Session 13
David Dror
Micro Insurance Academy

My point of departure is that for people in the informal sector in low- and middle-income countries (LMIC), "shared prosperity" is a collective attribute, not an individual right. In this context, which includes most poor persons and overall about 3 billion people globally, *welfare gains can occur either through pooling (of resources and efforts) within communities, or through charity/subsidies coming from outside*.

I. Charity/subsidies

Most of the population of LMIC is "in the informal sector". In context, this means small-scale, self-employed activities (with or without hired workers), typically unrecorded, unregistered and conducted without proper integration with the administrative machinery responsible for enforcing laws and regulations. The strong incentive to be in this informal context is that people usually escape the attention of the authorities through which most governments collect taxes or dedicated contributions. Being in the informal sector has down sides as well, notably being de facto excluded from the arrangements through which governments recognize universal rights for all citizens (to health, education, food security, social security…). LMIC governments, with few resources to redistribute, rarely succeed to manage priority setting within severe rationing. *Consequently, **subsidies and charity payments** cannot secure welfare gains for the majority, and **have been neither scalable nor sustainable***. Nor is there any evidence that free or almost-free access to healthcare, education and social insurance are likely to be generalized by governments in LMIC countries (e.g. in South Asia: India, Bangladesh, Pakistan, Nepal, Afghanistan); most of SE Asia (e.g. Indonesia, Cambodia, Laos, and Philippines) and most African countries (e.g. Nigeria, Ethiopia, Egypt, Uganda, Sudan, Cameroon…). Moreover, since the majority of the population of LMIC is *in the informal sector, governments cannot impose any form of universal mandate* (look at the miserable record of requiring drivers to have minimal third-party liability insurance).

II. Community-based welfare gains

We observe in the informal sector of LMIC the emergence of voluntary and local organizations similar to those which prevailed in Europe in the 19th and early 20th century which allow farmers / rural poor to contribute small amounts into village-level asset pools, which they also govern[1]. These pools can protect the members against poverty-generating shocks. One of the most common formats is community-based insurance, often called today *micro-insurance,* which unfold often as "mutuelles de santé" **or** "mutuelles agricoles*" etc.* The state can encourage this movement since, when ***many small micro-insurance units are aggregated through a federated structure, the cumulative assets collected can reach considerable quantum that the state could never collect in the informal sector in other ways***.

The salient point is that such micro-insurance is based on voluntary, contributory, and participatory (self-governed) enrolment, *based on assets rather than on debt or dole*, with profit-sharing rather than profit-taking. Socioeconomic status of the members is usually much more equitable than in national and mandatory insurance.

III. What have we learned from health micro-insurance experience in the informal sector?

[1] Benjamin Fernandez : *L'autogestion mutualiste, voie inexplorée vers la santé pour tous*. Reportage dans le district de Vaishali au Bihâr, l'état le plus pauvre de l'Inde, où la Micro Insurance Academy (MIA) accompagne des communautés rurales autour des principes et savoir-faire inspirés du premier souffle du mutualiste. Altermondes, Août 2014

1. People are interested that community-based health insurance (CBHI) should deliver *benefits to many members of the group*, rather than just to a few people[2]. And they are more likely to enroll *when they understand what the CBHI offers*, and how it works[3]. Group dynamics and intra-household pecking order are more influential than HH income or general education[4].

2. Even *very poor people are willing to pay, but the price determines the package*, not the other way around. Therefore, *group consensus on the package is more important than covering specific risks*[5],[6].
3. The package never covers all risks[7]; it can deal with idiosyncratic risks, but scaling and covering covariant or outlier risks will need reinsurance[8].

4. The most likely *initial impact of CBHI is to reduce hardship financing*[9] (and Dror *et al*, Impact of CBHI, in process, 2014).

5. People in the informal sector *prefer proximate care* over better quality or cheaper care[10],[11],[12].

[2] Dror DM, Firth L: *The demand for (micro) health insurance in the informal sector*. Geneva Papers on Risk and Insurance, Oct 2014
[3] Panda P, Chakraborty A, Dror DM: *Building Awareness to Health Insurance among the Target population of Community-Based Health Insurance Schemes in Rural India. A*ugust 2013
[4] Pradeep Panda; Arpita Chakraborty; David M Dror; Arjun S Bedi. *Enrolment in community-based health insurance schemes in rural Bihar and Uttar Pradesh, India.* Health Policy and Planning 2013; doi: 10.1093/heapol/czt077
[5] Dror David M., Pradeep Panda, Christina May, Atanu Majumdar, Ruth Koren: *"One for all and all for one"; Consensus-building within communities in rural India on their health microinsurance package*. Risk Management and Healthcare Policy, June 2014 Vol 2014;1 DOI: http://dx.doi.org/10.2147/RMHP.S66011
[6] Binnendijk E, Dror DM Gerelle E, Koren R: *Estimating willingness-to-pay for health insurance among rural poor in India, by reference to Engel's law*. Social Science & Medicine, Volume 76, January 2013, Pages 67-73
[7] Binnendijk E, Koren R, Dror DM. *A model to estimate coverage levels of rural poor enrolled in community-based health insurance schemes in developing countries*. Submitted for publication Health (special issue on health economics) Health**,** 2014**, 6,** 822-835 (March)
[8] Dror DM, Armstrong J. *Do Micro Health Insurance Units Need Capital or Reinsurance? A Simulated Exercise to Examine Different Alternatives*. The Geneva Papers on Risk and Insurance (2006) 31, 739–761
[9] Binnendijk E, Koren R, Dror DM. *Hardship financing of healthcare among rural poor in Orissa, India*. BMC Health Services Research Jan 2012, **12**:23 doi:10.1186/1472-6963-12-23
[10] Gautham M, R. Koren, E. Binnendijk, DM Dror: *"First We Go to the Small Doctor": 1st Contact Healthcare Providers of Rural Communities in Andhra Pradesh and Orissa, India*. Indian J Med Res 2011. **134** (11) pp. 627-63
[11] Raza WA, E Van de Poel, P Panda, DM. Dror, A Bedi: *Healthcare Seeking Behavior among Self-help Group Households in Rural Bihar and Uttar Pradesh, India* Submitted for publication
[12] May et al qualitative analysis of health seeking behavior, BMC health services research, 2014