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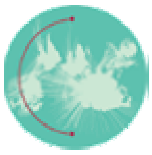

DISCUSSION PAPER No. 1

Extending Social Security to Developing Countries

Particular Emphasis on Healthcare and Informal Economy Workers

A literature review by Isobel Frye

NALEDI
NATIONAL LABOUR & ECONOMIC DEVELOPMENT INSTITUTE

The Global Union Research Network (GURN) is a cooperating project of the International Confederation of Free Trade Unions (ICFTU), the Trade Union Advisory Committee to the OECD (TUAC), the ILO's International Institute for Labour Studies (IILS) and the Bureau for Workers' Activities (ACTRAV) of the ILO. The aim of the research network is to give union organizations better access to research carried out within trade unions and allied institutions.

This literature review is the first in a series of discussion papers to be published by GURN. It was prepared by Isobel Frye, senior researcher in socio-economic rights of the National Labour and Economic Development Institute (NALEDI).

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ABSTRACT

Access to social security is internationally acknowledged as a human right, but in fact is one that is far more honoured in its breach than in its enforcement, and is frequently not readily accessible to the most vulnerable in society. The growth of the informal economy, both in developing and developed countries has exposed the weaknesses and shortcomings inherent in the traditional approach to the provision of social security for those who fall outside of the formal economy. Social security has also traditionally been a vehicle to promote social cohesion and solidarity between different sectors of society, yet it is clear that marginalised workers in the informal economy and the poor in general are often excluded from this solidarity. Through the prism of access to healthcare, this paper seeks to explore some of the reasons for the shortcomings in the current cover of social security, to consider what options exist for extending healthcare provision, and to consider the role that trade unions could play in extending healthcare.

INTRODUCTION

This literature review seeks to achieve an ambitious number of outcomes. Prior to the review itself, we set out certain crucial policy/political questions about the desirable nature and the role of social security. We then consider the literature available on social security in both developed and developing countries and consider how the effects of globalisation and structural adjustment programmes have affected states' capacities to provide social security. This is followed by an investigation into the characteristics of the informal economy, and consideration of the added vulnerability experienced by women in this sector. The paper then examines the need articulated by poor workers for access to healthcare and the phenomenon of the 'medical poverty trap'. Thereafter we consider the three main options for extending healthcare, and evaluate the potential impact of each of these. In the third part of the paper we look at particular challenges for

the development of mutual health organisations, and in the final part we examine various roles for trade unions in extending the coverage of healthcare to workers in the informal economy.

POLICY ISSUES

Most of the literature reviewed acknowledged that one of the main obstacles to accessing social security lies in the limited resources available in most developing countries for social spending, and that these restraints are to a large extent due to political and economic policies forged in an increasingly global economy and influenced by neo-liberal beliefs about the appropriate size, shape and role of the nation. Developing countries have, in addition, been affected by structural adjustment policies and spending conditions. Four critical questions regarding extension of social security need to be addressed as a preliminary step as they will influence the choices of options for the extension of social security.

1. Universal provision of social security benefits by the state

The first question that needs to be addressed is whether there is consensus that the optimal system of social security provisioning should be that the state should be the provider of free universal access to social security benefits, funded from state revenue.

Universal provisioning would prevent the wastages caused by targeting, as well as ensure that informal workers and the very poor do not slip through the targeted schemes, which has been shown time and again to happen. The notion of universal protection also situates the concept of social protection in the ambit of ‘social citizenship’, rather than limiting it to ‘economic citizens’ (Hickey, 2005, p. 21).

The voices that oppose the notion of universal social protection in part base their argument on the age old distinction between the ‘deserving’ as opposed to the ‘undeserving’ poor. According to

this argument, poor people, even those living in chronic poverty, should be able to work themselves out of poverty, or 'pull themselves up by their own bootstraps', and thus should not require social assistance. This line of argument in fact criticises social assistance on the basis that a right to access such assistance will dissuade people from seeking work altogether.

Article 71(1) of Social Security (Minimum Standards) Convention 102 of the International Labour Organisation states that "(T)he cost of the benefits provided in compliance with this Convention and the cost of the administration of such benefits shall be borne collectively by way of insurance contributions or taxation or both in a manner which avoids hardship to persons of small means and takes into account the economic situation of the Member and of the classes of persons protected."

Is it necessary to include a clearer commitment to an ultimate goal of universal state provisioning of social security benefits?

2. Cross-subsidisation

Much of the literature examines ways to accommodate the poor to enable them to afford contributions to schemes to assist their access to affordable healthcare.

Most mutual health organisations (MHOs) are formed from a membership that comes from similar situations of poverty and marginalisation. The poor thus effectively cross-subsidise the poor, without benefiting from cross-subsidisation with the better off, and often healthier, members of society. This can lead to the development of a two-tier health system as the package of benefits that wealthier citizens can afford through formal schemes is usually more extensive than that which can be provided by the mutual health organisation.

If cross-subsidisation and national solidarity is a desirable outcome, it may be useful to consider the total value of contributions paid by workers and employers in the formal economy to social insurance schemes against the cost of the establishment and management of a national health system.

3. Marginalisation of the poor

This paper and the literature reviewed focuses on the extension of social security – and in particular healthcare – to informal economy workers in developing countries. Accordingly we must acknowledge that these considerations fundamentally seek to address the effect of structural and manufactured poverty under a global system that has caused social fragmentation and accommodated the marginalisation of many of the poor from formal labour rights and social security.

This marginalisation of the poor and poverty can also be seen in the difference in influence between the ministries of finance compared to social development, health and education in many countries (Hickey, 2005, p. 23).

Consensus on how to extend social security to workers in the informal economy must be located in a conscious cognisance of these constraints.

4. The politics of social protection

The form and nature of social protection policies and programmes in any country is informed by the prevailing political ideology regarding distributive and redistributive justice, the allocation of national resources and the extent to which the state should actively intervene in such distribution (Hickey, 2005, p. 8).

While highly redistributive programmes of social protection are widely acknowledged to be progressive, there is a countervailing argument that suggests that social protection can also be regressive if it garners popular support for a conservative regime and enables such governments to gain sufficient support to undermine initiatives for progressive structural political transformation (Hickey, 2005, p. 10).

Bodies that organise the poor and working poor, such as trade unions, can act to ensure that the agenda for social security reform is consistent with progressive transformation of any given society.

PART ONE: DISCUSSION OF THE NEED FOR SOCIAL SECURITY AND THE PRIORITISATION OF ACCESS TO HEALTHCARE

1.1 Social security and the development of Convention 102

In 1883, Chancellor Bismarck of Germany introduced the first mandatory health insurance scheme in terms of which employers and workers were obliged to contribute towards the cost of low paid workers' health insurance (WHO, 2000, p. 4; McIntyre, 1997, p. 35).[2] This decision sought to take over the trade union sickness funds as a deliberate move to reduce the influence of socialist workers movements over workers in the country (WHO, 2000, p. 12). In the United Kingdom a similar scheme was introduced in 1911 (WHO, 2000, p. 12), although the provision of public health under the National Health Service was only introduced in 1948, due in part to the destruction to the health infrastructure wrought by the Second World War (WHO, 2000, p.4). Social security was seen as a way to help people through adverse conditions and shocks which would inevitably affect vulnerable workers and poor people more disastrously than wealthier classes (Bloom, 2005, p. 2). This constituted a fundamental acknowledgement of the failure of the emergent self-regulating market system to address needs that were vital to the sustainability of a stable society (Hickey, 2005, p. 10).

In 1952 the International Labour Organisation (ILO) adopted the Social Security (Minimum Standards) Convention 102, which proposed minimum social security cover to address a number of contingencies namely healthcare; child maintenance; invalidism, old age and death of a breadwinner, financed by a combination of social insurance and social assistance sources (Naidoo, 2004, p. 2). Convention 102 was drafted as a benchmark for the political objectives of

[2] New Zealand was the first country to introduce a national health system in 1938, followed by Costa Rica in 1941 (ibid).

governments seeking to address the social, political and economic reconstruction challenges occasioned by the Second World War.

The adoption of Convention 102 guided the design and establishment of a number of diverse social security systems throughout the world. The Convention provides a framework for the progressive roll out of social security from a set of minimum standards towards the ultimate goal of universal access and cover.

Both the German and the British models of healthcare (although they now provide a social health insurance and a national health system respectively) are examples of comprehensive coverage that grew out of disparate private mutual health organisations established alongside guild or trade union structures until the state assumed responsibility of the function and began to regulate schemes (WHO, 2000, p. 4; WHO/EIP, 2004, p. 5). This review will consider the emergence of similar small schemes under the section on mutual health organisations, and what conditions were favourable to the amalgamation of the small schemes under central state regulation.

The roll out of any national social security system should be seen as a dynamic process influenced by the available resources, the extent that social contestation influences policy choices, and the changing needs of society, i.e. between the economic and the political.

Subsequent to the Second World War, the welfare policies of Beveridge in the United Kingdom and the Keynesian concept of the welfare state attained dominance in Europe (Estivill, 2003, p. 6). The introduction of social welfare systems in western European countries was accommodated by an upsurge in economic growth in the countries in question.

Since the adoption of Convention 102, both the developed and the developing countries have faced severe challenges to the attainment of universal social security. These challenges have arisen from the vacuum caused by the retraction of the state of its responsibility for

comprehensive social protection provision, and market failure from the private sector to step into the breach that was ascribed to it (Dror and Preker, 2002, p. 1).

Hickey, (2005, p. 9) however argues that over the last ten years there has been a positive shift in global and many national policies with regard to social protection, catalysed in part by the failure of the unfettered East Asian markets in the mid 1990s. This is evidenced most clearly in the new international development approach articulated in the Poverty Reduction Strategy Paper processes in many developing countries.

Certain conventions and recommendations have been adopted by the ILO since 1952 to address the question of access to social security by workers not covered through formal employment-based systems, such as the Home Work Convention, 1996 (No. 177) and the Part-Time Work Convention 1994 (No. 175) (Chapter 3 of report VI of the 89th session of the ILO, in Reynaud, 2002, p. 16).

To address the impact of these realities and changing needs, the ILO committed itself to increase the scope of social protection to include these marginalised sectors in the recommendations of the 89th International Labour Conference, and informed the adoption of the Global Campaign in Social Security and Coverage for All by the ILO (Estivill, 2003, p. i). Social security is further considered by the ILO to be one of the keys to Decent Work (Bangkok, 2004, p. vii).

Three of the eight Millennium Development Goals adopted by 189 countries in 2000 pertain directly to health, as do eight out of sixteen targets and eighteen out of forty-eight indicators (WHO Millennium Development Goal Brief).[3] However evaluation of progress of countries to meet

[3] The eight Millennium Development Goals are:

1. Eradicate extreme poverty and hunger.
2. Achieve universal primary education.
3. Promote gender equality and empower women.
4. Reduce child mortality.
5. Improve maternal health.

these goals after five years shows little progress in sub-Saharan Africa in particular, with low income countries not spending enough to ensure that these goals are met (WHO Millennium Development Goals Scorecard at Half Time Brief). The evaluation estimated that donor funding would have to increase five times to developing countries to enable these goals to be met (ibid).

Society in general benefits from social protection[4]. When people do not have to worry about providing for their basic needs when these are addressed by a safety net, they are better able to contribute to society. In addition the presence of a safety net lessens the possibility of individuals and families being dragged into poverty traps when unforeseen contingencies occur (van Ginneken, 2003, p. 12). Decreased protection for workers as a result of rising patterns of casualisation of jobs in the workplace has been linked to a decrease in worker productivity. Security enhances productivity which can be positive for workers as well as employers (ILO, 2002(a) p. v). In the absence of security in the formal workplace, the need for accessible social protection for workers is vital (Fall, 2002, p. 8). This is particularly relevant to workers in the informal economy.

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6. Combat HIV/AIDS, malaria and other disease.
7. Ensure environmental sustainability.
8. Develop a global partnership for development.

www.un.org/millenniumgoals/index

[4] Social Security/ Protection

Subsequent to the early post war years, the concept of social security itself has been interrogated. The 9 elements of traditional social security was criticised for being too narrow, and this led to the development of the broader concept of social protection which seeks to promote living standards in addition to the traditional approach of seeking to prevent a fall in living standards (van Ginneken, p. 10. ILO, p. 38).

Social security can be described as: "benefits that society provides to individuals and households through public and collective measures to guarantee them a minimum standard of living and to protect them against low or declining living standards arising out of a number of basic risks and needs" (van Ginneken, p. 11).

Social protection is broader than that, and includes "social security, labour protection, labour market policies and social services" (van Ginneken, p. 10).

This paper shall use the two terms where applicable in accordance with the above definitions.

The literature on the extension of social protection includes both an assumption that citizens have a right to social protection through the right of social citizenship, and that social protection should be extended because it enhances the capacity of people to act as productive, economic citizens (Hickey, 2005, p. 21). Another way of articulating this difference is whether social protection should be seen as providing a safety net, or a rope by which poor people can be expected to pull themselves out of poverty.

1.2 Casualisation, poverty, globalisation and social security

Public financing for social security has shrunk across both developed and developing countries as a result of neo-liberal economic polices that seek to reduce spending by the state in favour of private markets, and the structural adjustment policies rooted in the same neo-liberal system introduced through international financial institutions. Many of the international health reforms have been driven to differing degrees by the search for alternate, non-state sources of financing for healthcare (McIntyre, 1997, p. 1). Casualisation of jobs in the formal economy has led directly to the exclusion of many workers from benefits to which they would previously have been entitled. Rapid urbanisation in developing countries has resulted in the breakdown of traditional structures of support and security which have not been replaced with formal safety security nets since the majority of jobs that have grown in developing countries have been in the informal economy.

1.2.1 Social security in developed countries

The effects of the global economic shock of the 1970s, exacerbated by rapid globalisation and the resultant drive towards more competitive (i.e. cheaper) production of goods, saw developed countries adopting labour policies that have made inroads into the social protection gains previously regarded as being integral to the welfare state (Estivill, 2003, p. 8). The labour market has become increasingly casualised with new job opportunities being offered in terms of a limited, short term contract, often without formal workplace benefits. Outsourcing of jobs further removes the obligation on the effective workplace to provide benefits for the workers.

Most formal social security schemes are administered and regulated through the employer, and are thus not accessible to self employed workers. In addition, many schemes depend on joint contributions from workers and employers. Where schemes' membership is open to self employed or informal workers, they have to pay the full contribution, which makes it unaffordable for most vulnerable workers.

Under their dominant neo-liberal economic imperatives, many Western countries have greatly cut their spending on social security. Since 1993, European Union member states have sought further to rationalise their social protection systems (Estivill, 2003, p. 98). This trend was part of a global re-evaluation of the role of the state as provider of benefits, and the introduction of the private sector with for-profit insurance policies (Estivill, 2003, p. 8) as part of a way to tackle high public budget deficits. There are however some exceptions to this trend. Spain introduced a national health service in 1986, which in the next decade provided access to almost all workers (although this benefit is not available to undocumented workers who face extreme vulnerabilities) (Reynaud, 2002, p.2).

1.2.2 Social security in developing countries

In sub-Saharan Africa and south Asia, more than 90% of workers are not covered by social security, while internationally only 20% of people are adequately covered by social security (van Ginneken, 2003, p. 7). There is a large discrepancy in levels of cover in Latin America, ranging from 10% to 80% of workers. This is in contrast to the situation in developed countries, where, until fairly recently, with the exception of some East European countries, almost all workers have access to social security (Sabates-Wheeler and Kabeer, 2003, p. 5). This trend of almost complete cover has been decreasing in recent years with the influence of informalisation and increasing flexibility of labour markets, which leaves workers outside of social security systems (ibid).

Many of the newly independent countries in Africa had extensive social security systems in place after independence which provided free or heavily subsidised healthcare (Atim, 1998, p.1).

However, as a result of the economic effects of the international economic crisis of the 1970s (Atim, 1998, p. 1) and the impact of structural adjustment programmes, countries have reduced their social spending, which has led to the demise of many of the social protection programmes, as well as a reduction in the state's capacity to implement the remaining programmes (Van Ginneken, 2003, p. 9; Steinwach, 2002, p. 1). Reform processes often are introduced to protect the interests of the incumbents of power. Similarly to the motivation that convinced Bismarck to introduce state controlled health insurance in Germany, Hickey (2005, p. 9) argues that some social protection programmes in developing countries undergoing structural adjustment were introduced to reduce the sway of opposition political parties who were resisting the adoption of social adjustment.

Developing countries found themselves besieged by contrasting demands by foreign donors. Donors both provided financing for social programmes to reduce the impact of structural adjustment programmes, and also supported the systematic reduction of the size and role of the state and hence its capacity to deliver (Hickey, 2005, p. 28).

What do developing countries spend on healthcare? According to a 2000 WHO report (Scheil-Adlung, 2004, p. 3), in 1997 it is estimated that Indonesia only spent 1.7% of its GDP on healthcare, Thailand spent 5.7%, India 5.2%, Vietnam 4.8%, the Philippines 3.4% and Malaysia spent 2.4%. In the same year, Belgium spent 8%, Canada 8.6%, France spent 9.8%, German, 10.5%, Sweden, 9.2%, the United Kingdom spent 5.8% and the United States of America spent 13.7% of their respective GDPs on healthcare. (WHO Report, 2000, pp. 192-195). A more detailed analysis of healthcare spending and sources between 1997 and 2001 is set out in Annexure One.

It is also important to interrogate the distribution of a country's health spending. According to the World Development Report 2004 (p. 3), the bulk of public health spending is generally enjoyed by the 'non-poor'.

In considering the ability of countries to expand social security coverage it is important to distinguish between middle income and poor countries in the developing world given the varying abilities of the state to raise revenue required for state support for social security programmes (Reynaud, 2002, p. 3).

By 1993, almost all sub-Saharan Africa countries had introduced some form of cost-recovery[5] system for healthcare provision, to the extent that this is now accepted uncritically as the legitimate way of financing healthcare (Atim, 1998, p. 1), even though these systems present an often insurmountable obstacle to the poor in accessing healthcare (Sabates-Wheeler and Kabeer, 2003, p. 40). Few of these countries have developed goals of universal comprehensive protection even subject to progressive realisation within available resources.

A rapid increase in urbanisation in developing countries has led to a diminution in the role of traditional community based or family based safety nets that provided various forms of security in the past (Sabates-Wheeler and Kabeer, 2003, p. 10). Growing poverty in Africa, exacerbated by the effect in part of the reduction in the real terms of trade between countries in the South and the North (Estivill, 2003, p. 7) has led to the rise of informal economies, with workers forging livelihoods for survival in an environment that is usually beyond the ambit of state regulation and protection.

Bloom (2005, p. 11) argues that policy makers should ensure that new policies do not push out existing systems that work. It is important, however, to interrogate whether existing systems that have been established, for instance in the face of state absence, are beneficial or purely survivalist responses. If the latter, the question may be how to improve and develop what has been developed by people through increased financing and resources.

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[5] Cost recovery refers to the policy that users should pay for the service. In practice the amount of the actual cost that is recovered from the user varies from authority to authority.

Poverty denies people free choices, including whether to choose traditional healing or hospital based healthcare; preventative or remedial (Lalitpur, 2002, p. 7). The articulation of preferred choices by the poor is essential to the development of strong, appropriate and accountable institutions (WDR, 2004, p. 1).

It is also important to consider *how* public funds are spent, including both the question of whether funds favour preventative or curative responses to healthcare, and whether state policies favour supply-side or demand-side financing. Many argue that the latter, through for instance cash transfers, empowers poor people by enabling them to choose their preferred healthcare provider, and in this way also forces healthcare providers to provide high levels of service through the threat of competition (Bloom, 2005, p. 9).

Deliberations regarding appropriate forms of social security for workers in the informal economy must take into account the peculiar characteristics and needs of these workers and the conditions under which they work and in which they live. This paper cannot do justice to the very complex discussion and debates pertaining to the nature and character of the informal economy, but will in the following section consider some of the more general characteristics covered in the literature.

1.3 Characteristics of the informal economy

Original theories about informal workers referred to people in the informal 'sector'. This term has since been replaced by informal 'sector' as people came to realise that the informal economy exists in and cuts across various sectors throughout the whole economy (ILO, 2002(a), p. 58). The nature of the informal economy, its size, components, turnover and its total contribution to national economies is very difficult to capture given the paucity of official statistics kept about this economy. It is a composite term which covers a plethora of livelihood strategies, from someone living in poverty who is unemployed or underemployed, to successful self-employed people. The nature of the linkages between the formal and informal economies is also constantly subject to change.

The term informal economy covers a large diversity of workers, enterprises and entrepreneurs, and includes "…all economic activities by workers and economic units that are – in law or practice – not covered or insufficiently covered by formal arrangements" leaving them vulnerable to exploitation and unsafe working conditions. Workers in the informal economy are often trapped in poverty, whether they are wage workers or own account workers (International Labour Conference Resolution Concerning Decent Work and the Informal Economy, 2002, p. 53 and 54).

Lund (2005, p. 6) notes that the previous attempts to delineate workers between the formal and informal economies has been replaced by an acknowledgement that the economy as a whole should be seen as a "continuum having a more formal and a less formal end" (Lund, 2005, p. 6).

The term informal economy thus covers a number of diverse conditions and livelihoods. Standing (quoted in Sabates-Wheeler and Kabeer, 2003, p. 7) distinguishes between traditional informal economy workers who are mainly survivalist, and the casualised component of the former formal economy. It is important to note that the majority of people in the informal economy are likely to remain informal workers – it is a long term existence, rather than a temporary stepping stone to entering the formal economy (Sabates-Wheeler and Kabeer, 2003, p. 17). This is important to acknowledge when considering methods to extend the cover of social security to workers in the informal economy; it is not sufficient to extend cover to the formal economy, relying on an eventual movement of workers from the informal to the formal economy. On the other hand, the provision of social security to workers in the informal economy can enable workers to move from the informal to the formal economy as a result of increased security (ILO, 2002(a), p. 26).

Of the vulnerable workers, women are most at risk in terms of insecurity. Women are over-represented in the informal economy, and more likely to undertake non-wage labour, such as caring for members of the household (Sabates-Wheeler and Kabeer, 2003, p. 15). Female headed households are more likely to be poorer than male headed households, and statistically

the head of the household is more likely to work in the informal economy. More women are also involved with casual or part time work, which erodes eligibility from many formal social security schemes (ibid).

Women are thus most likely to be involved with the least protected employment conditions. One way of alleviating these conditions is through the extension of social protection to address some of the challenges, such as the cost of reproductive responsibilities and lack of access to capital – both human and financial.

The challenge inherent in the informal economy with regard to the extension or provision of social security lies in its very fragmented and officially invisible nature. Self employed workers are often not registered in any way. Most social security systems have failed to accommodate the needs of the growing numbers of atypical workers (Fall, 2002, p. 8). A general challenge with regard to the informal economy is to identify methods of supporting workers to organise themselves and to build institutions that strengthen and protect their rights (ILO, 2002(a), p. 26). SEWA, a registered trade union for self employed women in India, is a highly successful example of this, as is set out in Section Four below.

Collection of workers' and employers' benefits in formal social security schemes is usually administered through the employer, but in the informal economy this edifice is removed, and hence the issue of collection of contributions from, and the allocation of benefits to, disparate self employed workers has been identified as a major obstacle to extending protection to the informal economy.

Workers in the informal economy face clear and distinct threats to their human security, and within this vulnerable economy certain hierarchies pre-ordain further patterns of marginalisation, including for women. The economy is deeply fragmented and diverse, with each group having its own needs. Most of the workers are officially invisible, which serves to reduce the pressure on

government to consider and address their needs. Economic and distributive structural conditions, under which the informal economy is capable of growing more 'jobs' than the formal economy, are root causes of the production and reproduction of poverty.

1.4 Prioritisation of affordable access to adequate healthcare for informal economy workers

There have been two shifts in the general approach to healthcare provisioning. The first approach in the 1940s and '50s was based on national health systems funded through state revenue in richer countries. The high costs associated with these systems and their decreasing ability to provide decent healthcare led to the adoption of a primary healthcare policy, in which state resources were transferred to primary, cheaper interventions, leaving people to fund more expensive health interventions out of their own pockets. The last shift has been an ideological shift from government's responsibility for healthcare provision or financing responsibility. This has been replaced by an increasing reliance on insurance schemes, including private insurance such as has been seen in certain Asian countries (WHO Report, 2000, pp. 14-16). This, in turn, has led to a blurring in many countries between public and private sector provisions and formal and informal arrangements (Bloom, 2005, p. 6).

Accessible healthcare refers not only to affordable universal coverage, but also to acceptable levels of the healthcare that is provided (WHO/EIP, 2004, p. 2).

In terms of prioritising components of social protection for workers in the informal economy, the issue of access to affordable healthcare has emerged in study upon study as being of extreme

importance, followed by access to education, and illness-related income supplements (van Ginneken, 2003, p. 9; Fall, 2002, p. 15; Bangkok, 2004, p. 2; Bloom, 2005, p. 4).[6]

There are strong links between poverty and ill health, with illness having an economically detrimental impact due to high absenteeism, reduced life expectancy and costly inroads to a household's income through medical costs (Scheil-Adlung, 2004, p. 1).

The financial impact of ill health consist of both direct and indirect costs (McIntyre and Thiede, 2003, p. 1), and health costs impact not only on the user, but also the healthcare provider, the insurer and government. Direct costs include: transport; drugs; the cost of consultation; user fees which include 'unofficial' user fees[7] (facilitation payments), food for the patient if the hospital does not provide adequate nutrition, and transport, accommodation and food for any family member who might accompany the ill person; and funeral costs (McIntyre and Thiede, 2003, p. 5). User fees of themselves often act as an absolute obstacle to many poor people accessing healthcare (Scheil-Adlung, 2004, p. 2; van Ginneken, 2003, p. 25).

Indirect medical costs include the cost of time spent in healthcare seeking activities rather than on productive undertakings, as well as premature death for productive workers (McIntyre and Thiede, 2003, p. 4). These costs clearly affect the self employed and workers in the informal economy more severely where income depends on daily activities. In order to compensate for the unavailable labour of the ill worker, members of the household usually assist in undertaking these activities, which can in turn lead to children being taken out of school (McIntyre and Thiede, 2003, p. 18).

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[6] It is important to acknowledge that a diverse range of factors contribute to good health, including nutrition, sanitation, access to potable water, education and access to shelter (McIntyre, 1997, p. 2). This review focuses primarily on access to curative healthcare.

[7] These amounts sometimes charged by health officials can be twelve times the amount of the official user fees. Unofficial user fees are likely to increase as public sector wages fall, according to McIntyre and Thiede, 2003, p. 11).

In terms of the notion of 'fair' healthcare financing, the ratio of non-food household expenditure that is spent on healthcare should not exceed 50% of total non-food expenditure (WHO Report, 2000, p. 36). When families exceed this ratio, they are likely to fall into poverty (ibid).

Studies of how poor households cope with direct costs indicate that household savings are usually first used to cover these costs, accompanied by a reduction of household consumption, and thereafter the liquidation of household assets, with productive assets generally being liquidated last, and then recourse being to borrowing from family, community or micro-lenders (McIntyre and Thiede, 2003, p. 17).

It is clear that each of the above coping mechanisms can lead to an impoverishment of the household and the individual members of the household, and often it can take a household two generations to emerge from such a trap (McIntyre and Thiede, 2003, p. 27. Van Ginneken, 2003, p. 23).

The resultant poverty trap that can be caused by medical costs has at least two potential impacts, either pushing a household into poverty, or destroying strategies that a household has developed to enable it to move out of poverty.

In Vietnam, it has been estimated that approximately three million people were forced into poverty just in one year (1998) as a result of having to pay for medical attention (WDR, 2004, p. 135).

The WHO Executive Board Secretariat Report of 2 December 2004 on Social Health Insurance (p. 2) estimates that 178 million people may suffer 'financial catastrophe' as a result of out of pocket health expenditure per year, and that 104 million people are forced into poverty for health payments.

While low and middle income countries account for 18% of global income, they represent 84% of the world's population and carry 93% of the disease burden, but only access 11% of the world health spending (WHO, 2000, p. 7).

Strategies for providing for affordable access to healthcare in a way that supports the predictability of household expenditure (van Ginneken, 2003, pg. 9) would clearly improve both the health and the quality of life of workers in the informal economy and would have a positive impact on economic productivity and workers' abilities to generate income in a sustainable manner. It also has a beneficial impact on the health and safety of women and children through childbirth and beyond.

Access to healthcare is a rights-based question of equity. Frequently one sees the emergence of two-tiered health systems, with the poor accessing state healthcare financed by ever shrinking budgets, and the rich accessing private healthcare, often financed through private health insurance, the contributions for which earn the member a tax deduction.

PART TWO: POLICY CHOICES AND COST IMPLICATIONS OF EXTENDING HEALTHCARE TO WORKERS IN THE INFORMAL ECONOMY IN DEVELOPING COUNTRIES

Introduction

The 2001 report of the WHO Commission on Macroeconomics and Health emphasised two important aspects to the question of the cost of providing healthcare. Firstly, according to a United Nations Millennium Poll (2000), good health was the first priority rated across the world. The second point was that there is clear evidence between accessible healthcare and human, and economic development (WHO, 2001, p. 21). Health has a positive correlation with poverty eradication. Each year the poorest countries lose "dozens of percentages of GNP" arising from the failure of these countries to be able to address the health needs of their people (WHO, 2001, p. 22).

Cost can thus either be considered from a number of different perspectives – the impact of not providing healthcare for the quality of lives of people, or the amount foregone in terms of economic development arising from a failure to provide such access, or cost can be considered strictly in terms of how much it costs each country to provide reasonable healthcare.

The Commission's report calculated that the minimum cost to cover one person's essential health needs per annum on average was between US$30 and US$40 (WHO, 2001, p. 55). These costs were sufficient to cover basic minimal services, namely major communicable diseases, maternal and peri-natal services. This did not cover trauma or emergency services, any tertiary hospital care or family planning (WHO, 2001, p. 56). On average, the least developed countries contribute about US$13 to healthcare per person per annum, while the average in other low income countries is US$24 (van Ginneken, 2003, p. 25). By comparison, the annual cost *per capita* in high income countries was $2 000 (WHO, 2001, p. 55). The 2001 Report of the Commission on

Macroeconomics and Health found that in order to provide adequate healthcare, national budget allocations on healthcare should constitute 4% of Gross National Product (quoted in Pal, *et al*, 2004, p. 18).[8]

There are three basic sources for financing health: out of pocket expenses by the user as and when they arise; pre-payment through some form of insurance; or funding by the state through revenue raised. Healthcare is generally financed through a combination of these (McIntyre, 1997, p. 4). Healthcare financing sources can also be categorised according to public, quasi-public and private expenditure (ibid).

Historically in developed countries social security schemes embraced two forms of benefits, namely state funded social assistance and contributory social insurance. Social assistance is funded by the state through taxes, while historically social insurance was paid through joint contributions by a worker and his or her employer to a scheme that is either run by the state, or by a private insurance company operating under state regulation. Any source or combination thereof must be both sufficient to meet all the costs, and sustainable (WHO/EIP, 2004, p. 23). There is still little consensus in international literature as to what constitute effective or sustainable social protection programmes in contexts of high levels of poverty and inequality (Hickey, 2005, p. 8).

It is essential that as far as possible policy makers identify any unanticipated consequences that might occur as a result of healthcare reform. An example of this is the risk that healthcare costs might rise in response to the roll out of social health insurance, which would impact very negatively on the uninsured (Bloom, 2005, p. 6).

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[8] Cf Annexure One for percentages of GDP spent on healthcare in selected countries.

Of the 30 OECD member countries, 15 have social health insurance schemes, 12 largely tax funded systems, and three have mixed systems. Most receive state subsidies of a varying amount. The WHO Secretariat Report (2004) notes: “Little advantage is discernable in one financing system over another in terms of impact on health outcomes, responsiveness to patients, or efficiency” (p. 3). This does not however address the efficiency of the various financing systems in terms of equity.

However the ultimate structure adopted by any country will depend on a combination of issues, including what forms of institutions are already in existence, government leadership and political will, the state of the economy – both in terms of the division between formal and informal structures and the rate of growth of the economy, and the levels of administrative skills that exist (ibid).

User fees

The introduction of user fees as advocated by the World Bank is still a highly contested terrain. While the World Bank posited its position on an assumption that people are both able and willing to pay user fees, overwhelming evidence suggests that user fees can represent an insurmountable obstacle to the poor being able to access healthcare, which raises serious questions about the equity of using user fees as a source to finance healthcare (McIntyre, 1997, p. 10).

One motivation of the Bank for the introduction of user fees was that it would reduce unnecessary use of state funded healthcare. However, a study in Swaziland found that the introduction of user fees affected essential healthcare services, namely immunisation programmes and care for dehydrated children (McIntyre, 1997, p. 13) far more than more than what have been called ‘frivolous’ health interventions (ibid).

The ability of user fees to act as a sustainable and effective source of financing has also been questioned. Actuarial predictions of recovery levels often fail to take into account the fact that

many people will stop accessing healthcare if they cannot afford the out of pocket user charges (McIntyre, 1997, p. 11), which leads to a decrease in the opportunities to collect user charges and thus a decrease in the total amount recovered. Furthermore there is evidence that the introduction of user fees for primary healthcare can lead to an increase in hospitalisation rates (McIntyre, 1997, p. 17) which has attendant implications of higher costs to the state and to the patient (both direct and indirect costs). A WHO/EIP paper notes that user fees or 'co-payments' are not generally considered to be a 'generator of resources' for healthcare financing, at least as far as social health insurance financing is concerned (WHO/EIP, 2004, p. 28).

The WHO Commission on Macroeconomics and Health reported that user fees have been shown from experience to act as an obstacle to health services for the poor, while through user fees providers have only been able to recover a tiny fraction of the actual cost of providing the healthcare (WHO, 2001, p. 61).

Many systems that charge user fees do have established processes for granting exemptions to poor people. The efficacy of exemption schemes are however often undermined by high administrative costs, the resultant stigmatisation of the poor, and the fact that the poorest are often excluded either through a lack of information and knowledge, or as a result of an inability to afford and negotiate the administrative process that precedes each exemption application (McIntyre, 1997, p. 19).

In Thailand, a residual universal health service exists for those not covered by social insurance. This is known as the '30 baht' system (US$0.70), which refers to the cost of the user charge. An exemption scheme exists for those who cannot afford the 30 baht fee. Of the 46.5 million people registered under the 30 baht system in Thailand, over half qualify for an exemption (Technical Note, p. 3). The collection of the 30 baht payments contributes only 2.4% of the total healthcare revenue (Technical Note, p. 10). For policy makers, the amount that can be potentially recovered must be weighed up against the administrative costs associated with administering the fee

collection system as well as the impact that user fees will have on the accessibility of healthcare to the poor.

Evidence exists that those who are eligible in Thailand for exemption from the 30 baht payment use the health systems more than those who have to pay. This could either be an example of “moral hazard” as cautioned by the World Bank, or it could suggest that those who are not eligible for the exemption are not able to afford regular access to healthcare due to the user fee. Education drives, effective primary healthcare and an effective referral system could address the former possible answer; if the cause is the latter then policy makers need to decide whether the priority of their policies should be to make healthcare available to all who need it, or whether their priority is to cap expenditure on healthcare below a certain limit.

There are three main approaches to extending social security to workers both in the formal and informal economies. These are through the extension of tax funded social assistance, whether universal or residual; extending membership of and expanding eligibility for, formal social insurance schemes, and developing smaller decentralised mutual health organisations which are generally funded mainly if not exclusively by the member. The most pro-poor of these options is the first, however this may not be feasible in the short to medium term for many countries. After considering the main characteristics of each of these we shall consider the comparative advantages of each approach.

2.1 Social assistance

Social assistance provision is fully funded from state revenue, and is usually available in kind, through the provision of free healthcare services. Funding can either be sourced from income tax or indirect taxes. Income taxes are generally structured in a more progressive way than indirect taxes which tend to be set at a flat rate for all, which proportionally tax the poor more (McIntyre, 1997, p. 6). ‘Sin’ taxes on alcohol and tobacco are sometimes specifically used to finance

healthcare, both to raise extra revenue (McIntyre, 1997, p. 8) and to discourage the use of these substances, and so curtail illnesses that arise from such use (Technical Note, 2004, p. 16). Generally, the only indirect taxes that are progressive are taxes on luxury goods (McIntyre, 1997 p. 9). Indirect taxes are however usually easier to collect in developing countries that have a large informal economy than income tax, given that much of the business in the informal economy is beyond the regulation and reach of the state.

Social assistance schemes can either provide universal access, or targeted residual universal provision.[9] Examples of countries that provide the former are Cuba (van Ginneken, 2003, p. 26) and the United Kingdom[10] (Bangkok, 2004, p. 47). Targeted residual universal social assistance (usually through means tests) is available in a number of countries for those who are unable to afford any insurance schemes, such as the 30 baht system in Thailand (Bangkok, 2004, p. 21). Costa Rica, Tunisia and Japan also provide in kind healthcare for those outside of any other system.

In order to ensure access to healthcare for the poor and vulnerable informal workers, it is imperative that countries apply themselves to the provision of social assistance to the very poor and those who are not able to pay for user fees and other charges that may be levied.

A study is currently being undertaken by the ILO International Financial and Actuarial Service Social Protection Sector. This study has set out to investigate the total cost implications of providing universal social protection, including old age pensions, disability pensions, child

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9 Means testing can act as an obstacle to assistance for those most in need for a number of reasons, including the accompanying social stigma, the failure of awareness about people's eligibility, inability of people to comply with application procedures and the possibility for corruption that accompanies the often wide discretion that is an institutional part of assessment of eligibility. It can also have perverse consequences, such as discouraging savings among the poor (ILO, p. 66).

10 It is anticipated that the cost of providing universal access to free healthcare will cost the equivalent of 9.4% of GDP in 2007/08 in the United Kingdom (Bangkok, p. 47).

benefits and universal healthcare in Burkina Faso, Cameroon, Ethiopia, Senegal, Guinea, Kenya and Tanzania. It considers this against each country's current GDP and total government expenditure, and then considers the shortfall in financing which could be covered by donors.

The initial findings of the team are that a basic level of social protection could be affordable within a reasonable time frame in the selected countries, initially drawing on donor assistance which would decline as countries progressively increased their expenditure on social protection, optimally to one third of total government expenditure (Pal, *et al*, 2004, p. 18).

2.2 Formal social insurance schemes

Formal social insurance schemes provide for access to healthcare for the majority of formal economy workers. The schemes are generally regulated by the state, and are funded by joint contributions from workers and their employers. Schemes can are either be privately or publicly operated, and can be for-profit or not-for-profit.

Health insurance can be either compulsory or voluntary. The former is usually known as social health insurance, while the latter is often used by people to supplement more basic state provision of healthcare (WHO/EIP, 2004, p. 2). Compulsory schemes avoid the dangers of adverse selection, but then face the challenge of affordability of membership to the poor and vulnerable workers (WHO/EIP, 2004, p. 33). In a number of instances however, social health insurance has been used as the vehicle for gradual expansion of universal coverage of healthcare financing (WHO/EIP, 2004, p. 2).

The selected choice of financing options will shape the type of care that is provided, and hence, the ultimate costs to the state and society. Research has shown that social health insurance promotes a doctor-centred, curative health system as opposed to more preventative, primary healthcare interventions (McIntyre, 1997, p. 42).

Social insurance schemes can either be general in coverage, or be designed for specific types or sectors of workers. Many countries have a designated scheme for public sector workers. Germany has designed a special scheme under the formal social security system that provides health insurance specifically for agricultural sector workers on the motivation that their needs and conditions require a different approach to scheme design than other formal economy wage earners (Bangkok, 2004, p. 48).

Many formal insurance schemes do not allow for membership by self employed people. In addition, the unaffordability of contributions for poor and informal workers presents a further obstacle to the accessibility of formal social insurance schemes.

In Taiwan, the state pays the full contribution for low income workers (van Ginneken, 2003, p. 118). In Costa Rica, the state subsidises the contributions of self employed workers, thus while membership of the insurance scheme is voluntary, many workers in the informal economy belong to it on order to benefit from the subsidy (van Ginneken, 2003, p. 20). A compulsory insurance scheme were launched by the state in Senegal in response to informal economy trades and crafts workers. This is supported by the state social security system, and workers do not have to contribute an amount equal to the standard employer's contribution (Fall, 2002, p. 9). In Brazil, contributions for farm workers' social health insurance is covered by the proceeds of a specially introduced tax on specific agricultural products (McIntyre, 1997, p. 44).

The Mutual Society for Health Care in the Informal Sector (UMASIDA) is a participatory scheme in Tanzania for five informal economy groups based in Dar Es Salaam. This is funded jointly by the participants and by public financing. The state also provides technical support for the management and administration of the scheme (Sabates-Wheeler and Kabeer, 2003, p. 46).

Should the extension of social insurance coverage to currently excluded citizens be considered a useful strategy, it is clear from the lessons of many developing countries that the most feasible approach is to extend social insurance gradually through compulsory coverage limited to various criteria, starting where sectors are most organised and the extension is easier to administer (van Ginneken, 2003, p. 16). For instance, Thailand identified the largest sector within the informal economy, the agricultural workers, and extended membership to them as a first stage of the extension.

In many countries, social health insurance schemes developed from small autonomous mutual help funds which were then coordinated under government regulation (WHO/EIP, 2004, p. 11).

Conditions for effective expansion, such as was achieved by South Korea and Taiwan, include:

- a highly urbanised population
- relatively high level of income among the population
- a largely waged formal economy with a relatively small informal economy
- high economic growth levels for the country
- the state of healthcare institutions themselves needs to be high in order to ensure the beneficial effect of coverage (van Ginneken, 2003, p. 19).

To these can be added:

- solidarity among citizens
- government stewardship/leadership (WHO/EIP, 2004, p. 11).

The practical implementation of the roll out of social health insurance in South Korea took place over twelve years (although there was a far greater lag from the initial adoption of policy proposals which explains the figure of 12 years below). Cover was first extended to formal economy workers, and then to the self-employed through the establishment of a number of small schemes (Kwon, 2002, p. 7). Given the booming economy, the state was able to subsidise the contributions of the self employed. The farmers, for instance, protested about the level of the

contributions they were being required to make, and the state agreed to increase their contribution from one third to one half of premiums, and yet high co-payments still act as an obstacle for the poor (McIntyre, 1997, p. 39). In 1998 the funds from the schemes for the formal informal economy workers was merged with the 227 funds that had been developed during the extension of protection to the informal economy workers (van Ginneken, 2003, p. 17). The main reason for the merger of the funds was to spread risk and to enable members to benefit from economies of scale (Kwon, 2002, p. 17).

In a study done by WHO and EIP of eight countries that have rolled out universal social health insurance, namely Korea, Costa Rica, Japan, Belgium, Germany, Austria, Luxembourg and Israel, the average time taken for the attainment of universal cover was 70 years, ranging from 26 years for Korea to 127 years for Germany (WHO/EIP, 2004, p. 4).

In South Korea however, the benefits of the compulsory social insurance scheme are so low that the majority of the cost of medical care is still paid directly by the member through out of pocket expenses. In 1997, South Koreans had to cover 40% of inpatient costs and 61% of out-patient costs as out of pocket payments (Bangkok, 2004, p. 55). This clearly undermines the aim of healthcare provision in cushioning the financial effects of medical treatment. Membership of the state health insurance is however compulsory, and so members have to pay their contributions and cannot opt out of the scheme, or seek a competitor.

For developing countries with lower levels of revenue than South Korea or Taiwan, and a larger informal economy, to develop a system of compulsory social health insurance that accommodates workers in the informal economy poses many challenges. Wealthier self-employed members will be able to contribute, but the poor will continue to be uncovered, which will generally see the development of a two-tier health system. Given the length of time of the average roll out of universal social health insurance schemes to date, the question is also how the poor should access healthcare if the social health insurance system is adopted by a

government. One response of poor people to unaffordable social health insurance schemes has been the development of various types of mutual health organisations, which are explored in the following section.

2.3 Mutual Health Organisations

Mutual health organisations (MHOs) typically arose in communities in response to inaccessible healthcare through public and market failure (van Ginneken, 2003, p. 26). The emergence of MHOs represents the growth and development of civil society in developing countries in the 1990s in which people at grass roots level began to forge their own solutions in response to a growing disillusionment in state institutions (Atim, 1998, p. 2. Bloom, 2005, p. 11).

The term 'mutual health organisation' is usually used interchangeably to refer to any one of a number of different vehicles for providing health insurance cover, including micro-insurance, co-operatives and 3rd party schemes.[11]

MHOs usually grow organically out of existing social networks in communities, such as burial or savings societies (Atim, 1998, p. 4), or work-specific guild formations, trade unions and worker cooperatives. There are also instances in Tanzania and the Democratic Republic of Congo in which healthcare providers themselves have established MHOs to guarantee a dependable revenue base through ensuring affordable care (van Ginneken, 2003, p. 27. Atim, 1998, p. 4). In Lalitpur, Nepal, United Missions Nepal through their Community Health and Development Project, a health provider, set up an insurance scheme in consultation with local communities in order to ensure good quality healthcare. This occurred in response to the reduction in the quality of care

[11] The term 'micro-insurance' refers to the ability of a scheme to operate with small amounts of money, rather than to the size of the scheme and its membership (Reynaud, 2002, p. 8).

and absence of medicines arising from the national government's decision to privatise healthcare and reduce state funding to healthcare provisioning (Lalitpur, 2002, p. 5).

In determining the efficiency of MHOs, weaknesses that emerge generally concern financial viability, staff capacity and the dearth of information kept about members and the community which affect the ability of the scheme to predict issues of affordability of contributions and frequency of benefit access (Dror and Preker, 2002, p. 8). Financial viability includes a lack of sound actuarial computation of contribution levels; schemes' covering too small a group of people to benefit from risk-pooling; and the lack of insurance and re-insurance options to spread risks. A fragmented pool size threatens the longer term financial sustainability and the capacity of a scheme to flourish (WHO, 2000, p. 103), especially in the absence of any state subsidisation (Scheil-Adlung, 2004, p. 18). Communities may also be wary of joining a scheme due to suspicions about governance of the scheme and the proper use of resources (Bloom, 2005, p. 11). The usefulness of MHOs in extending access to healthcare to the poorest and most vulnerable is limited by the fact that the very poor are not able to afford to belong (ibid).

One way in which MHOs have been able to support themselves is through the formation of networks. Where MHOs form networks between themselves they generally find greater stability, and are able to contemplate more technical issues such as the potential for re-insurance (van Ginneken, 2003, p. 29). MHOs can also form networks of support with cooperatives and trade unions, private companies and state agencies as was done by the Self Employed Workers Association (SEWA) in India.[12]

An innovative network of mutual health organisations, including micro-insurance schemes, has been set up in west and central Africa. The network is known as the 'Coordination network between actors involved in the development of mutual health organisations in western and central

[12] SEWA is a registered trade union established in 1972 for self employed women in India.

Africa' (IDEASS, 2003, p. 2). It was started in April 1999, arising from a meeting of emerging African benefit organisations held in Abidjan, Cote d'Ivoire, in June 1998, out of which meeting a reference document, the Abidjan Platform, was created which served to record the experiences of all of the participants in their initiatives to extend access to healthcare in their own countries (IDEASS, 2003, p. 4).

The network serves to keep organisations in touch with each other, both through the internet (www.concertation.org), a newsletter, and a monitoring system of the methodology of the development of different mutual organisations to enable the members to reassess their strategies. The network also hosts a bi-ennial forum at which members can compare analyses and strengthen their own methodologies.

The development of linkages between MHOs in different sectors is also able to provide stabilisation for possible fluctuations that might affect specific sectors (Steinwach, 2002, p. 11).

The ILO cautions that given the inherent limitations of MHOs, they should be seen as a way to assist members meet unpredictable out of pocket expenses rather than being seen as a way to achieve comprehensive health insurance (ILO, 2002(a), p. 63). However in many poor countries, it may be inevitable that a form of comprehensive cover begins with the development of a network of community-based MHOs as part of a plan for gradual incorporation into a national scheme. One of the most important inherent limitations in this regard is the low levels of potential co-subsidisation given the small size of the pools of MHOs (WHO Report, 2000, p. 98). At best, MHOs should be seen as a way to complement existing healthcare systems (McIntyre, 1997, p. 31).

While MHOs generally emerge as civil society community-based organisations, in some countries, the state has made efforts to incorporate them into a national plan for healthcare access, whether on an interim basis or for an indefinite period. In the Philippines, the National

Health Economy Reform Agenda provides for the accreditation of alternative community-based MHOs as the first level of healthcare access. Initially this approach was not successful due to a high drop-out rate of members from these schemes, but a subsequent redesign of the system which places a greater reliance on community organisations and cooperatives both to educate people about the system and to collect contributions from members will hopefully address this (Bangkok, 2004, p. 80).

There is little available data in international literature on MHOs' capacity to generate revenue (McIntyre, 1997, p. 30).

Vietnam has committed to providing universal healthcare coverage to everyone by 2010. To address the question of how to extend protection to informal economy workers they have begun to consider how MHOs can be incorporated into the state social insurance system.

The SHINE (Social Health Insurance Networking and Empowerment) project in the Philippines is part of a design that seeks to integrate a number of grassroots MHOs into the public social security through a partnership with the German Technical Cooperation Development Agency (GTZ), the national department of health, and the Philippine Health Insurance Corporation. The Philippines aims eventually to centralise all existing healthcare programmes into one National Health Insurance Scheme (Sabates-Wheeler and Kabeer, 2003, p. 46).

It is clear that poor communities develop MHOs to reduce their exposure to costly unexpected health costs; however it is also apparent that of the three methods of healthcare provisioning set out above, MHOs place the greatest relative financial burden on the poor. In addition, the standard of benefits is usually lower than that available from universal health systems, or from social insurance schemes.

MHOs can however provide the first point of entry for people into organised schemes. Innovative designs from countries such as the Philippines demonstrate how the state can be active in facilitating and enabling the incorporation of these schemes into the national scheme. Contributions for poor people would have to be subsidised by the state, or cross-subsidised by other members as a form of national solidarity.

It is important to consider that many of the social health insurance schemes that offer universal coverage today had roots in similar mutual health organisations at the end of the eighteenth and early nineteenth centuries. This section has highlighted however the factors that supported this development, including the benefits of industrialisation on increasing the number of workers in the formal economy. Currently we are witnessing a global informalisation of the workplace. Analysis of the ability of MHOs to act as building blocks for a national social insurance scheme must take cognisance of this fundamental difference in the structure of the economy and accompanying challenges that this presents.

Table 1: Tabulated comparison of the effectiveness, efficacy and physical feasibility of the above options

Option	Effectiveness	Efficiency	Physical feasibility
1.Social assistance **a. Universal**	• Universal social assistance funded through state revenue is the most effective approach to provision of benefits, and covers all those who require the various services. • There is no social stigma to drawing on the benefits, and no inappropriate targeting or danger of the most vulnerable failing to negotiate complex means testing. • Effectiveness depends on quality of state institutions. • Effective as a tool for social solidarity and redistribution.	• Universal benefits are highly efficient as they require no means testing. The state is able to regulate healthcare providers from a very strong position. • When state funding is reduced, the whole system is threatened, as has been experienced in the UK and Canada. • A danger with the state being sole survivor of healthcare is that lack of competition may allow inefficient delivery to creep in. Must have effective and accountable management. • Revenue from income tax sources can be	• Depends on state revenue and thus whether the economic policies of a country or its tax base are capable of providing enough funding. • Low levels of public spending as a result of structural adjustment programmes in many countries will not accommodate universal social assistance. • Needs to be international pressure for higher levels of spending on health.

		progressive, but indirect taxes generally regressive.	
b. Residual	• Provides targeted assistance to those who fall outside of the reach of contributory insurance. • Targeting, however, often prevents those most in need from accessing benefits, due to social stigma, lack of knowledge about eligibility and often inability of the most vulnerable to negotiate means testing. • Allows for some redistribution and social solidarity, but welfarist, rather than developmental, in design. • Can lead to the development of a two-tier system of benefits.	• Targeting requires administrative capacity and thus increases costs. • Targeting provides opportunity for fraud, corruption and patronage. • Targeting discourages savings and self provisioning among poor people.	• Due to lower financial burden on the state, this represents a feasible option in a number of developing countries. • Requires public finance and state infrastructure, thus where these do not exist, feasibility reduces.
2. Social insurance	• Effective in countries that have high levels of income among workers and a large formal economy. • Has the benefit of being able to develop schemes that cater for specific needs of workers in different sectors. • Is not easily able to accommodate informal economy workers which results in a two-tier benefit system for those who are and those who are not covered. • Effectiveness depends on the package of benefits that can be provided in exchange for the contributions (see South Korea).	• Ability to cross-subsidise members and pool risks important for the stability of the scheme. • Removes burden for provision of benefits from the state and places it on members and their employers. • Can encourage inflated medical costs which negatively impacts in the uninsured.	• Common in high income and developed countries. • Feasibility declines as proportion of workers in the informal economy rises. • In some countries the state subsidises contributions for workers in the informal economy, otherwise not a feasible option for such workers.
3.Mutual health organisations	• Often only accessible scheme for affordable healthcare for many poor people and informal economy workers. • Huge financial burden on each member compared to social insurance contribution burden, as member in MHO usually	• Usually fully member-paid, thus full burden is placed on the poor, with no cross-subsidisation from better off people. • High risks for scheme viability and small risk pool. • MHOs can establish networks that increase their capacity, builds social	• MHOs have emerged in a number of countries where no alternative exists for the poor. • Development of linkages to formal schemes, or networks positive. • Could be seen as preliminary means to ensure all covered under

	carries all costs with no subsidisation by state or 3rd party (e.g. employer). • Medium to long term viability of MHOs often precarious. • Often the benefit package is very basic in order to match low levels of contributions. • Lack of technical and administrative expertise often weakens scheme. • Definite risk of developing inferior access to healthcare due to reduced benefits many MHOs can afford. • Does provide opportunity for organising individual demands (for better standard of healthcare for instance) which provides greater negotiating power.	capacity. • Small and decentralised and thus easier to administer among informal economy. • Transparent governance systems vital to win members' trust.	some scheme to provide affordable access as first step towards social assistance universal benefits.

PART THREE: REVIEW OF CHALLENGES IN ORGANISING SUCCESSFUL MHOS

MHOs are more likely to flourish in countries that have unaffordable user fees for health systems, and where the inaccessible health provider is seen as offering high quality healthcare. MHOs are more likely to be established among communities that have a high level of social cohesion, and also where the scheme has the endorsement of community leaders (McIntyre, 1997, p. 34).

Atim (1998, p. 27) identifies six elements of MHOs that are vital to the success of the scheme.

3.1 Institutional arrangements

This includes the manner of payment by the mutual health organisation to the healthcare provider. Alternative methods include:

- Capitation payment, in which the MHO pays a set amount to a healthcare provider per member per annum.
- Payment of a set fee for each incident by the MHO to the provider on behalf of each member.
- Cash indemnification to members for payments made out of pocket by members.
- Fixed cash subsidy or grant by the MHO to the member on the occasion of a defined incident.
- Service benefits in which the MHO pays the provider directly for expenses incurred by the member.
- Third party subscription – through the payment of a regular subscription to an MHO, the member can benefit from a discount or reduced tariff from the healthcare provider.
- Loan advance to the member for a low interest or an interest free repayment.

3.2 Administrative and management capacity

Close contact is preferable between both the administrators and members, and between the administrators and healthcare providers to ensure optimal trust and efficiency (Fall, 2002, p. 31).

3.2.1 Technical expertise

The establishment and administration of schemes often requires technical expertise. This can be provided either through state support, or through the support of social security agencies, or through donor support (Bangkok, 2004, p. 20). In the Lalitpur scheme in Nepal, a donor, the Community and Development Health Project (CDHP) of the United Mission Nepal, provided all the technical and managerial assistance in setting up the insurance scheme, and over a gradual period handed the management over to a community health committee. Technical assistance is however still provided by the CDHP (Lalitpur, 2002, p. 15).

3.2.2 Setting of contributions

Few MHOs have any system of subsidisation, whether from the state or donors. Given the small size of most such schemes, there is also little scope for benefiting from cross-subsidisation between wealthier and/or healthier members and people who cannot afford to pay high premiums. In addition, many schemes suffer from the absence of actuarial involvement in determining the necessary level of premiums that will ensure the viability and sustainability of the scheme. Tension always exists between setting premiums that are affordable to the members, and ensuring that the level of contribution will ensure the sustainability of the scheme and ensure adequate benefits (Fall, 2002, p. iv).

Optimally from a pro-poor perspective in order to ensure cross subsidisation between members, contributions should be paid on a sliding scale, but few organisations have the capacity to determine or enforce this (Bangkok, 2004, p. 8). A number of schemes for people in the informal economy set flat rates for members, whether across the board, or by a range of rates that are determined according to sector, in which case they can be based on an average income in a sector, the size of a business, or a means or asset based test. Although flat rates are agreed to

be regressive, the benefit in efficient administration can be considerable (Atim, 1998, p. 31. Chaabane, 2002, p. 17. McIntyre, 1997, p. 32).

In Tunisia, contributions vary in value from sector to sector and what the average worker can afford (Chaabane, 2002, p. 8). In Costa Rica, if a worker earns below the minimum wage, the state will contribute to the worker's contributions to the extent of the shortfall (Van Ginneken, 2003, p. 20).

While there is keen awareness that a flat rate contribution will have regressive implications for poor informal workers, its expediency from an administrative perspective has meant that a flat rate contribution is used by various schemes. Ways of mitigating the regressive impact for workers include the use of sectoral determinations or minimum wages. These rates will be above what many workers in the informal economy actually earn. To address the negative consequences of this for workers who earn below the minimum wage, solutions can be developed, such as the initiative in Costa Rica in which the state contributes the difference for such workers.

3.2.3 Collection of contributions

3.2.3.1 Regularity of payment

Due to the often cyclical and irregular income of most workers in the informal economy (Fall, 2002, p. iv), the regularity of payments has a direct bearing on the ability of many informal economy workers to belong to a scheme or organistion, specifically seasonal workers and self employed farmers and fishermen (Chaabane, 2002, p. 11. Steinwach, 2002, p. 12). Innovative scheme design can be used to provide that members can contribute on a daily, monthly or annual basis (Sabates-Wheeler and Kabeer, 2003, p. 20).

Contribution arrears threaten the viability of organisations. In the study undertaken by Atim (1998, p. 44) of 30 MHOs, 79% had outstanding contributions.

3.2.3.2 Collection of contributions in the informal economy

Collection of contributions in the informal economy can be done in a number of ways. This can include direct payment by members, or indirect collection through community organisations or trade unions on behalf of the MHO, as happens successfully in Costa Rica (Van Ginneken, 2003, p. 21).

3.2.4 Reinsurance

The question of reinsurance has relevance with regard to the financial viability of a scheme. An epidemic in a small community has the potential to wipe out a local scheme if there is no recourse to reinsurance. Reinsurance can enlarge the risk pool across larger population groups (Dror and Preker, 2002 p. 3). Dror and Preker (ibid) set out a number of ways to reinsure, including having recourse to state reinsurance, or the regulation of private insurance schemes to reinsure smaller schemes.

3.2.5 Compulsory or voluntary nature of scheme?

An ILO study in Thailand (Bangkok, 2004, p. 6) recommended that membership of a scheme operating within a sector or community should be compulsory for three reasons, namely:

- **Missing the target**. Those most in need of healthcare protection will often not voluntarily join a scheme.
- **Adverse selection**. Where schemes are voluntary, people most likely to need access to healthcare will be more likely to join. The effect of this is that more claims will be made to the scheme, reducing the benefits inherent in cross-subsidisation.
- **Long term planning**. If a scheme is compulsory it is far easier to be able to predict membership numbers over the long term. However if the state introduces compulsory membership of a scheme, it will have to consider subsidising contributions for informal economy workers.

  However it is acknowledged that compulsory coverage to workers in the informal economy is difficult to enforce, given the largely unregulated nature of the economy.

3.3 Financial performance indicators

Rigorous actuarial calculations and assessment at the inception of the scheme of whether in the long term there will be sufficient resources required to continue with the scheme is essential for its success (Chaabane, 2002, p. 23). This should take into account whether or not the state is prepared to contribute to the costs of the scheme (Scheil-Adlung, 2004, p. 10).

The state can play an important role in providing regular monitoring and evaluation of the financial health of a scheme, as well as establishing clear regulations to vouchsafe members' investments within a scheme (Bangkok, 2004, p. 20).

3.4 Package of benefits for MHOs

Most MHOs provide cover for unexpected large risks which entail expensive hospitalisation (Atim, 1998, p. 22. Fall, 2002, p. iv). The effect of this is that members still have to pay out of pocket for smaller healthcare needs. The actual benefits are determined within the scheme, and will cater to the specific needs of the group; so, for instance, a scheme that emerged from a women's organisation will be more likely to include a bias towards the costs of childbirth and young children.

The question of benefits is clearly linked to the level of contributions paid, however it is important for the member to be able to see a clear benefit from belonging to the scheme.

It has been recommended that MHOs that provide for poor workers should consider reducing the package of benefits in order to ensure that the contributions are more affordable to members (Bangkok, 2004, p. 10). This may have the effect of discouraging poor workers from contributing to a system if they do not believe that the benefits they receive will be adequate for their needs (ILO, 2002(a) p. 57).

In Nepal, the micro-insurance scheme linked to the health provider provides primary healthcare and a number of specific services (such as gynae-obstretrics) as part of the benefit. Should members need to be referred to a hospital, the member has to pay for the hospitalisation costs, however the member is given a discount to these fees as a result of this membership.

It would be useful for MHOs to consider including ways of addressing direct as well as indirect health costs, including transport costs to health providers (Scheil-Adlung, 2004, p. 9).

3.5 Risk management

The following potential hazards should be borne in mind when assessing or establishing any MHO (Atim, 1998, p. 22):

- Moral hazard, where people tend to use the healthcare system more than is necessary because it is affordable.
- Adverse selection, in which those with ill health elect to join a scheme more readily than healthy people, which affects the viability of risk-pooling.
- Cost escalation of healthcare provisioning as a result of inflation.
- Systems for preventing fraud and abuse.

Risk management can be contained through the design of the benefits package, including co-payment; deductibles; mandatory referral from a primary healthcare institution; family coverage; compulsory membership to a scheme of all members of a particular group or community; initial waiting periods; and introducing a ceiling on benefits (Atim, 1998, p. 22).

3.6 Governance

It is clear that good governance, including transparent systems and accountability is required for the successful development of healthcare organisations. The most successful schemes have

been those in which the community or members are represented at governance level, and who are required to report frequently to the members. If participation around decision making is mandatory for all members, there is greater potential for the development of trust, which will in turn lead to greater chance for the sustainability of a scheme (van Ginneken, 2003, p. 28). An increase in the size of a scheme will usually mean that decision making becomes more centralised, and this can lead to an increase in suspicion of members towards governance of the scheme.

PART FOUR: THE ROLE OF TRADE UNIONS IN EXTENDING ACCESS TO HEALTHCARE TO WORKERS IN THE INFORMAL ECONOMY

Trade unions have always played a progressive role in improving the livelihoods of workers and the broader working class. The labour movement played a significant role in bringing pressure to bear on employers and governments to adopt worker benefits in the formal sector. Trade unions provide an organised front within civil society that is more able to challenge hegemonic state power around the extension of progressive reforms for vulnerable workers.

The literature suggests three main ways in which trade unions are effective in the extension of healthcare to vulnerable workers, namely through organising vulnerable workers to form a stronger pressure group, by politically advocating for an extension of health benefits, and in providing healthcare at union clinics, or providing health insurance to union members.

Organised workers are able to negotiate from a far stronger position with employers and the state (Kanhere). Workers in the informal economy who have been able to organise themselves, whether into formal trade unions or other networks, have been found to be far better able to access social protection whether from the state or private providers or community based schemes, are in general more knowledgeable about state assistance programmes, are less invisible and thus are more able to influence legislation and policies (Kanhere). Access to information is crucial for people to be able to benefit from programmes (Bloom, 2005, p. 9), and thus this is a vital role for unions to play.

Trade unions are critical leaders in any move by civil society to increase social protection due to the political strength that they have as a result of their ability to organise workers. It is the lack of organisation of many civil society bodies and individual workers in the informal economy that fundamentally weakens the strength of their demands to government (Hickey, 2005, p. 26).

Trade unions can also negotiate non-hazardous and hygienic working conditions for both organised and informal workers.

The General Federation of Nepalese Trade Unions (GEFONT) started a health cooperative clinic in 2000 as a result of the inaffordability of healthcare for most of their worker members in conjunction with an NGO called the Public Health Concerned Trust (PHECT – Nepal). The clinic offers cheaper medical attention, and while it is available to all vulnerable people, cooperative members receive assistance for even lower costs (www.gefont.org).

In India, SEWA has negotiated a tripartite scheme to provide health insurance for its members. This scheme is financed through contributions to which the member pays one third, a third of the contribution is funded from the interest from a grant made by GTZ, and the state pays the remaining third through subsidies to the two insurance companies through which the state social insurance systems are managed (Sabates-Wheeler and Kabeer, 2003, p. 42). SEWA's health insurance scheme further benefits from being able to have access to the management system of the state social security schemes.

In addition, trade unions in a number of countries such as Costa Rica and Indonesia have been instrumental in publicising the availability of health provision schemes, and in liaising between the schemes and workers. They can also play a role in collection of contributions and the distribution of benefits.

In Senegal, the role of trade unions in designing the health provisions, as well as the subsequent role of the National Union of Trade Chambers in disseminating information about the scheme and encouraging voluntary membership thereof is hailed as being one of the reasons for its success (Fall, 2002, p. 10).

Trade unions can also play a role in the prevention of illness through educational campaigns on sanitation, nutrition and basic healthcare knowledge.

It is clear that the extent of the role of trade unions in extending benefits to informal economy workers depends on their conception of their role in organising these workers. The challenge of extending healthcare benefits to informal economy workers may provide an organising platform for trade unions to begin to organise informal economy workers.

CONCLUSION

The literature reviewed has revealed the very high numbers of vulnerable workers in developing countries who do not have access to affordable healthcare, as well as the devastating impact that both direct and indirect healthcare costs can have on households.

Challenges in championing a roll out of social protection to the poor include both questions of affordability and political will.

The ILO study on six developing countries is innovative in that it seeks to find ways that comprehensive basic social protection can be made to be affordable, rather than assuming that it is not feasible for developing countries.

Questions of political will are influenced by where a government believes the burden of paying for social protection should fall, as well as whether governments see social protection as constituting a safety net, or a rope for people to help themselves out of poverty. The role of the state as provider, regulator or enabler for social protection is also deeply contested.

Internationally there has been a definite shift in mainstream thinking about social protection, towards a more developmental approach. Global campaigns around poverty, including the Millennium Development Goals provide ways to challenge both local and international thinking around social protection.

Trade unions in developing countries have become involved in extending healthcare coverage in a number of different ways. Trade unions in many developing countries are the most significant voice among the poor and vulnerable as a result of their ability to organise poor workers; the challenge is to see this power focused on progressive extension of benefits to people who have not traditionally been trade union members, namely informal workers.

ABBREVIATIONS

GDP	Gross Domestic Product
GTZ	German Technical Cooperation Development Agency
GEFONT	General Federation of Nepalese Trade Unions
ILO	International Labour Organisation
MHO	Mutual health organization
NGO	Non-Government Organisation
OECD	Organisation for Economic Cooperation and Development
PHECT	Public Health Concerned Trust
SEWA	Self Employed Women's Association
SHINE	Social Health Insurance Networking and Empowerment
WDR	World Development Report
WHO	World Health Organisation

GLOSSARY

Casualisation	The process by which traditionally secure formal structures and ways of relating (e.g. relationships of employment) are broken down and replaced by less secure, *ad-hoc* single instances of exchange.
Curative healthcare	Healthcare aimed at curing existing ailments.
Cross-subsidisation	Financing a function with funds from another source.
Decentralised	Distribution of functions such as healthcare from a central authority to regional and local divisions.
Diminution	Decrease in size.
Economic citizen	Generally refers to someone who is integrated into the formal economy in a productive way.
Formal economy	An economy that is regulated and protected by formal state and legal processes.
GDP	Gross Domestic Product
Globalisation	Integration into a global community. Usually refers to the integration of domestic economies beyond national borders.
Industrialisation	Development of industrial capabilities.
Informal economy	An economy that exists beyond the recognition, protection and regulation of formal state and legal processes. (see *casualisation*).
Marginalisation	To relegate to a position of less significance within a group.
Means test	An eligibility test based on a person's income and or assets usually used to determine access to free or subsidised state benefits or programmes.
Micro-lender	A person or institution that lends money for interest. Both the loan amounts and repayments usually represent very small amounts relative to mainstream lending.
National resources	Resources, such as agriculture, fishing and human skills, which are available to a country.
Neo-liberal	A political outlook that seeks to contain the role of the state beyond that of regulator.
Participatory scheme	A scheme which allows individual participation in the management process.
Per capita	Per person
Preventative healthcare	Healthcare directed at preventing illnesses before they are contracted.
Progressive transformation	Incremental change. When applied to the extension of state programmes, it usually refers to an incremental extension within existing resources.
Social security	Programmes and delivery systems that provide for people's needs in a number of set situations, such as old age and healthcare. Historically made up of social insurance and social assistance, representing contributory and non-contributory, state-funded assistance respectively.
Social solidarity	Cohesion within a group.
Stigmatisation	To be described or identified in a contemptuous manner.
Survivalist	Behaviour which has survival as its primary objective, which is often seen as having short term imperatives.
Tripartite	Involving three parties. Often used to refer to the state, organised labour and business.
Urbanisation	To develop urban (city) characteristics. It also refers to the migration of people from rural areas to urban areas.
Welfarist	Policies, attitudes, and beliefs associated with a welfare state.

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ANNEXURE ONE

Selected National Health Account Indicators: measured levels of expenditure on Health, 1997 to 2001.[13]

The World Health Report 2004

Table 2: Total expenditure on health as percentage of GDP

Country	1997	1998	1999	2000	2001
Angola	3.9	3.5	3.3	3.5	4.4
Argentina	8.1	8.2	9	8.9	9.5
Benin	3.7	3.8	3.9	4.2	4.4
Botswana	5.7	5.5	6	6	6.6
Brazil	7.4	7.4	7.8	7.6	7.6
Burkina Faso	3.5	3.5	3.8	3.5	3
China	4.6	4.8	5.1	5.3	5.5
Costa Rica	6.7	6.7	6.5	6.9	7.2
Cuba	6.6	6.6	7.1	7.1	7.2
Democratic People's Republic of Korea	2.2	2.8	2..6	2.4	2.5
Dominican Republic	5.8	5.8	5.7	6.2	6.1
Ethiopia	3.4	3.6	3.5	3.2	3.6
Ghana	4.1	4.3	4.2	4.3	4.7
Malawi	8.7	8.5	8.7	8.2	7.8
Malaysia	2.8	3	3.1	3.3	3.8
South Africa	9	8.7	8.8	8.7	8.6
Thailand	3.7	3.9	3.7	3.6	3.7
Uganda	3.7	4	4.1	5.6	5.9
United Kingdom	6.8	6.9	7.2	7.3	7.6
Zambia	6	6	5.7	5.5	5.7

Table 3: General government expenditure on health as percentage of total expenditure on health

Country	1997	1998	1999	2000	2001
Angola	45.2	39.8	44.3	55.8	63.1
Argentina	55.5	55.2	56.2	55.2	53.4
Benin	34	36.5	38.6	43.3	46.9
Botswana	58.8	59.7	60.6	62	66.2
Brazil	43.5	44	42.8	40.8	41.6
Burkina Faso	67.1	65.3	66.6	63.5	60.1
China	40	39	38	36.6	37.2
Costa Rica	70.7	67.6	68.5	68.5	68.5
Cuba	83.7	84.7	85.5	85.8	86.2

[13] Countries selected from report by author to illustrate developing countries in all continents.

Democratic People's Republic of Korea	71.4	76.9	75.3	73.5	73.4
Dominican Republic	32	31.4	32.2	35.4	36.1
Ethiopia	37.9	39.3	37.7	34.5	40.5
Ghana	47.6	53.8	53.9	55.9	59.6
Malawi	35.6	35.5	37.8	36.9	35
Malaysia	53.5	51.6	52.9	53.1	53.7
South Africa	46.1	42.4	42.6	41.8	41.4
Thailand	57.2	61.2	57.6	56.8	57.1
Uganda	29.1	38	40.9	56.1	57.5
United Kingdom	80.1	80.2	80.5	80.9	82.2
Zambia	55.1	56.9	54.8	52.5	53.1

Table 4: Government expenditure on health as percentage of total government expenditure

Country	1997	1998	1999	2000	2001
Angola	4.6	2.5	2.4	3.3	5.5
Argentina	22.8	22.6	23.3	22	21.3
Benin	6.7	8.5	8.7	8.9	10.9
Botswana	7.8	7.2	7.4	8.4	7.6
Brazil	9.1	9	9.3	8.4	8.8
Burkina Faso	9.6	9.6	8.8	8.1	8.1
China	14.2	13.3	11.8	10.8	10.2
Costa Rica	20.8	20.5	20.1	20.4	19.5
Cuba	10	10.3	11.1	10.8	11.4
Democratic People's Republic of Korea	3.5	3.3	3.2	2.9	3
Dominican Republic	12.2	11.8	11.3	14.6	13.5
Ethiopia	5.8	5.9	4.3	3.2	4.9
Ghana	9.4	9	9.2	8.1	8.6
Malawi	12.2	12.9	13.9	12.2	12.3
Malaysia	6.1	5.1	6	6.1	6.5
South Africa	12.4	11.3	11.1	11.2	10.9
Thailand	10.2	13.3	11.6	11.6	11.6
Uganda	6.5	8.1	8.4	16.4	16.4
United Kingdom	13.4	13.9	14.8	15	15.4
Zambia	13.1	12.5	13.7	13.6	13.5

Table 5: External resources for health as percentage of total expenditure on health

Country	1997	1998	1999	2000	2001
Angola	9.4	5.6	8.7	14.3	14.2
Argentina	0.3	0.3	0.3	0.3	0.3
Benin	20.9	20.1	20.4	21.3	21.5
Botswana	1.8	1.4	1.4	1.3	0.4
Brazil	0.2	0.3	0.5	0.5	0.5
Burkina Faso	32.5	24.7	26.4	23.9	25.6
China	0.3	0.2	0.3	0.2	0.2
Costa Rica	1.7	1.7	1.6	1.3	1.3
Cuba	0.1	0.1	0..2	0.2	0.2
Democratic People's	n/a	0.2	0.2	0.3	0.3

Republic of Korea					
Dominican Republic	1.5	3.2	3.2	2.5	1.8
Ethiopia	9.3	23.5	27.6	29.6	34.3
Ghana	6.8	8.2	8.6	13.2	23.2
Malawi	22.8	20.4	22.9	32.3	26.5
Malaysia	0.9	1.1	1	0.8	0
South Africa	0.2	0.2	0.1	0.4	0.4
Thailand	0.3	0.4	0.5	0.5	0.1
Uganda	24.4	41.7	22.9	41.2	24.8
United Kingdom	0	0	0	0	0
Zambia	23.5	26.1	40.1	33.5	48.7

Table 6: Out of pocket expenditure as percentage of private expenditure on health

Country	1997	1998	1999	2000	2001
Angola	100	100	100	100	100
Argentina	63.2	63.8	64	63.3	62.4
Benin	100	100	100	100	100
Botswana	26.3	28.8	30.3	30.8	35.3
Brazil	66.9	66.9	67.1	64.9	64.1
Burkina Faso	99.6	97.3	97.4	97.4	97.4
China	94.2	94	94.9	95.2	95.4
Costa Rica	90.1	91.5	91.6	91.8	92.1
Cuba	72.8	78.5	76	75.6	76.8
Democratic People's Republic of Korea	100	100	100	100	100
Dominican Republic	88.6	88.4	88.4	88.4	88.4
Ethiopia	86.2	85.7	85.4	84.6	84.7
Ghana	100	100	100	100	100
Malawi	40..3	40.4	41.3	39.7	43.7
Malaysia	100	94..2	93.9	93.4	92.8
South Africa	19.7	21.9	21.7	21.8	22.1
Thailand	86.2	84.9	84.9	85	85
Uganda	54	54	55.4	55.6	53.4
United Kingdom	53.5	55.1	54.7	55	55.3
Zambia	70.9	74.1	70.7	71.1	71.8

Table 7: Private pre-paid plans as percentage of private expenditure on health

Country	1997	1998	1999	2000	2001
Angola	0	0	0	0	0
Argentina	33.4	32	31.9	32.6	31.1
Benin	n/a	n/a	n/a	n/a	n/a
Botswana	24.1	23.8	22.7	20.8	20.5
Brazil	33.1	33.1	32.9	35.1	35.9
Burkina Faso	n/a	n/a	n/a	n/a	n/a
China	0.4	0.6	0.4	0.4	0.4
Costa Rica	2.1	1.8	1.6	1.6	1.5
Cuba	0	0	0	0	0
Democratic People's Republic of Korea	0	0	0	0	0
Dominican Republic	0.1	0.4	0.4	0.4	0.4

Ethiopia	0	0	0	0	0
Ghana	0	0	0	0	0
Malawi	1.4	1.8	1.5	1.7	1.6
Malaysia	n/a	5.8	6.1	6.6	7.2
South Africa	78.3	76.4	76.7	76.6	72.2
Thailand	8.6	9.6	9.6	9.6	9.6
Uganda	0.5	0.5	0.5	0.5	0.5
United Kingdom	17	17.2	16.7	16.7	17.2
Zambia	0	0	0	0	0