per cent in North Africa, 51 per cent in Latin America, 65 per cent in Asia and 72 per cent in sub-Saharan Africa (78 per cent if South Africa is excluded). If informal employment in agriculture is included in the estimates, the proportion of informal employment increases significantly: from 83 per cent to

93 per cent in India, from 55 percent to 62 per cent in Mexico and from 23 per cent to 34 per cent in South Africa [ILO, 2002b]. Statutory social security schemes' attempts to extend coverage did exist in some countries, but remained insufficient.

❖ *Priority to extend social protection coverage and possible strategies*

It is therefore necessary to find supplementary ways to translate the right to social protection into appropriate operational, organizational and institutional arrangements. This priority to extend coverage ensues from the principles of universality and equality mentioned before and was reaffirmed by the International Labour Conference in its 89th session, 2001, where governments, employers' and workers' organizations agreed that "Of highest priority are policies and initiatives which can bring social security to those who are not covered by existing systems." (§5) [ILO, 2001b]. The ILC 2001 proposes several ways of extending coverage: "When coverage cannot be immediately provided to these groups, insurance — where appropriate on a voluntary basis — or other measures such as social assistance could be introduced and extended and integrated into the social security system at a later stage when the value of the benefits has been demonstrated and it is economically sustainable to do so. Certain groups have different needs and some have very low contributory capacity. The successful extension of social security requires that these differences be taken into account. The potential of micro-insurance should also be rigorously explored: even if it cannot be the basis of a comprehensive social security system, it could be a useful first step, particularly in responding to people's urgent need for improved access to health care. Policies and initiatives on the extension of coverage should be taken within the context of an integrated national social security strategy." At the suggestion of the Conference, the ILO launched in 2003 the "Global Campaign on Social Security and Coverage for All".

Facing present situation where a large (and growing) number of persons are excluded from social protection and where existing social protection schemes provide most of the time insufficient levels and scope of coverage, it is necessary to conduct proactive strategies to extend social protection. These strategies aim at increasing the number of persons covered and at improving the level and the scope of existing social protection benefits. There is a large range of mechanisms that can be used to implement these strategies.

- Social insurance schemes can extend existing or modified benefits to previously excluded groups or contingencies, either on a compulsory or voluntary basis. They may also enhance their effectiveness through improved governance and design.
- Special social insurance schemes can be set up for excluded groups.
- Universal benefits covering the whole target population without any condition or income test (for instance, those over a certain age) can be implemented.
- Social assistance programs targeting specific vulnerable groups can also be implemented: waivers, social pensions / cash benefits, conditional cash transfers (for instance on school attendance).
- A complementary option is to encourage and support the development of micro-insurance and innovative decentralized social security schemes to provide social protection through communities, social partners or civil society organizations.

Following examples illustrate part of the variety of paths that can be followed and the multiplicity of actors involved.

Some countries managed to include new categories of workers within compulsory health insurance schemes. It is the case of the Republic of Korea [Kwon, 2002] which has gradually extended compulsory health insurance to all workers over a period of 12 years (from 1977 to 1989): wage earners of large corporations with more than 500 workers were first to be covered, government employees and teachers came next, followed gradually by

workers in increasingly small enterprises. Extension to the self-employed began through pilot programmes before being generalized.

Extension of social insurance on a voluntary basis does not very often gain much success. In Senegal [Fall, 2003] a special social protection scheme for the workers in the informal economy was implemented in 1996, ie at the inception of the health mutual benefit associations movement in this country providing coverage of various social risks but living workers free to seek coverage for one or several risks. The contributions were not based on the actual income of the workers (for difficulties of assessment) but on a flat rate. Insufficient information and communication on the programme, and a too high level of requested contributions (compared to the willingness to pay of the target population) explain that the programme did not gain much success (1,000 workers had joined in 2000).

Some others chose to develop special public schemes for excluded groups. In Uruguay [Reynaud, 2002], precise understanding of the characteristics of different excluded categories of workers in the informal economy, namely construction workers, domestic servants and the self-employed, led to the design of specific arrangements for each category: one scheme covering construction workers for old-age pensions, sickness, family and employment injury benefits; a health insurance scheme for domestic servants; and coverage for the self-employed by the country's main social security institution for old age pensions, survivors, invalidity and sickness benefits.

Welfare funds represent one of the models developed in India for providing social protection to workers in the informal economy. They are occupation based and financed by levying a cess on the production, export or sale of specific goods, or by collecting contributions from various sources including employers and employees. These funds have been promoted and implemented by Central government and State governments. The Beedi workers⁴ Welfare Fund was created in 1976 by the Central government; it is financed by a cess in the nature of an excise duty on manufactured beedis. The benefits provided include among others: scholarships, coverage of cost of treatment in dispensaries and hospitals, maternity benefits.

When these special schemes are to include very poor households, it is usually necessary that subsidies of the contributions be implemented. These subsidies may be financed from the fiscal budget and/or through transfers of the active contributors to the social insurance system, such as in Colombia (Régimen Subsidiado de Salud), see further § 3 section *The development of linkages*.

In Brazil [Swarzer; Querino, 2002] the health care services have been transferred in the mid-1980s from social insurance to the Health Ministry and eventually decentralized in the 1990s to States and municipalities. The services were transferred into a universal basic health care system, which offers primary, secondary and tertiary health care, in principle for any person without charge.

Some developing countries, particularly in Latin America, have set up tax-financed cash benefit schemes that provide basic income security for those in need. They are generally targeted to categorical groups (elderly people, widows and children) who have few or no potential links with the labour market. Benefit levels are frequently lower than the poverty line, but they appear to be a welcome supplement to family income and encourage the integration of children and elderly into the household [Van Ginneken, 2003].

Among these programmes, conditional cash transfers provide money to poor families contingent upon a certain verifiable actions, such as sending children to school or bringing them to health centres on a regular basis. CCT programs have been successfully implemented on a large scale in several middle-income, high inequality countries such as Brazil, Chile, Colombia, Ecuador, Jamaica, Mexico, South Africa and Turkey [Rawlings; de la Brière, 2006]. Examples include the so-called PROGRESA (Programa de Salud y Educacion) in Mexico and Bolsa Familia in Brazil. The CCT programmes in Latin America have had reasonable success in meeting their basic welfare objectives, namely reducing short-term poverty through increased total and food expenditures, decreased malnutrition among young children, higher educational enrolment, lower dropout and repetition, and reduced child labour. The cost of these programs does not usually exceed 0.5% of GDP (0.32% in Mexico, 0.36% in Brazil).

In addition, various forms of linkages can be developed between the different schemes and other public policies, including a wide range of public-private or public-third sector partnerships.⁵

BOX PPP to be written by GTZ

⁴ Beedi workers are cigarettes rollers.

⁵ For a typology of the different possibilities, see [Kannan, 2004].

2- What are the current potentials and limitations of micro-insurance as a mechanism of extension of social protection?

As said previously, ILO considers that it is the States' responsibility to define their own social protection policy and to design the organization of their social security schemes. Some of them may consider micro-insurance to be a tool for the extension of social protection, and may include this mechanism in their strategies of extension.

❖ Types of micro-insurance schemes concerned

It is necessary to precise that not all micro-insurance schemes may play a role in the extension of social protection. The importance of some micro-insurance products is recognized and supported, although these products are not strictly speaking providing social protection coverage. It is the case of assets, livestock, housing, car accidents micro-insurance. It is also the case of credit life and credit disability micro-insurance that merely consist in covering the repayment of the outstanding balance of the loan in case of death / disability of the borrower, although life and disability are part of the contingencies listed in ILO Convention 102. On the contrary some micro-insurance products such as health micro-insurance (hospitalisation, primary health care, maternity, etc.), life, old age pensions, disability and loss of income are entering into C 102's list of contingencies, and may thereby play a role in the extension of social protection.

❖ Positive contribution of micro-insurance in the extension of social protection

In a context of low financial and institutional capacity of the State (low income countries) micro-insurance schemes may raise supplementary resources (financial means, human resources, etc.) that benefit to the social protection sector as a whole and contribute to facilitate and improve the governance of the social protection sector.

More specifically, health micro-insurance schemes contribute to improve access to health care: utilization of health services is facilitated through the reduction of the financial barriers that delay access, in some cases quality of care is improved when the scheme signs agreements with health care providers on the quality of delivery (availability of medicines, effective presence of the health care staff, effective use of treatment protocols, etc.). Contracting with health care providers also contributes to increase transparency in billing and invoicing practices and thereby to improve the way the health sector is managed.

Micro-insurance has also several positive effects in terms of participation of civil society, empowerment of socio-occupational groups including women. Since many schemes are being set up and operated by women's associations they may contribute to strengthen women's capacity to meet their health needs including those linked with their reproductive role.

Moreover, micro-insurance as a mechanism of extension has several added values or comparative advantages as compared to classical social security schemes.

1- Micro-insurance has a good capacity to reach groups excluded from statutory social insurance, such as most categories of the workers in the informal economy and rural workers.

2- The transaction costs necessary to reach these populations are reduced, since micro-insurance schemes are often operated by decentralized civil society organizations that are

usually implemented in the vicinity of their target populations; their staff includes social workers that are used to work and communicate with these populations; etc.

3- Micro-insurance benefits package are most often designed in close partnership with the target population. This participation is highest in mutual benefit associations where the choice of the package is the result of a voting in the general assembly. In other types of micro-insurance schemes, less participative, the target groups are usually consulted for instance through households surveys. As a result, the benefits package is often customized i.e. responding to the coverage needs of the target population with affordable contributions.

4- Small community-based micro-insurance schemes usually record less problems of frauds and abuses than centralized systems of social protection since members often know each other, belong to the same community and share the same interests. This social vicinity may help also in the distribution of the product. However it raises the problem of the sustainability of small scale schemes and that of the weak social pressure to pay contributions on a regular basis resulting in high levels of drop out. Some schemes manage this issue of drop out (low renewal / repayment rates) through the implementation of group insurance contracts with organized occupational groups (such as cooperatives).

❖ *Current limitations of micro-insurance as a mechanism of extension of social protection*

The development of micro-insurance is ongoing, with a kind of proliferation of new schemes. This shows that these schemes respond to a real demand and that they manage, at least at the local level, to solve a certain number of issues.

India's 2003/2004 inventory published in 2005 [ILO-STEP, 2005b] found 60 micro-insurance schemes covering 5 200 000 people. The inventory is being updated ; the current (beginning 2006) number of scheme stands at 71 covering more than 6 800 000 people.

It seems however that this development faces problems that limit micro-insurance schemes' contribution to the extension of social protection:

1- The total population covered in most countries is far from reaching the target (populations excluded from legal social protection schemes). In fact, many of these schemes (particularly in Africa) have great difficulties in extending their geographic or socio-occupational outreach and in increasing the size of their membership.

2- Many micro-insurance schemes have poor viability and sustainability.

These 2 points are linked (particularly in Africa) with poor management skills (not enough financial resources in order to hire professional staff) and information systems (difficulties to produce information and monitor the scheme's operations).

3- Members' ability to pay is most often very low, which leads also to a very limited coverage in the absence of subsidies.

4- Most of these schemes do not take over the functions that are usually played by statutory social security schemes such as redistribution / solidarity between richer and poorer segments of the population (since contributions in such schemes are very often flat rate), and do not reach the poorest segments of the excluded groups (those that cannot contribute).

5- In many countries the legislative framework and regulations are not adapted to these schemes and do not facilitate their extension.

6- Micro-insurance schemes are most often self-governing organizations. They may pursue objectives that are not in line with government's strategy of social protection and their promoters may be unwilling to participate in the design and set up of national systems of social protection for this participation would challenge the schemes' autonomy.

3- How can micro-insurance be used to achieve the extension of social protection?

An increasing number of States consider micro-insurance to be a tool for the extension of social protection, and include this mechanism in their strategies of extension. In several countries micro-insurance schemes are already part of the process of designing and implementing progressively more coherent and integrated social protection systems: in India the partner-agent model contributes to increase the formal acceptance of these schemes; in Senegal micro-insurance schemes are mentioned in the national social protection strategy as key mechanism to extend social protection; in Rwanda and Ghana, the State implements nation wide social protection schemes in health that are built on district and community based mutual organizations.

To overcome the limitations mentioned above one suggest three pathways (developed in following paragraphs): First that the further development of micro-insurance be enhanced and accelerated (in terms of population covered, scope of the benefits package, technical and financial capacities of the schemes, etc.); Second that linkages be developed⁶ with other actors and institutions (e.g., outsourcing of management functions) as well as other components of social protection and the health sector (contracting with health care providers at local level but also defining contractual frameworks at national level); Third that micro-insurance be further integrated in coherent and equitable national systems of social protection.

❖ *The further development of micro-insurance*

This further development has implications for various actors, particularly the State and the promoters / operators of micro-insurance schemes.

The State may support this development through increased efforts of promotion of micro-insurance and sensitization of the public opinion (particularly the target populations). It may also support this development through the improvement of design management and monitoring of micro-insurance schemes. The State could for instance support structures aiming at providing technical support and training to micro-insurance schemes' operators. It could facilitate the share of experiences between actors (e.g., development of networks) and the access to information and knowledge, also to make sure that isolated experiences can be replicated to other groups or geographic areas. Governments could more specifically (such as in Cambodia's Master Plan) formulate recommendations on design: benefits package, affiliation, administration, payment methods of health care providers; they could implement mechanisms aiming at strengthening the viability of the schemes (management information systems) and their financial capacities (e.g., reinsurance mechanism, guarantee funds); they could also set up structures able to produce information (statistics, indicators) on these schemes and to monitor the performance of micro-insurance schemes. The State could finally promote public-private partnerships (see further, paragraph on linkages).

In Cambodia the Master Plan for Social Health Insurance in Cambodia recommends the set up of Community Based Health Insurance schemes that respond to certain characteristics in terms of levels of contributions (flat rate corresponding to not more that 4% of the family income), type of affiliation (all the members registered in the family book are registered in the CBHI), benefit packages (list of services to be covered), payment methods with health care providers (capitation mode of payment), etc. [WHO Cambodia, 2003].

For promoters and operators of micro-insurance schemes this further development may in some cases mean altering the way the schemes currently operate: making their management become more professional which goes hand in hand with challenges (e.g., increased complexity) that many promoters and operators of micro-insurance are not yet ready to face;

⁶ Note: This second pathway may contribute both to the development of micro-insurance and to its integration in national systems of social protection.

outsourcing some of their management functions to other more specialize organizations (see next paragraph on linkages). It may also mean setting up new schemes targeting the members of already large organizations (trade unions, cooperatives, occupational associations, etc.). In fact, schemes with larger membership are in a position to provide more comprehensive coverage to their members (particularly against major risks like hospitalization) and are often more sustainable (for instance, they can more easily build up financial reserves).

❖ *The development of linkages*

Linkages are all sorts of relations that may be developed between a micro-insurance scheme and other organizations, institution or systems. They may be classified according to the types of mechanisms used and to the actors (or partners of micro-insurance schemes). Following typology is not exhaustive.

Mechanisms	Actors / partners
Subsidies (local, national, international)	Other micro-insurance schemes, Federations of schemes
Contracting with health care providers	Civil society organizations, MFIs, trade unions, networks of cooperatives ...
Outsourcing management functions	Health care providers
Technical advise	Service providers: TPAs ...
Financial consolidation (reinsurance, guarantee funds)	Private sector, pharmaceutical industry
Distribution of insurance products	Central and local governments
Distribution of public goods (immunization, social assistance)	Public health programs
Bargaining	Social assistance programs
Exchange of information, practices	Social security schemes, Private or public insurers
Regulation, control	International cooperation

Linkages aiming at improving the functioning of the schemes

The sharing of functions / responsibilities according to each others core competences and scope of activities (with other schemes or with service providers such as TPAs) may create economies of scale and make the micro-insurance schemes become more efficient. Examples of linkages include: outsourcing management functions to Third Party Administrators (TPAs) in India, distribution of formal insurance companies' products in the Indian partner-agent model, creation of economies of scale and of a bargaining power through the grouping of micro-insurance schemes (such as emerging African federations).

Functional linkages may also be established with other components of social protection; they contribute to improve the coherence of the national system of social protection. Examples of linkages include: channeling social assistance and social services to eligible members; distribution of social insurance services. These linkages have to be defined in national master plans.

In the Philippines, Philippine Health Insurance Corporation (PHIC), or "PhilHealth", has a mandate to achieve universal coverage by 2012 [GTZ-ILO-WHO, 2005]. One of the paramount challenges is to provide health insurance coverage to workers in the informal economy which is estimated at 19.6 to 21.7 million workers or approximately 70% to 78% of employed population. In response to this challenge, PhilHealth approved the Board Resolution No. 569 (PBR 569) in June 2003 which allowed partnerships with organized groups on a pilot basis. The partnership, called PhilHealth Organized Group Interface (POGI1), is seen as an innovative approach to reach out to workers in the informal economy through micro-credit cooperatives. The initiative is being tested with six (6) cooperatives in Cavite and five (5) cooperatives in Southern Leyte agreeing to enter into a partnership with PhilHealth. The cooperatives act as marketing and premium collection agents for PhilHealth.

As far as health micro-insurance schemes are concerned, the decentralization of the health care sector and the design and implementation of a contractual framework between micro-insurance schemes and health care providers as well as a set of tools may facilitate the establishment of contractual arrangements with health care providers.

In Senegal most of the mutual health organizations sign contractual agreements with health care providers but the relation is often unbalanced (information asymmetry) and the mutual has no real means to compel the health care provider to respect its commitments. To face this problem the Ministry of health recognized the necessity to design a contracting framework that gives guidelines and concrete tools to facilitate the contracting process: stages in the design of an agreement, minimum content of an agreement, commitments of both parties (including financial aspects, invoicing and payment methods), monitoring tools and procedures, State's role and implication. A working group has been created in 2006 in order to design a first draft of this framework that will next be presented to the actors involved (mutual health organizations and their federations, ministry of health, health care providers, support structures, social partners, etc.).

Linkages for redistribution

Micro-insurance schemes can constitute mechanisms of redistribution of public subsidies (e.g., premiums subsidies coming from the statutory social insurance system or equity funds) that can help to provide poorer households or individuals with low contributive capacity and / or high social risks (e.g., the Elderly, the chronic ill, some occupational groups) with a package of social protection. Such mechanisms are legitimate as far as they aim to provide an equitable access to social protection (independently of individuals' characteristics and financial capacity). Beside their redistribution role these subsidies also make the beneficiary micro-insurance schemes more attractive and contribute to increase their membership.

Within the reform of the health care system in Colombia [Pérez, 1999] in the 1990s, a special scheme (Régimen Subsidiado de Salud) was introduced to finance health care for the poor and vulnerable groups (including their families) who are unable to pay contributions to the general insurance scheme. The funds are raised through a solidarity contribution collected under the contributory social insurance scheme (50%) and a State subsidy (50%). They are then channelled to several institutions (including 8 mutual benefit associations and several private insurance institutions) that are managing the scheme. Today this subsidized scheme covers 8 million people.

The mission of the GLOBAL SOCIAL TRUST Network is to systematically reduce poverty in developing countries through a partnership that invests in and sponsors the development of sustainable national social protection schemes for people and groups which have been excluded from the economic benefits of development. The basic idea is to request people in the richer countries, i.e. OECD countries, to contribute on a voluntary basis a rather modest monthly amount (say €5 per month or about 0.2 per cent of their monthly income) to a GLOBAL SOCIAL TRUST which will be organized in the form of a global network of National Social TRUSTs supported by the ILO, which will then: invest these resources to build up basic social protection schemes in developing countries; and sponsor concrete benefits for a defined initial period until the basic social protection schemes become self-supporting.

For more detailed information:

<http://www.ilo.org/public/english/protection/socfas/research/global/global.htm> [2006]

❖ The integration in coherent and equitable national systems of social protection

Providing social security to citizens remains a central obligation of a society as a whole. Government has to organise the access to and level of services through legislative and regulatory means. This does not mean that all social security schemes have to be operated by public or semi-public institutions. Governments can delegate its responsibility to various institutions and organisations in the public, private, co-operative and non-profits sectors. What is needed, however, is a clear legal definition of the role of the different players in the provision of social security to all members of a society. The definition of these roles should be complementary while achieving the highest possible level of protection and coverage. A government could develop a social security development plan that defines the scope and

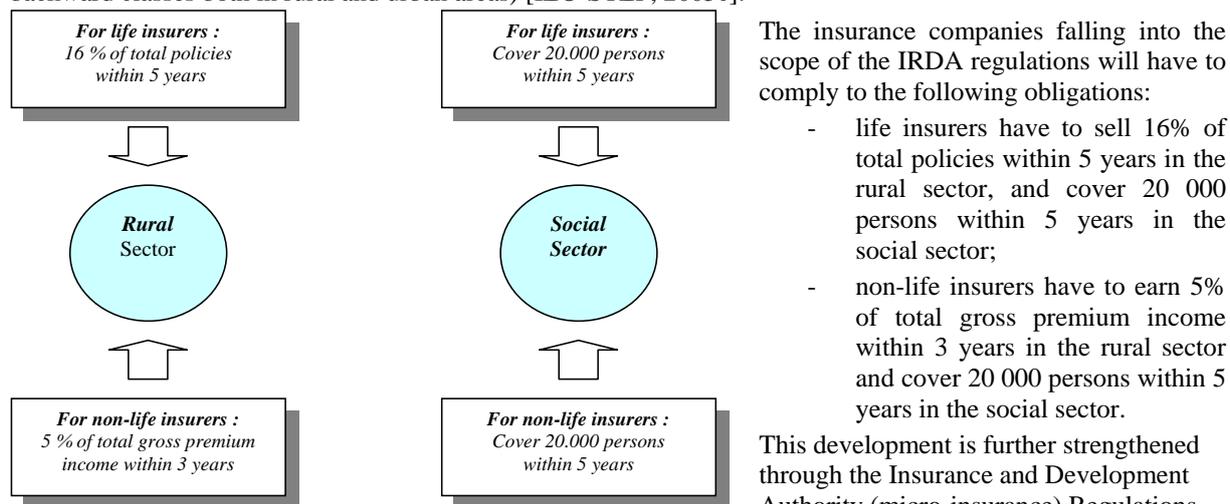
coverage of public provision of services through government agencies, social insurance, private insurance, employers and micro-insurance schemes. It is therefore desirable that governments and social partners explicitly recognise micro-insurance as a tool for the extension of social protection, which implies that micro-insurance be integrated in national strategies of extension of social protection, health development and poverty reduction (e.g., PRSPs). The role of *health* micro-insurance in an overall health financing policy coordinated by the State should be as well recognized. The overall aim of such a policy is universal access to health, based on pluralistic financing structures.

In Cambodia the government recognizes the potential of social health insurance as a major health care financing method in the future. Cambodia's Master Plan for Social Health Insurance recommends – in order to reach universal health insurance coverage - to follow a parallel and pluralistic approach which comprises: (1) Compulsory social health insurance through a social security framework for the public and private salaried sector workers and their dependants; (2) Voluntary insurance through the development of community based health insurance schemes (CBHI) and (3) Social assistance through the use of equity funds and later government funds to purchase health insurance for non-economically active and indigent populations [WHO Cambodia, 2003].

The design and adoption of appropriate legal frameworks is a key step towards this integration. Such a framework may specify – among others - the role of micro-insurance in the national system of social protection and introduce a set of rules and institutions for the supervision of the operations of micro-insurance schemes: regulatory body (e.g. ministry in charge), procedures of agreement, etc. Legislative frameworks may moreover be a strong factor of development of these schemes. On the opposite, frameworks with too high financial requirements or a too strong supervision from the public authorities may restrain this development.

ILO / STEP supports the construction of a regional framework for the development of health mutual benefit organizations in several UEMOA countries (Benin, Burkina Faso, Mali, Niger, Senegal) and, within this framework, the design and implementation of national legislations that will regulate mutual benefit organizations and support their development.

In India the Insurance Regulatory and Development Authority (IRDA) adopted in 2002 regulations aiming to extend the insurance coverage to the rural sector (cultivators, agricultural labourers, workers in livestock, forestry, fishing, etc.) and social sector (unorganised sector, informal sector, economically vulnerable or backward classes both in rural and urban areas) [ILO-STEP, 2005c].



This development is further strengthened through the Insurance and Development Authority (micro-insurance) Regulations, 2005 which officially recognizes the micro-insurance partner-agent model [Official Gazette, 2005].

1. IRDA regulations

The supervision of micro-insurance schemes' internal regulation, operations and financial statements, are moreover useful to check that these schemes effectively contribute to an equitable

access to social protection and are accountable for the efficient use of public funds (e.g. tax financed funds channeled to subsidize the premiums of the poorest members of these schemes).

For the promoters of micro-insurance, the integration in national systems of social protection has various implications. The benefits package that they provide should include an insurance coverage against one or more social protection contingencies (Cf. those listed in C 102). Moreover, when a minimum guaranteed package of social protection has been defined by the legislation, these schemes should provide this minimum coverage to all their members. Micro-insurance schemes' internal regulations should abide by the principles of equity defined by legislation (if any). Rules such as the exclusion of members over a certain age or calculation of premiums based on individuals' risks may not be in line with such principles. If micro-insurance schemes are to receive public financial support (such as equity subsidies) they should be accountable for the efficient use of these public funds. This implies that strict rules of management and accountancy be enforced and that micro-insurance schemes' operation and management be more professional. Micro-insurance schemes should also agree that their financial statements be supervised by a public or independent regulatory body.

More generally it is important that promoters and operators of micro-insurance be involved - either directly or indirectly (through groupings and federations of schemes representing their interests) - in national consultations and negotiations with the State and other stakeholders (social partners, legal/statutory social security schemes) on social protection issues, such as the design and implementation of national strategies of social protection.

Such integration needs that a climate of trust and confidence be created between operators of schemes, networks and federations of schemes, other civil society organizations representing the populations covered by these schemes (trade unions, cooperatives, etc.) and the government.

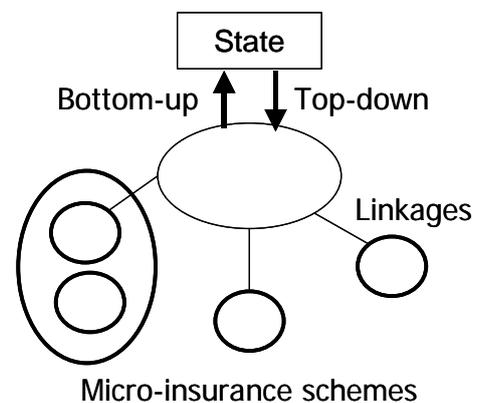
❖ *The dynamic of extension using micro-insurance*

The dynamic of extension of social protection may be fed by:

✓ Bottom-up initiatives: further development of micro-insurance, advocacy, sensitisation of public opinion, policy makers, donors and development agencies as well as social partners, and other social protection components.

✓ The development of linkages: with other micro-insurance schemes, with health care providers, with service providers such as TPAs, with social security institutions, etc.

✓ Top-down efforts: recognition of the potential for micro-insurance by a number of actors including social partners, local and central governments, supporting structures and donors, etc.; willingness to organize coherent social protection systems including micro-insurance schemes.



2. Micro-insurance and the dynamic of extension of social protection

In Senegal, joined efforts of a large number of actors (civil society organizations, the State, local governments, social partners, support structures and donors, health care providers) have contributed to accelerate the process of extension. Several events have been significant:

- in 2003 : the law on mutual health organizations was adopted, a national concertation framework on the development of mutual health organizations was created, the national committee on social dialogue (Comité National du Dialogue Social, CNDS) in charge of the implementation of the national charter on social dialog was created as well.

- in 2004 : the global campaign on social security and coverage for all was launched in Senegal, the trade union of transport operators (Syndicat National des Travailleurs des Transports Routiers du Sénégal, SNTTRS) included in its claims platform social protection issues ; the Law on agriculture, forestry and breeding (Loi d'Orientation Agro-Sylvo Pastorale, LOASP) that plans the design and implementation of a social protection scheme for rural workers was adopted.

These events or elements have been integrated in the logical framework of the national strategy of extension of social protection and risk management (SNPS/GR) formulated in 2005 with the active participation of a large number of actors. This strategy aims at extending social protection from 20% to 50% of the population by 2015 through the design and set up of new schemes responding better to the priority needs of the informal economy workers.

These events and the national strategy formulation lead in 2006 to the conduct of feasibility studies aiming at the design and establishment of two nation-wide social protection schemes: one for the transport operators and their families (target population of 400 000 people) and the other for the rural workers and their families (target population of 5 000 000 people).