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Strengthening Social Security Systems in Rural Areas of Developing Countries

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Abstract

It is now generally accepted that the approach of enlarging state-based social security systems in developing countries in order to achieve universal coverage has failed. It is the poor and rural population in particular who are largely excluded from any kind of social insurance. This paper reviews the literature to identify the major reasons for state and market failure, describes the existing systems and their institutional strengths and weaknesses and analyses the possibilities for a public-private partnership. To this end, the paper identifies four main providers of social security, namely the state, the market, member-based organisations, and the private households.

Whereas the reasons for state failure – inadequate and inefficient programmes to deal with the socio-economic realities – and market failure - information problems and high transaction costs - have been analysed in great detail, there is controversy over how adequately member and private household-based systems can protect members against basic risks such as illness, disability, accidents and death. Several empirical studies in rural areas have shown the limits of traditional insurance arrangements, which basically provide insufficient coverage against co-variate risks while entailing high costs in terms of pursuing less risky activities. Moreover, these systems are under heavy pressure from change in the socio-economic environment, such as market penetration and population growth. Given this situation, the paper explores the possibilities of a public-private partnership that are created by exploiting local information, on the one hand, while enhancing the possibilities of risk pooling, reinsurance and better access to risk capital, on the other. However, a successful partnership depends on several factors. The ones identified and discussed here are the willingness of the state to withdraw from certain activities and the political and economic environment required for wider private engagement in general.

The paper concludes by introducing a preliminary agenda for policy action and research. The literature survey has shown that a lot of questions about the appropriate institutional design of social security systems in rural areas remain unanswered. More research is needed to identify the population's actual needs and its demand for insurance in a specific socio-economic context and agro-ecological zone, to analyse the economic and social impact of innovative insurance schemes recently evolving in many countries, to identify conditions for a successful private-public partnership for social security provision and finally, to find appropriate ways of translating the findings into adequate policy measures.

Kurzfassung

Es wird heute allgemein davon ausgegangen, daß die Übertragung des Modells sozialer Sicherung auf Entwicklungsländer mit dem Ziel einer vollständigen Integration der Bevölkerung in das staatliche System sozialer Sicherung gescheitert ist. Insbesondere die arme und ländliche Bevölkerung ist von einer Sozialversicherung nahezu ausgeschlossen. Basierend auf einem Literaturüberblick erörtert dieses Diskussionspapier die Gründe für das Versagen von Staat und Markt, beschreibt bestehende Systeme sozialer Sicherung mit ihren institutionellen Stärken und Schwächen und analysiert die Möglichkeit einer *public-private partnership*. Dazu werden vier Anbieter von sozialer Sicherung identifiziert: der Staat, der Markt, auf Mitgliedschaft basierende Organisationen und die privaten Haushalte.

Während die Gründe für das Staatsversagen – ungeeignete und ineffiziente Programme angesichts der sozio-ökonomischen Realitäten der Länder – und Marktversagen – Informationsprobleme und hohe Transaktionskosten – in vielfältiger Weise analysiert wurden, gibt es eine Kontroverse darüber, inwieweit auf Mitgliedschaft basierende Organisationen und auf privaten Haushalten basierende Systeme ihre Mitglieder gegen existentielle Risiken wie Krankheit, Unfälle, und Tod schützen können. Eine Vielzahl von empirischen Studien in ländlichen Räumen haben die Grenzen von traditionellen Versicherungsansätzen aufgezeigt: ein unzureichender Schutz gegen kollektive Risiken und hohe Kosten verbunden mit der Durchführung risikoärmerer Aktivitäten. Darüber hinaus sind diese Systeme einem starken Druck durch Veränderung der sozio-ökonomischen Rahmenbedingungen ausgesetzt, wie beispielsweise die zunehmende Marktintegration und das Bevölkerungswachstum. Angesichts dieser Situation diskutiert dieser Beitrag die Möglichkeit einer *public-private partnership*, welche zum einen auf der Ausnutzung lokaler Informationen und zum anderen auf Riskostreuung, Rückversicherung und einem besseren Zugang zu Riskokapital basiert. Eine solche Partnerschaft hängt jedoch von mehreren Faktoren ab wie u.a. dem Willen des Staates, sich von bestimmten Tätigkeitsfeldern zu trennen und dem politischen und ökonomischen Umfeld für privates Engagement im allgemeinen.

Der Beitrag schließt mit einer vorläufigen Agenda für Politik und Forschung. Die Literaturauswertung hat deutlich gemacht, daß es eine Vielzahl von offenen Fragen über das geeignete institutionelle Design von sozialen Sicherungssystemen in ländlichen Räumen gibt. Forschungsbedarf gibt es bei der Identifizierung der Nachfrage der Bevölkerung nach sozialer Sicherung im jeweiligen sozio-ökonomischen und agro-ökologischen Kontext, der Analyse der ökonomischen und sozialen Wirkung von innovativen Versicherungsansätzen, die z.Zt. in einer Vielzahl von Länder entstehen und ausprobiert werden, bei der Identifizierung von Bedingungen für ein *public-private partnership* und schließlich bei der Frage, wie Forschungsergebnisse in konkrete Politikempfehlungen umgesetzt werden können.

1 Introduction

In recent years, a great deal of attention has been given to the reform of social security systems in developing countries as well as in developed countries. In both cases, the debate has centred on the question of what kind of social security system is appropriate in a rapidly changing economic and social environment. Whereas, in the industrialised nations, more than 90% of the population are covered by various forms of state or market-organised social security systems, in developing countries, despite considerable effort on the part of policy-makers, development institutions and donor agencies, well over 50% of the population remains uncovered against basic risks. Exposure to risk is therefore a major threat in the day-to-day life of people in developing countries. Illness, disability, death, widowhood, riots and natural disasters are some examples of typical risks which lead to fluctuating incomes and thereby affect the quality of life. In developed countries people are often protected by state or marked-based insurance schemes. In developing countries, however, not only are insurance markets missing, but possible substitutes in the form of labour markets and credit markets are either non-existent or do not function properly.

While the majority of the population in developing countries still has no access to state or market-based social security, the most important alternative – systems based on reciprocity and solidarity at the household or community level - are facing tremendous adjustment problems due to economic and social changes. Market penetration, population growth, migration and a change in social habits can lead to an erosion of the moral economy, so that a basic minimum access for all members is no longer guaranteed. Moreover, in rural areas, the institutional development of insurance schemes is hindered by the existence of covariate risks, adverse selection problems and high unit transaction costs per contract.

Given this background, this paper seeks to provide an overview of the kinds of social security systems that are currently in place and discuss the major institutional strengths and weaknesses of their various components. As stated at the World Summit on Social Development in 1995, access to social security lays the foundation for sustainable development and is one of the prerequisites for eradicating poverty. However, not much is known about the risk-reducing effects of social security on investment, specialisation and growth, which are of great importance and call for a deeper understanding. The current debate[1] on the reform of welfare systems in developed countries does, however, offer some insight into how social security provision can be improved in developing countries. Obviously, there is a strong need for the government to withdraw from some activities in the provision of insurance and basic social services in order to leave more space for private for-profit and non-profit engagement. The challenge which policy-makers and researchers

[1] For an overview of the main issues see: “Social Insurance Survey” in The Economist October 24th 1998.

are now facing is to find the right mix between state activity, the market mechanism and civic engagement. Institutional innovations that help to lower transaction costs by using local information and integrate risk-pooling and reinsurance mechanisms are called for.

The paper is organised as follows: Section 2 describes common concepts and understandings of "social security" and explores why the framework has changed during the last two decades. Having identified some of the disadvantages of the conventional approach to social security systems, we present an alternative that focuses on institutional aspects. Adopting this classification system, Section 3 gives an overview of state, market, member and private household-based systems in the developing world. Section 4 then goes on to analyse more closely the consequences of the specific situation in rural areas for the institutional design of a social security system. The idea and possibilities of a public-private partnership are also discussed here. The paper closes in Section 5 with a provisional policy and research agenda.

2 Concepts and Understandings of Social Security

2.1 Definition

In Germany, the first broad system of social insurance was created at the end of the last century under Chancellor Bismarck, between 1883 and 1889. It was compulsory for wage earners, although at the early stage the sole contributor was the insured person. The term "social security" was first officially used in a piece of United States' legislation entitled the Social Security Act of 1935. This act initiated programmes to cover the risk of old age, death and unemployment. It appeared again in an act passed in New Zealand in 1938, but this time expressing a broader understanding that included more benefits. The ILO then adopted the term and, through its official actions taken between 1952 and 1982, elaborated a formal concept of social security. This concept of social security was characterised by the ILO (1984a, p. 3) as follows:

> *"... the protection which society provides for its members, through a series of public measures, against the economic and social distress that otherwise would be caused by the stoppage or substantial reduction of earnings resulting from sickness, maternity, employment injury, unemployment, invalidity, old age and death; the provision of medical care; and the provision of subsidies for families with children."*

The ILO definition expresses the main-stream understanding of social security that lasted until the mid-80s. Three points are noteworthy. First, according to this understanding, social security has to be organised largely by the state and/or public institutions. Second, the definition presumes that the members of society have already reached an acceptable standard of living. The main ambition of social security therefore is to protect members of society from a fall in their standard of living, rather than to help them achieve a higher level of the latter. Third, the risks enumerated in the ILO definition refer to a specific ecological and socio-economic setting found in developed countries. It does not cover risk insurance against environmental and medical contingencies such as droughts, earth-quakes, floods, epidemics (Leliveld 1991).

The concept of social security described here has greatly influenced discourse on social security. For a long time, the ILO was the only international agency with academic depth as well as field experience in designing state-organised social security systems and thus dominated the international debate. In fact, the understanding of social security as something that essentially refers to public programmes involving social assistance, social insurance and redistribution is based on the experience and situation in developed countries (Kotlikoff 1987, Atkinson and Hills 1991).

This situation has itself changed tremendously in recent years. Neither the definition, nor the concept is still accepted as a universal basis for analysing and designing social security systems[2]. Furthermore, other development organisations – with the World Bank at the forefront - are becoming increasingly active on this issue. The current discussion of a reform of social security systems within developed countries further demonstrates the fact that the concept of social security as a purely state-provided system has been strongly questioned.

In the following, social security refers mainly to the protective aspect[3]. We therefore concentrate on risk management and insurance schemes which allow people to cope with individual risks, such as illness, accident, widowhood, disability, old age and death, as well as with collective risks, like drought, bad harvests, natural disasters, riots, etc. Hence, our definition of social security includes both personal risks as well as co-variate risks. Social security systems in this context help to mitigate the consequences of these risks, e.g. a reduction of earning capacity. Given this definition, broader aspects of poverty alleviation in its overall economic and social context are not discussed in this paper. However, the concept of social security employed here does go beyond the understanding found in discussion on social safety nets which, on the one hand, narrows the focus to state-financed activities while, on the other hand, addressing aspects of social policy that lie outside the scope of this paper[4].

2.2 Determinants of social security systems

Among the various approaches taken in the literature to explain the extent of social security, the “convergence theory” has, for a long, time played a significant role. We shall briefly describe the main ideas and the methods applied in order to show how much the perception of social security by developed countries has influenced research.

The convergence theory emphasises that social security systems are a product of the needs generated by industrialisation and economic development. Wilensky (1975, p. 86) argues that “with economic growth, all countries develop similar social security programs”. Tang (1996, p. 377) therefore comes to the conclusion that “obviously, the industrial society perspective is seen by its supporters as a grand theory to explain and predict social welfare development, applicable and relevant to all parts of the world”. This is the concept of “Soziale Marktwirtschaft”.

2 For different definitions of social security see: Drèze and Sen (1991), Leliveld (1991) and Van Ginneken (1997).

3 Drèze and Sen (1991) distinguish between a `protective´ and a `promotive´ aspect of social security. The former aspect focuses on mechanisms to prevent a sharp decline in income (entitlement, living standard,..), whereas the latter deals with public action to raise persistently low incomes (improve living standard,..).

4 Social safety nets involve targeted social services and benefits as well as project-based social funds.

A model which tries to explain the extent and qualitative form of social security systems and which has gained some attention in Germany is the Zöllner model (Zöllner 1983). Zöllner used the social expenditure share[5] as an indicator for social policy activity. He presumes that the social expenditure share increases with rising GDP. In the literature, "Zöllner's law" describes the close relationship between the social expenditure share and the dependent labour force (Schmidt 1989). The latter is defined as the proportion of non-agricultural workers among the total number of people in employment. Zöllner (1983) argues that, with a shift of employees from the agricultural sector into the industrialised sector, the introduction of a social security system becomes inevitable. Once such asystem has been installed, a change in the structure of the working population and total population leads by itself to an expansion of the social security system irrespective of any change in the legal framework. The number of insured persons rises constantly. The proportion of women in the working population and the share of older people rises as well. In addition to this, Zöllner points out that an improvement in the standard of living due to the process of industrialisation itself leads to an increase in the social expenditure share.

The existence of more than 50 studies on social security systems provides a solid, empirically supported basis for formulating a hypothesis concerning the factors driving the development of a social security system in a specific country (Tang 1996). However, Tang (1996, p. 378) points out that the majority of these studies only include developing countries to a very limited extent. This leads him to caution that "it is doubtful, whether research findings on developed countries can help explain social security development in developing countries".

Tang (1996) himself conducts a regression analysis based on 51 countries (29 of which are developing countries) that includes the following variables: change in GDP for a given period, the proportion of people over 65, the proportion of people living in urban areas, the number of non-agricultural workers as a percentage of the total work force, the average total number of strikes for a given period, and the level of military spending as a proportion of gross national output. He concludes that the age and the proportion of people living in urban areas are the only significant variables to explain social security expenditure, with the latter aspect being closely related to migration. In contrast to Zöllner and the revised Zöllner model (Gans 1996), the variables related to industrialisation[6] are not significant. Moreover, no influence of working-class conflicts on social development could be found. When dividing the number of countries into two groups – developed and developing countries – the proportion of people living in urban areas remains the only significant variable to have an influence on social expenditure in the 29 developing countries. Taking this into account, Tang (1996, p. 386) concludes that "the utility of the industrial society perspective is much watered down".

5 (=public social levies/gross domestic output)

6 (dependent labour-force ratio, changes in GDP)

A recent study by Gertler (1998) on the development of social health insurance in Asian countries seems to support some of the findings mentioned above. Gertler concludes from the successful implementation of social health insurance in the economically wealthier countries such as Japan, Korea, Singapore and Taiwan that this only takes place when the countries have already achieved a relatively high income, are largely urbanised and have large wage sectors relative to informal sectors.

All the studies cited are based on cross-sectional analysis. With this research method it is not possible to capture dynamic aspects such as the significance of a variable over time. An example would be the impact of migration on social security provision. In order to test this, one needs to pursue a time series approach. Due to data scarcity, however, the possibilities for implementing such an approach are rather limited. Beside the criticisms already made of the convergence theory, it underestimates historical and political reasons for the development of a social security system within a country. The introduction of the Bismarckian social insurance in Germany at the end of the 19th Century, for instance, cannot be adequately explained by socio-economic factors. At that stage, Germany had a lower level of economic wealth than Britain, France and Belgium. A major motivation for the introduction of a social insurance scheme for workers at the time was to stabilise the economic and social system in order to prevent civil unrest and political instability. Hence, concessions have been made to organised working forces. Political reasons therefore have to be taken into account when looking at the different directions of social security systems within developed countries.

Schmidt (1989) distinguishes between the political approach, in which spending on social purposes is a product of choices in the political decision-making process, and the socio-economic approach, which is equivalent to the covergence theory. Ahmad (1993, p. 362) argued that “the different configurations of political and interest groups influenced the varied directions that social provision has taken in the industrial countries”. A major difference in this respect can be found in the respective institutional designs of the Bismarckian model and the Beveridge model (Beveridge 1942). Whereas, in the former model, the scope of application is geared towards the socio-professional groups to which the beneficiaries belong (e.g. employees or self-employed people), the latter applies to all the citizens of a country. This difference has strong implications for the financing of the system, the nature and distribution of benefits, as well as the impact on the economy.

A major lesson to be learnt from the literature on the determinants of social security systems is that socio-economic factors as well as political and historical considerations have to be taken into account. However, both approaches focus almost exclusively on state managed social security schemes, while ignoring the variety of other institutions providing social security. Institutional aspects of social security systems have been widely overlooked. Before we introduce a classification framework based on institutions, we shall describe the conventional approach to classifying social security systems.

2.3 The conventional approach to classifying social security systems

Similar to the lack of agreement regarding the actual definition of social security, no clear classification framework of social security systems exists that is widely accepted in the international community. German authors, in particular, often use an approach which classifies social security systems as either "formal" or "traditional", sometimes including a third category "informal" (e.g. Schmidt 1995, von Hauff 1994, Gans 1996). Other authors use categories such as "traditional systems", "private" vis à vis "state" based systems or "collective arrangements" (e.g. Benda-Beckmann et al. 1988, Abraham and Platteau 1995, van Ginneken 1997).

According to these classifications, the *formal systems* mainly cover the state-organised and private-run systems, which are contributory (social insurance) or financed by taxes (social assistance) and are linked to employment in the so-called formal or modern sector. In contrast, the *traditional systems* are generally based on the development of traditions of social groups. Solidarity and reciprocity, rather than efficiency considerations, underlie these systems, which find their expression in specific norms and moral codes. Often the allocation and wage mechanisms for land and labour already contain important social security elements, which are backed up by specific insurance arrangements (Gans 1996). These systems are not generally integrated into the national economy. Finally, there are *informal systems* or *collective arrangements* that stand between the formal and traditional systems. Their existence is related to either the squeezing out of traditional systems due to the structural change of the societies driven by economic and social forces or in response to the low coverage of the formal systems. Just like traditional systems, they are also based on the principles of solidarity and reciprocity. Typical forms like savings and loan groups, associations and co-operatives are based on mutual self-help. To become a member of this groups, there are certain conditions to be met (e.g. regular payments), often making it difficult for poor people to join these groups. The informal systems may be linked to the national economy but are not as fully integrated as the formal systems (Friedrich-Ebert-Stiftung 1997).

The approach which has been described so far to classify social security systems is not convincing for different reasons. First, frequently it is difficult to distinguish between "traditional" and "informal" as the example of the "informal" saving and loan groups which already exist in several Latin American countries since the 18th Century show. Second, this classification scheme assumes a quasi-automatic development from traditional to formal systems in the developing world following a sort of path dependency. The ILO formulated a dynamic three-phase model describing the development of a social insurance system from a paternalistic phase (phase 1), through the introduction of social insurance with limited coverage (phase 2), and finally on to the maturation (phase 3) of the social insurance system with universal character (ILO 1984b).

In reality, however, this has proven not to be the case. Moreover, the distinction between what is "traditional" and what is "informal" or "formal" is not very helpful in classifying the various social security systems, which can incorporate a mixture of all three elements. Finally, it is a distinction that lacks theoretical underpinning, offering no clear reference to institutions as providers of social security. We therefore need a new classification system which is built on institutions, rather than on the criteria used in the conventional approach.

2.4 An institutional classification system

North (1984, p. 8) defines institutions as "a set of constraints on behaviour in the form of rules and regulations; a set of procedures to detect deviations from the rules and regulations; and finally, a set of moral, ethical behavioural norms, which define the contours that constrain the way in which the rules and regulations are specified and enforcement is carried out". When we conceptualise a more elaborate classification system, it is useful to start by addressing the question of which organisations provide social security in a society. Burgess and Stern (1991) provide some examples of the enormous variety of different combinations of social provision which exist in different societies: religious groups in Muslim countries (Quershi 1985, Weidnitzer, 1998), the firm in China (Hussain and Liu 1989), trade unions in Israel, and central government as well as local authorities in the UK (Barr 1987). In contrast to the developed countries, it is the family, neighbourhood and organisations operating at the community level that play a dominant role in developing countries. While state and market-based systems have only a very low coverage rate or are even non-existent, these organisations are the back-bone of social security systems in developed countries.

In the following we will refer to member-based organisations (MBOs) which – alongside the state, the market and private households - provide social security for their members. We are thinking here of civic organisations in the form of the various sorts of self-help groups organised to improve social security at the community level[7]. Major activities could encompass the provision of health insurance, access to credit and saving, or giving people a voice to formulate their needs and interests. Robinson and White (1997, p. 6) characterise the form of cooperation within civic organisations as "episodic or long term and intergenerational, framed by norms of exchange and reciprocity, mediated by rules and institutions which may not assume concrete organisation forms".

[7] In the literature there is no clear and accepted typology of organisations operating between the state and the market. For this paper we choose the term "member-based organisation" instead of "voluntary", "collective action", "grassroots", "non-profit etc. organisations because the incentive structure for cooperation in the provision of social security is largely dependent on a close relationship between the organisation and their members and between the members themselves. For a different conceptualisation see Uphoff (1993) and Salamon and Anheier (1996)."

From an institutional perspective, the main difference between such organisations lies in their incentive structure for securing cooperation and compliance (Van Til 1987, Salamon and Anheier 1996). The state depends on the rule of law and regulations backed by coercion, the market relies on commercial pressure, MBOs are bound together by self-interest, local affiliation and solidarity and the private household essentially by social norms and values (Table 1).

Table 1: Characteristics of social security-providing organisations

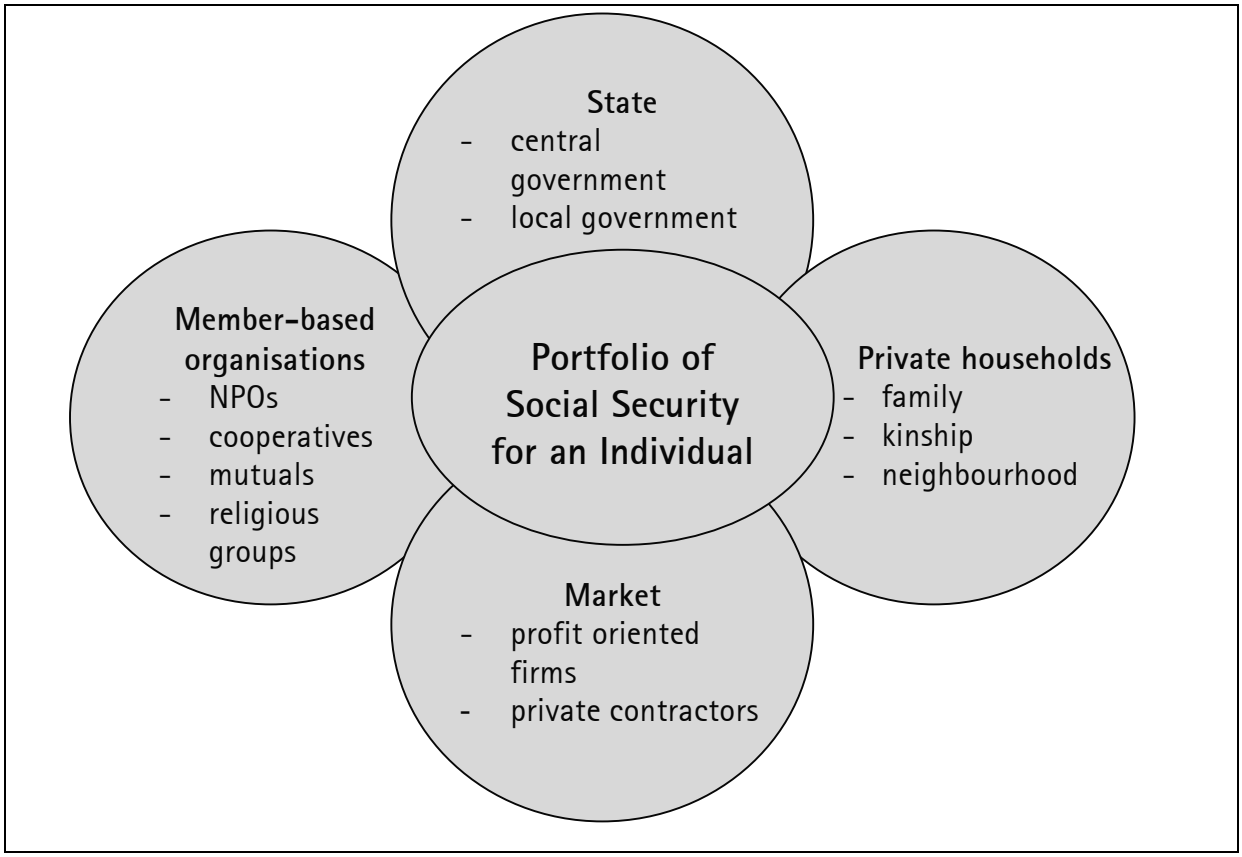
	State	**Market**	**Member-based organisations**	**Private households**
Instruments	Social insurance, social assistance, transfers, provident funds	Insurance policy or contract	Mutual arrangements, voluntary work	Gift exchanges, state contingent loans, remittances, transfers, crop insurance
Mode of operation	Top-down	Individualistic	Mainly bottom-up	Bottom-up
Incentives	Rule of law, regulations	Maximisation of profit and/or utility, price signals and quantity adjustment	Balanced reciprocity, self-interest, voluntarism, solidarity	social norms and values, altruistic behaviour, charity; self-interest
Sanctions	Exclusion of people from programmes; withdrawal of programmes	Level of premium, limit supply of insurance	Social pressure, exclusion from the organisation	Social pressure, inherent family contract

Source: own presentation

With this in mind, we can identify four broad categories for a social security classification scheme: there is the state, which has implemented social security programmes and social insurance schemes as well as specific policy measures like transfers and subsidies; there are market-based systems, in which firms offer social insurance on actuarial calculations; there are member-based organisations, some of them called non-profit organisations, cooperatives, mutuals and self-help groups, which on a voluntary basis provide services to their members; and finally, there is the private household level, at which family members provide social security mainly on the basis of social norms and values.

The four organisations identified here are useful as a conceptual framework. We shall use this in the following sections to describe what kind of social security systems are actually in place in developing countries (Figure 1). While such a classification system is useful for taxonomic purposes, one should not overlook that the boundaries are sometimes fluid. An example of this kind are MBOs which have a formal corporative relationship with the state in the form of the local government. Moreover, the existence and the importance of MBOs in providing social security often depends on how well the state and the market are established and what kind of services they supply at what price. The portfolio of an individual, therefore, depends on the socio-economic setting and can vary considerably. Finally, this classification system should not be regarded as a static concept, but as a scheme in which the importance of the different organisations in their contribution to the portfolio of an individual varies over time and with the development process.

Figure 1: Classification system for social security



Source: own presentation

Using our classification system, we can now look in detail at the kinds of social security systems in developing countries that are actually in place and ask why specific institutions emerge and function while others do not.

3 Social Security Systems in Developing Countries: An Overview

3.1 Generic constraints on insurance contracts

Before describing the different types of social security systems in developing countries according to our classification scheme, we shall first briefly introduce inherent problems of insurance markets. We do so because viable insurance arrangements are essential to achieve social security. An insurance can be characterised as a contract in which the insured person pays a premium for the right to receive a compensation in the case of contingency. Important constraints on insurance contracts are moral hazard, adverse selection, free riding and exclusion as well as covariate risks and information problems (Burgess and Stern 1991).

Moral hazard arises "when an individual takes an action to maximise his own welfare that is to the detriment of others in situations where information problems prevent the assignment to the individual of the full damage caused by this action" (Hoff et al. 1993, p. 5). In insurance economics moral hazard plays an important role. In the early works of Arrow (1963) and Pauly (1968, 1974), who first formulated the moral hazard problem in the context of medical care, it was shown that individuals are less risk-adverse when they are insured. This means that some of the cost of an accident is borne by the insurance company, and in deciding on the level of care, the insured does not take into account the insurer's costs (Hoff et al. 1993). Government intervention designed to solve the problem of moral hazard is seen as extremely problematic. Hoff et al. (1993, p. 5) state that "government intervention may cause more problems than it solves". One possibility of reducing moral hazard is to use a form of co-insurance, a deductible (franchise) or a reduced premium bonus for the future. "To the extent that the compensation is less than the value of the damage according to the policyholder's own evaluation, he is burdened with a part of the cost himself. If he can avoid this cost, at least partly, he will certainly try to do so" (Sonderström 1997, p. 67). Another possibility of coping with moral hazard is to arrange special contracts[8].

Adverse selection in insurance markets arises when the insurance companies cannot identify the risk category in which a specific person belongs. If this is the case, then the insurance company is forced to make all policy holders pay the same premium, corresponding to the expected compensation for the entire population plus an amount to cover administration profit.

[8] See section 3.3 for a discussion of rules and norms of special contracts to deal with moral hazard.

Individuals with a high exposure to risk will find these contracts very attractive, whereas those with a low exposure will find the premium too high and could search for alternatives. Such an insurance arrangement can therefore attract bad risks[9].

Free riding and exclusion can be a considerable obstacle for the creation of efficient insurance. Free riders do not pay insurance fees and rely on the charity of other fellow citizens. This can lead to an increasing demand for charity and lowers the demand for insurance. As a consequence, there is an evolution towards a more insecure and expensive insurance for those who stay in the pool. In the context of small insurance schemes at the community level, free riding can mean that individuals wish to join risk-sharing arrangements without reciprocity. Control or reduction of the free-rider problem can be achieved by establishing enforcement rules (loss of membership in the case of non-reciprocity behaviour) or by introducing waiting periods during which new affiliates would not be covered. On the other hand, there may also be people who want to insure themselves but cannot afford to pay the required premium. This is especially relevant for poor people with a high exposure to risk who face insurance premiums that are priced actuarially. The exclusion of potential members could be a consequence. To prevent this situation, the state often subsidises insurance schemes directly or indirectly. Society can deal with the problem of free riding by making insurance mandatory, as for instance in the car insurance schemes. A number of countries in different parts of the world have made pension and sickness insurance mandatory, too. In this case, the absence of an insurance in general only hurts the uninsured person himself. Hence, the inability of human beings to foresee future states of the world is a strong argument for the creation of other organisations alongside the market. Mandatory insurance schemes can be an example in this respect.

Covariate risks are an important element in risk theory. Covariate or collective risk means that a possible risk would cause damage to many or even to all members of the pool at the same time. In relation to such risks, there is nothing to be gained by cooperation (Sonderström 1997). The stronger the degree of positive covariance, the higher will be the costs, whereas negatively correlated risks will have the effect of reducing the total cost of risk-bearing (Platteau, 1991). As Newberry and Stiglitz (1981) and Newberry (1989) have shown, insurance pools work best with easily identifiable risks and damages. If all agents face similar risks, then risks cannot be reduced much by trading between participants. This is especially relevant for farmers in ecologically uniform areas who, from a risk point of view, carry out the same activities. If there is a high covariance in yields, each farmer could insure himself at the same cost as the premium in an insurance scheme.

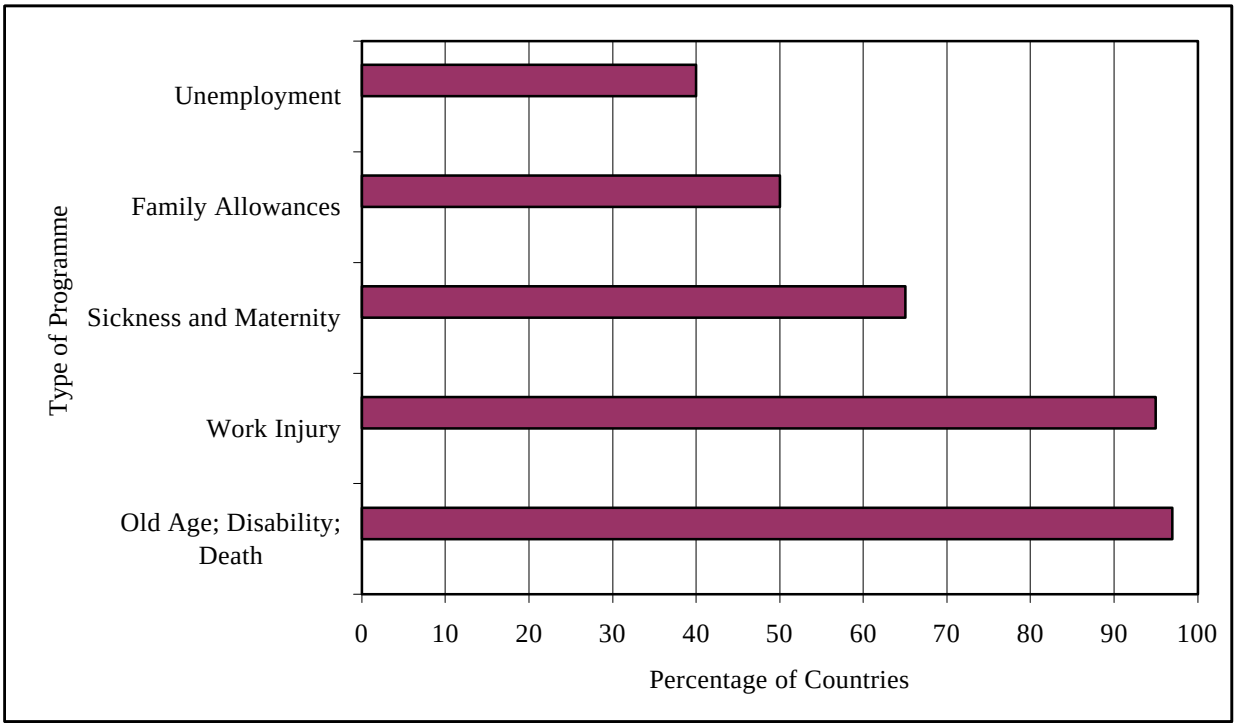
[9] A large amount of literature has been written on adverse selection, which was pioneered by the work of Akerlof's lemon principle (1970) and then extended by Spence (1973), Stiglitz (1975) and Rothschild and Stiglitz (1976).

Finally, *information problems* arise between the insurer and the insured person. The degree of information asymmetries explains the extent to which moral hazard and adverse selection play a role. Due to a low level of infrastructural development in several developing countries information problems hamper the development of markets, particularly financial and insurance markets.

3.2 State and market-based systems

Social security is a world-wide phenomenon and is not restricted to developed countries. Today, state-based social security in form of social security programmes exists in 172 countries (US SSA 1997). An analysis of the distribution of the different types of programmes in 1997 reveals an interesting break-down: Whereas 95% of the countries with social security programmes have provision against the risk of "work injury" and "old-age, disability and death", schemes have been introduced to cover "sickness and maternity" in only two thirds of the countries and "family allowances" and "unemployment" in less than half (Fig. 2).

Figure 2 : Percentage of countries with social security programmes

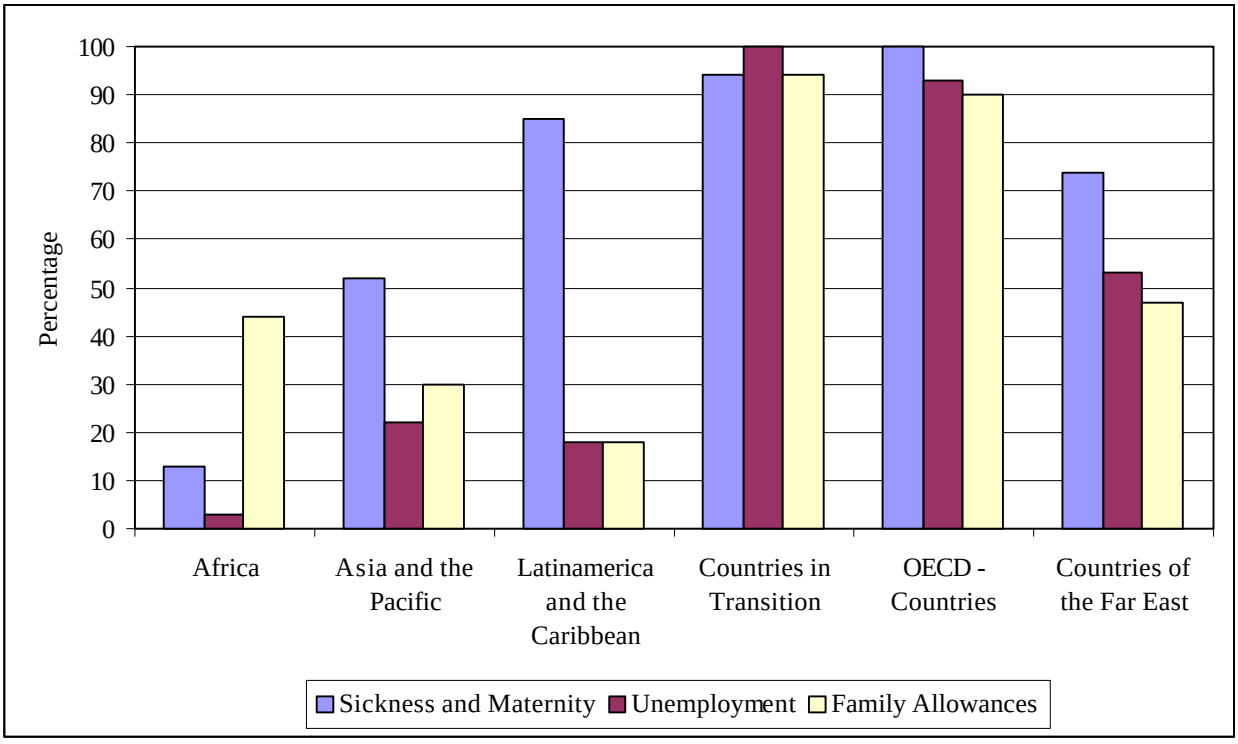


Source: US SSA (1997)

Work injury programmes are often the first programmes established in a country, followed by programmes against sickness and risks aligned to old age, disability and death. The relatively low number of programmes in the area of sickness and maternity can be explained by the fact that the coverage with these programmes has not been a priority in developing countries.

This contrasts with the historical development of social security systems in developed countries, where insurance against sickness was one of the first steps taken in creating the social security system. Some authors strongly criticise the fact that priorities are set in accordance with the model of the developed world, arguing that its systems are not in the interest of the poor (e.g. Gsänger 1993). Regional differences in providing social security programmes can also be observed.

Figure 3: Regional differences in the type of social security provision (countries with sickness and maternity, unemployment and family allowances programmes as a % of all countries in the region having social security programmes)



Source: US SSA (1997)

Between 50 – 85 % of the countries with social security programmes in Asia, Latin America, and the Far East have social security programmes which include a "sickness and maternity" component, whereas protection against "unemployment" and "family allowances[10]" plays only a minor role. On the other hand, in Africa only 15 % of the countries have this component, but more than 40 % spend money on family allowances. Obviously, the African countries have set different priorities, favouring the provision of family allowances and to a lesser extent to sickness and maternity programmes.

[10] Family allowances include primarily regular cash payments to families with children.

To measure the impact of state-provided social security programmes, we can look at the coverage rates of these schemes. The available data reported by the ILO have to be interpreted with caution and may lead to a considerable underestimation of the real coverage. In the case of health insurance, these data do not count enterprise health insurance schemes, which have recently grown significantly in countries like the United States and the United Kingdom and now cover a significant portion of the population (ILO 1996). Despite these limitations , the ILO data on coverage rates in different countries does lead to some interesting conclusions:

Not surprisingly, developing countries have significantly lower coverage rates in comparison to developed countries. Whereas in most of the OECD countries more than 50 % of the population is covered, in most of the developing countries less than 20 % have access to state-organised social security. Taking a closer look at developing countries, we can observe significant regional differences: In the case of old age provision, the ILO data (ILO 1996) shows that the coverage rate calculated for Asian countries is twice as high as that of Latin American and even four times higher than in African countries[11]. A study by Gruat (1990) supports the findings of a coverage rate for African countries that is on average significantly lower than 10 %. In the 20 African countries that could be analysed thanks to reasonable data availability, the general social security scheme (applicable to wage earners) covered between 0.7 and 24 % of the working population in 1989, with the rate of coverage amounting to 10 % in only five countries and over 20 % in just two. With few exceptions, the African social security schemes apply only to wage earners and sometimes exclude certain types of work, e.g. seasonal or casual and certain categories of wage earners, e.g. those employed in handicrafts, small enterprises, agriculture and domestic service (Gruat 1990).

According to a survey by Mesa-Lago (1985), countries like Uruguay, Argentina, Cuba, Brazil and Costa Rica – which he classified as a pioneer group due to their relatively early establishment (1920s) of social security programmes – had coverage rates higher than 70 % of the total population in 1980, which is a level similar to that of the developed world. He estimated that the coverage rate for the whole region is more than 40 % of the population (excluding Brazil with a coverage rate of over 90 %), which places these countries in a leading position in comparison to other regions. Guhan (1994) argues that the high degree of urbanisation in the middle income Latin American countries is a possible explanation for this high coverage.

Apart from differences between continents, there are also large variations among the individual countries within a continent. Thus, while less than 1 % of the population has access to old age provision in Uganda, around one third of the population is covered in Mauritius (ILO 1996). These huge differences in coverage rates between countries are not scheme specific but equally distributed. Coverage rates not only vary between different countries but also within social groups in a country. Workers outside the formal sector (especially women and the rural population), minorities and other disadvantaged groups are generally excluded from social security programmes.

[11] Data are available for 13 countries in Asia, for 22 countries in Latin America and for 20 countries in Africa. The data is weighted with respect to population.

The tremendous problems which state-based social security systems in developing countries currently face can be summed up in the following three points:

- **Low coverage rates.** Despite remarkable progress in expanding the coverage of social security provision, the existing - state or market-based - systems still exclude many poor people. It is estimated that more than two billion people in the world are not covered by any type of social security protection, i.e. neither by a contribution-based social insurance scheme nor by tax-financed social assistance (van Ginneken 1997).

- **Financing and management problems.** In most developing countries only a limited proportion of the population works in the modern sector in which employment contracts can be monitored and assessed for the purpose of contributions. The larger the informal sector, the less the organised, formal sector is able to finance social security for it. The alternative is to use the tax base (personal, enterprise income taxes and indirect taxes), but this is also limited, because it is difficult to collect direct taxes from informal-sector workers and indirect taxes are generally insufficient to fund a generalised social security system. In addition, criticism is frequently levelled at the effectiveness and efficiency of the organisations in charge of collecting contributions and paying benefits. The administration of the social security system is highly complex: keeping records, ensuring the compliance by employers and employees, organising effective control of the agencies and maintaining regulatory structure all demand a well-functioning administrative structure. In many developing countries, however, these arrangements are far from being properly run (Gillion 1997).

- **Changing economic and social environment and the ageing population.** The economic and financial crisis in which several developing countries found themselves at the end of the 1980s prompted governments to undertake strong measures to alleviate their budgetary difficulties. As a result, the proportion of the population which could be covered by social security declined due to an expansion of the informal sector and the growth of public debt (Koptis 1993). Recently, a new debate has arisen on the influence of the ageing of the population due to declining birth rates and rising life expectancy and its impact on social security, especially pension schemes. Taking the world as a whole, the proportion of the population over 60 will have increased from approximately 9 % in 1990 to just over 16 % by 2030. This has various impacts on the developing world. In countries like China, the question of how the older population will be supported after retirement is one of the main issues connected with the reconstruction of the whole economy. In this context there is a heated debate as to whether a revision of the common social security type found in Europe, i.e. a pay-as-you-go system, is adequate or if one has to make a radical shift towards mandatory retirement saving schemes (World Bank 1994, Feldstein 1996, Diamond 1996, Siebert 1998).

The overview of the tremendous problems facing state-based social security schemes clearly demonstrates the need for alternatives. We will therefore investigate whether market-based schemes can at least solve some of the problems raised above.

Market-based systems

Social security systems based on market principles are gaining importance world-wide, yet they are still at a rather low level. With the exception of the most prominent examples in Latin America, where several countries have embarked on a reform of their state-based social security systems, commercial insurance schemes still play only a very limited role. The reform in Latin American countries centres on a greater role for funded, privately managed pensions. The experience and success of Chile, which moved from a public pay-as-you-go to a private funded pension system more than one decade ago, has received a lot of attention and has been debated in the literature.[12]

In addition to the discussion on state-based pension systems in developing and developed countries, there has been discussion on the extent to which market elements can be introduced in the health sector . With regard to developing countries, a study by Berman (1998) in India has shown that the private for-profit and non-profit sector plays a substantial role in health care provision. Furthermore, according to World Bank figures, 80 % of the total health expenditure goes to the private sector. The Indian example shows that, in the case of health care provision, the private sector already plays an important role which is often ignored or even hindered by the government.

Whereas market elements in state-based systems are becoming increasingly important and their contribution to better access, efficiency and quality is acknowledged, commercial insurance policies as a separate system only play a very limited role. In most developing countries commercial insurance contracts are available but the access is mainly limited to the wealthier part of the population and to people living in urban centres. A risky environment, lack of resources and infrastructure and information problems lead to high unit transaction costs per insurance contract and therefore to high premiums, which cannot be paid by the majority of the population.

Because neither the state nor the market can provide sufficient social security for the majority of the population in developing countries, member organisations and private households have to mitigate the risk themselves. This may act as a complement or as a substitute for the government and the private sector (Lam 1996, Ostrom 1996, Uphoff 1993, Thorbecke 1993).

[12] A detailed analysis on the pension reforms in Latin America is given by Queisser (1998). For a critique on the concept of a mandatory saving schemes see Beattie and McGillivray (1995).

3.3 Member organisations and private household-based systems

Although data on the role of MBOs in social security provision on a world-wide level are not available, their role can hardly be underestimated. MBOs are involved in financing and in the provision of health care, financial and social services all over the world. Moreover, they can help to set up viable insurance markets. A recent example has been the emergence and fairly rapid growth of Mutual Health Organisations (MHO) in West and Central Africa, which attempt to improve their members' access to quality health care via the introduction of a health insurance scheme. Another well known example of this type can be found in India. The Self Employed Women Association (SEWA) in the state of Gujarat has developed an 'Integrated Social Security Insurance Scheme' for its members, which covers death, accidental death, sickness, accidental widowhood, loss of household goods and work tools in case of flood, fire, riot or storm. These two examples show the variety of activities that MBOs are undertaking in the area of social security provision. However, a specific focus lies on health care provision and credit and finance.

A survey by Robinson and White (1997) shows that generally MBOs have a more important role in direct health service provision in Sub-Saharan Africa and parts of South-Asia, while in India and much of Latin America, the non-state sector tends to be more important for mobilising resources or demanding services from the state. The role of MBOs is not only the provision of health facilities, disease prevention, and engagement in social welfare activities such as care for vulnerable groups or support activities like training and the procurement of drugs. MBOs also develop and promote new approaches such as primary health care and community financing, promoting health awareness and mobilising demand for health services (Gilson et al. 1994).

Looking at the regional level, there are significant differences in the form and extent of health provision. In Sub-Saharan Africa, MBOs are a major non-state actor, making significant contributions, whereas in Latin America state and market-based organisations are dominant (Zuckerman and de Kadt 1997). In Sub-Saharan Africa the economic and political factors have contributed to an expansion of the non-profit sector in health care provision. It is undisputed that the quality of state-based system in many countries is very poor and the low coverage is due to inadequate technical capacity, overcentralisation of the decision-making process, operational inefficiencies and corruption (Mburu 1994).

The high level of non-state provision of health services in Africa in the early 1990s is shown in Table 3. For a majority of the countries selected, church organisations are the dominant providers. In Tanzania, 40 % of the hospitals are run by church organisations and in Zimbabwe church missions provide nearly 70 % of all beds in rural areas. In Kenya about one third of the total health services are provided by NGOs and 40–50 % of the family planning services (Kanyinga 1995).

Table 2: Extent of non-State provisioning of health services in Africa

Country (organisation)	Percentage of Total No. Hospital/ Hospital Beds	Percentage of Total Services/Contacts
Cameroon	40 % (facilities)	
Ghana (church)	20 % (beds)	40 % (population) 50 % (outpatient care)
Kenya (NGOs)		35 % (services)
Lesotho (non profit)	50 % (hospitals) 60 % (clinics)	
Malawi (church)		40 % (services)
Tanzania (church)	40 % (hospitals)	
Uganda (church) (NGOs)	42 % (hospitals) 14 % (facilities)	31 % (services)
Zambia (church)		35 % (services)
Zimbabwe (church)	68 % (beds/rural areas)	40 % (contacts)

Source: DeJong (1991), Gilson et al. (1994), Nabaguzi (1995)

Beside the direct provision of health care, MBOs are also engaged in the production of a health infrastructure, as examples from Kenya, Tanzania and Uganda show. In Latin American countries the rise of MBOs is often associated with state inefficiencies and cut-backs in public spending (Zuckerman and de Kadt 1997). In Venezuela, MBOs have taken a leading role in the setting up and maintenance of local health services in various parts of the country (Cartaya 1997); and in Nicaragua, MBOs design and implement health projects without outside coordination (Barrett 1996).

Apart from health care providing organisations, credit and saving associations play a very important role for people who are otherwise excluded from financial services. Empirical studies have shown that due to a lack of usable collateral, the poor are often excluded from formal financial institutions (Thorbecke 1993). In this situation, organisations like a saving association can evolve and step in (Geertz 1962, Schrieder and Cuevas 1992).

These groups accumulate savings to be used for individual or group investment. Moreover, the groups pool risks such as individual crop failure or illness among group members. Zeller et al. (1997) quotes examples of rural organisations which provide access to credit as well as insurance services, such as the Burkinabé Caisse Villageoise d'Epargne et de Crédit den Bangh in Burkina Faso, the Grameen Bank and the Rural Advanced Committee in Bangladesh or the village banks in The Gambia, Madagascar, Mali and Senegal all serve the demand for insurance and combine lending operations with the clients' need to alleviate personal emergencies. These insurance policies are designed to cover individual or idiosyncratic risks as loan default, illness or death of family members via group emergency funds (Zeller et al. 1997).

Private household-based systems

Private household-based systems are the anchor and the basis for most people living in developing countries. As various empirical studies have demonstrated, these systems can – to a certain extent – cope with major risks affecting peoples lives (e.g. Townsend 1994, Morduch 1991, Paxson 1992, Jacoby and Skoufias 1995). A relatively smooth pattern of consumption among poor households is a strong indication that poor people employ risk-diversifying strategies in order to cope with income variation and expenditure shocks. Alderman and Paxson (1995) propose a distinction between risk management and risk mitigation strategies.

According to their classification, risk management encompasses all activities which households undertake to smooth their variability of income. This ex-ante risk mitigation strategy might include crop and field diversification, less application of riskier production techniques and the prudent use of new technologies as well as migration of family members (Stark 1995). Risk coping strategies are those which try to smooth consumption intertemporally through saving behaviour or across households through risk sharing. The former arrangement may be accomplished through borrowing or lending and changes in the stock of assets. The latter comprises institutions such as state-contingent transfers and loans, remittances, long-term labour contracts, share tenancy and crop insurance (Alderman and Paxsons 1995).

The underlying principle of the various arrangements is that they tackle the problem of information asymmetry and enforcement by establishing a long-term relationship and trust between the partners. Through information sharing, coordination of activities and a collective decision-making process, transaction costs are reduced. The literature shows that reciprocal gift giving and informal credit allow households to share risks within confined networks of family and friends (Platteau 1991, 1995; Fafchamps 1992). In addition, further studies (e.g. Rosenzweig 1988) show that intra- and inter-household transfers between related or proximate individuals are appropriate measures to deal with information asymmetries and resource constraints, which often prevent market institutions from developing or working efficiently. Fafchamps (1992) claims that transactions and mutual insurance may be achieved by contractual arrangements within the household or between members of a community. Moral hazard behaviour in this context bears the risk of being excluded from the intertemporal exchange of goods, services and financial intermediaries.

It has been shown that especially in small-scale rural societies moral hazard can be overcome "thanks to their members having close and continuous relations, thereby eliminating or reducing informational asymmetries and creating reputation effects" (Abraham and Platteau 1995).

The motivation for risk-sharing arrangements, such as crop insurances, is being discussed in the literature. Several authors argue that risk sharing is primarily driven by altruism and charity in a "moral economy" (Scott 1976, Cox 1987, Ravaillon and Dearden 1988, Altonji et al. 1992). This view is heavily criticised by authors like Popkin (1979), who try to explain risk-sharing mechanisms by self-interest behaviour. In this context, the argument of a "balanced reciprocity" was recently put forward (Cox and Jimenz 1989). This means that an individual or a household in a risky environment has a self-interest in transfer behaviour, because current generosity will ensure future reciprocity. Abraham and Platteau (1995) clearly demonstrate that in traditional societies individuals expect a return from any contribution they make.

There is some debate as to what extent private households can insure their members sufficiently against risks. It has been recognised that member and household-based systems in certain circumstances can effectively smooth consumption. But there are also indications that this is associated with high costs or with a lower potential income. The protection against covariate risks poses a specific problem, which can to a certain extent be solved by migration of some of the family members.

4 Institutional Aspects of Social Systems in Rural Areas

4.1 Constraints on the formation of state and market-based systems

In rural areas, the provision of social security services either by the state or by the market faces several difficulties that go beyond those of special relevance to urban areas. The following main points define the rural predicament:

- High dependence on agriculture as major income source
- High transportation and communication costs
- Lack of effective labour and financial markets that could substitute for insurance markets
- Weak political voice of the rural population

In rural areas the main sources of income are agriculture and related activities. These activities are mainly carried out by self-employed small-holders. The seasonality of the production cycles implies that income is rather unstable and demand for insurance peak-loaded. Even where there is a high demand for insurance, poor people will face serious constraints on their ability to pay their premiums on a regular basis. Moreover, people living in rural areas are often exposed to co-variate risks such as drought or flood , which make the establishment of viable insurance arrangements difficult.

A fundamental problem for the design of insurance schemes lies in the high level of information asymmetries in rural areas. The reasons for this can be mainly found in the costs arising from a physical infrastructure that only partly exists or poorly functions, especially in terms of facilitating information and communication, unspecified property rights and sometimes low levels of human capital (Jütting 1999). This leads to high unit transaction costs for small contracts and makes the setting up of insurance contracts very difficult (Braverman and Guasch 1993). Transaction costs are defined as “specifying and enforcement costs of contracts that underlie exchange”, and they arise because information is costly and asymmetrically distributed among the different actors in an economy (North 1984). In the case of insurance contracts, a specific sum for transaction cost has to be allowed for in every single insurance policy, no matter how high the premium. This fixed cost character leads to relatively high units of transaction costs for small insurance contracts, raising the price at which these contracts can be offered.

When insurance markets are non-existent or do not function properly, other markets such as labour and capital markets could act as substitutes (e.g. Grossman and Van Huyck 1988). However, in developing countries we must also consider the imperfections in these markets. Since employment is the primary source of income for the poor world-wide, well functioning labour markets are crucial for their welfare and social security. There is a large amount of empirical work that shows how employment may fluctuate a great deal and, as in the case of agriculture, is subject to risks that also involve seasonal variations (Rosenzweig 1988, Drèze and Sen 1989).

Capital markets may prevent an individual from severe disruption in one period by allowing the consumption stream to be independent from the income stream, subject to the overall constraint that loans must be repaid (Deaton 1990, Gersovitz 1988). A basic problem of capital markets is that the lender may not be prepared to take the risk of default or may find it too costly to ensure that the interest and principal are being repaid. Hoff and Stiglitz (1993) have shown that when lenders have imperfect information concerning the ability and willingness of potential borrowers to repay a loan, the implementation of credit schemes is strongly affected by the consequences of moral hazard.

Finally, the weak political voice of the rural population in most parts of the developing world is an obstacle to the introduction of state-based social security systems in rural areas. As Grindel and Thomas (1991) have pointed out, policy reforms and their translation into action heavily depend on the attitude of the political elite and the government administration. Since the rural population is not considered a powerful interest group, the pressure and incentive for an enlargement of the existing system is rather low. However, recent trends towards decentralisation and the devolution of fiscal and political power to local governments may induce a change in the attitude of public authorities.

4.2 Limits of member and private household-based systems

Member-based organisation systems

State and market-based systems have severe difficulties when it comes to dealing with the information problem in rural areas. As we have seen above, MBOs can handle the information problem quite well due to the social cohesion among the members. However, MBOs also have their limits, and their overall capacity to provide access to social security is sometimes overstated. In the following, we shall consider the case of health care provision in order to assess these limits. We shall take operational efficiency, equity of access and quality as our criteria for comparing the relative competence and deficits of MBOs in relation to state and market-based systems (Sauerborn et al. 1995).

With regard to the provision of health services, it is often assumed that non-profit organisations like MBOs are able to deliver high quality services at low costs to the poorest (World Bank 1993). Even though it is often stressed that non-profit organisations provide a higher quality of health care, empirical support for this assumption is rather limited.

Studies in Tanzania and Zambia are contradictory in this respect (Gilson et al. 1994). Concerning operational efficiency, a study by Berman and Rose in India (1996) reveals that the cost of health services provided by non-profit organisations is not significantly lower than it is for market or state-based organisations. This observation is further enforced by a study from Gilson et al. (1994), who identify in Tanzania a number of inefficiencies in the provision of health care by non-profit organisations. These include few outreach facilities, greater cold failures compared to government facilities, poor performance of health workers, low technical efficiency and employment of untrained or inadequately trained staff. Operational efficiency can also be affected when the project relies primarily on external funding and personnel. The results of research done by DeJong (1991) suggest that many health projects have poor prospects of long-term sustainability. Finally, equity of access cannot be taken for granted. There are numerous studies which confirm that MBOs work with poor people and disadvantaged communities (Pachauri 1994 for India). However, as the common bond of MBOs is often formed along religious or ethnic lines, so services might be restricted and part of the community might be excluded. This means that they can act as a powerful interest group that does not necessarily serve the interest of the whole community. Moreover, how well they function often depends on the commitment of their members and the leadership of the organisation, whose efforts are often constrained by opportunity costs of time, money and the like, not to mention the problems of knowledge and the capability to run such an organisation.

A recent study by WHO (1998) on 82 health insurance schemes for people outside formal sector employment has confirmed the above findings. A substantial part of the schemes reviewed are run by MBOs. The study identifies the following problems: limited coverage of the eligible population itself, substantial adverse selection problems, high dependence on external funding, exclusion of poor people, and management problems with running the schemes.

Private household-based systems

Private households in rural areas have to cope with an insecure and highly risky environment and can react by setting up institutions which provide risk-pooling and insurance mechanisms. However, the question still remains as to why in some cases these arrangements are either not working efficiently or are absent. In a recent study about risk-sharing networks in the rural Philippines, Lund and Fafchamps (1997) show that gifts and informal loans are partly motivated by consumption-smoothing motives but do not serve to share risk efficiently. Informal insurance arrangements are based on networks of friends and relatives. The quality of the network is important for the effectiveness of the arrangement. However, what remains unclear is what determines the quality of the network and what explains its existence. This leads to more fundamental considerations concerning the limits of informal arrangements. Two major points have to be taken into consideration:

Covariance of income risks leads to covariance of default risk. As a result, financial intermediaries would have to keep high reserve ratios. Moreover, the income of both depositors and borrowers would also be correlated. A possible solution to overcome the problem of covariate risk is the enlargement of the geographical area to widen the pool. However, this would reduce the incentive for participation, because it increases the problem of moral hazard. In a small group, control of moral hazard is more manageable than in larger groups distributed over a large area. Platteau (1991) describes this situation as the "incentive dilemma" for rural insurance arrangements.

Despite established social norms, moral hazard and free-riding behaviour cannot be fully excluded either in state and for-profit organisations or in MBOs. This is a permanent risk for the whole system. Moreover, as insurance in traditional agrarian societies is not regarded as a game with an outcome of winners and losers, several conditions for the sustainability of mutual insurance schemes have to be fulfilled. Platteau (1991) lists them as follows: random shocks are sufficiently frequent, human lives are at risk, or the need for easily enforceable rules is present. When risks are not independent, not only markets but also informal arrangements may be inadequate. To deal with the risk of natural disaster and crop failure, the insurance pool has to be enlarged. This could mean building institutions not only in one community but between several communities.

The preceding discussion suggests that, both state and market-based systems as well as member and private household-based systems have intrinsic - albeit different - strengths and weaknesses. The question arises as to what extent the provision of social security can be organised in a complementary way. The idea of organising synergy, partnership and co-production in the provision of public goods has for some time been a major component in the discussions of welfare reform in industrialised countries, but only recently has it been extended to apply to developing countries (Robinson and White 1997).

4.3 Public-private partnership to provide social security

We have so far discussed important institutional problems of building social security arrangements in rural areas of developing countries. Private household and member-based systems can handle the information problem, but have their limits in dealing with co-variate risks, in gaining access to financial resources, in internal organisation, in quality maintenance and in the sustainability of service provision. Moreover, it must also be recognised that provision by MBOs is often limited to a certain part of the population, leading to uneven or unequal coverage. Finally, the performance of these systems is highly dependent on the economic, social, political and cultural environment. Yet this environment is, for better or for worse, influenced by the state - either directly through the actions of state organisations or indirectly through the impact of policy and regulations on structural factors. In theory, the state "is the sole agency capable of providing welfare services on an across-the-board, universalistic basis founded on some principle of citizens' rights" (Robinson and White 1997, p. 24). However, as the overview of coverage rates in developing countries has shown, the reality is that this high demand could not be fulfilled in practice. Market-based systems,

on the other hand, can serve the demand for insurance for the economically wealthier part of the population by pooling risks and giving access to broader capital markets. However, due to high unit transaction costs per contract, the rural and poor population are largely excluded from market-based systems.

Table 3 summarises the strengths and weaknesses of social security providing organisations. The table should be interpreted with caution, because the + and – only indicate a relative comparative advantage and not an absolute one. Furthermore, with regard to "cost-efficiency" and "quality", we cannot generalise about a comparative advantage or disadvantage of MBOs or private households since it largely depends on the type of risk involved. MBOs and private households, for instance, have an advantage in the provision of protection against temporary disability to work, but can certainly not provide cost-efficient arrangements against floods. However, notwithstanding these limitations, the table clearly demonstrates the general point that there are strong arguments in favour of the search for prospects of a public-private partnership in the provision of social security.

Table 3: Strengths and weaknesses of social security-providing organisations

	Moral hazard	**Adverse selection**	**Covariate risks**	**Cost efficiency**	**Quality**	**Equity of access**
State-based systems[1]	--	+++	+++	--	-	++
Market-based systems[2]	+	--	++	++	+++	---
Member organisation-based systems	++	-	+/-	+/-	+/-	++
Private household-based systems	+++	++	+/-	+/-	+/-	++

+++ strong comparative advantage / (---) strong disadvantage

[1] insurance universal

[2] insurance not mandatory

Source: own presentation

The proposed partnership should extend the classical notion, meaning essentially that the state should provide an enabling environment. Evans' (1996, p. 1119) definition of synergy goes beyond mere complementarity and includes "embeddedness". He describes the basis of the partnership as "(an) intimate interconnection and intermingling among public and private actors [...] with a well-defined complementary division of labour between the bureaucracy and local citizens, mutually recognised and accepted by both sides". With regard to our conceptual framework, the "private actors" could be a set of private households, a profit-oriented firm or a non-profit oriented MBO.

Box 1 gives an example of how a public-private partnership can work in practice, highlighting some of the aspects discussed here.

Box 1: Example for public-private partnership

SEWA (*Self-Employed Women Association*) is a movement and organisation of poor self-employed women making their living in the Indian state of Gujarat. Founded in 1972, SEWA encompasses around 200,000 (1998) members.

SEWA started out by organising self-help through supporting services, including banking, child care and training. In addition to these services, the women showed a strong demand for arrangements to insure themselves against basic poverty-causing risks, such as maternity, communal riots, widowhood, accidents, death and natural disasters, which threaten their work and life. In response, SEWA began offering an "Integrated Social Security Scheme", which covers the following risks: death, accidental death, sickness, accidental widowhood, loss of household goods and work tools in event of flood, fire, riot or storm. This scheme is crucial for the long term viability of SEWA Bank, as members who face economic or social difficulties cannot pay their membership fees nor repay their loans. SEWA therefore forces its members to sign an insurance contract in order to guarantee the repayment of credit.

The evolution of membership shows that there has been a large demand for insurance. Starting with around 7,000 members in 1992, the scheme today covers more than 40,000 members (1999). In order to diversify risks, SEWA Bank has concluded group insurance contracts for life insurance with the Indian Life Insurance Company. Financing of the scheme is further ensured by German development cooperation, which donated a development and risk fund.

The role of SEWA can be seen as an intermediary between the insurance company and its members. The organisational structure of this insurance scheme offers advantages to all participants: SEWA members are insured against some basic risks, the SEWA organisation itself improves its financing base, and the insurance company has access to a new group of clients.

SEWA's success at providing social security to its members at relatively low cost can partly be explained by the organisation's experience with financial services (SEWA Bank) and the creation and accumulation of social capital among its members, which has reduced transaction, enforcement and control costs. Experience with the scheme has so far shown that insurance for people can work. However, several problems remain to be solved, the most urgent of which concern extending the systems to the entire family and integrating outpatient care into the benefit package.

Source: various publications from SEWA

In the literature there are many examples of successful cases of a public-private partnership (Taal 1993, Clark 1995) but, as Robinson and White (1997, p.31) point out, "the criteria for and evidence of success are often not specified clearly". In any case, the literature on the experience of public-private partnerships stresses the importance of the existence of social capital, which is shown to be a facilitating condition for organising complementarity (e.g. Brown and Ashman 1996).

From a theoretical point of view, the discussion on the concept of "social capital" has brought some insight into this question. The social capital of a society or a community has been defined in terms of "relationships that are grounded in structures of voluntary associations, norms of reciprocity and co-operation and attitudes of social trust and respect" (Brown and Ashman 1996, p. 1470). Empirical work has shown that social capital has a positive influence on economic growth (Knack and Keefer 1997), that it can lead to more efficiently operating government structures (Putnam 1993), that it has a positive influence on household incomes (Narayan and Pritchett 1997) and that it is an important element in the complex asset portfolio of poor people, which reduces their vulnerability (Moser 1998). In several of these and other studies, one important indicator for the level of social capital within a community is the existence of MBOs. Memberships in groups and networks and a local affiliation seem to facilitate information exchange and participation, thereby reducing transaction costs and helping to build trust and social cohesion.

Whereas it has widely been accepted that social capital somehow matters for successful cooperation between the state, market and MBOs, several questions remain open. A generally accepted definition or concept of social capital is still missing and the difficulty of how to create social capital where it does not exist or how to mobilise it for the pursuit of synergy still remains. More specifically, in an environment of economic crisis and fiscal distress it may be difficult to organise complementarity. As Putnam (1993) has found out, the building of social capital depends upon basic structural factors such as the state's capacity, the degree of cohesion within local communities and the extent to which the social structure is egalitarian. The key question now is how to build institutional bridges in a situation where there are insufficient resources and assets and where the relationship between public authorities and the private and non-profit sector has been distant or antagonistic.

In addition to the aforementioned factors, co-provision of social security largely depends on the willingness of the state to cooperate. A recent study by Berman (1998) of private health care provision in India is enlightening is this respect. The author describes the important role of private health care providers – both profit and non-profit – in financing health care and meeting the demand and needs of the population. Private outpatient health care providers account for about half of all health spending in the country and are the dominant source for almost all diseases of public health importance for which outpatient treatment is a significant intervention. Moreover, they are the dominant providers for the urban and rural poor. Despite this fact, the government largely ignores these activities in planning public action. Instead of considering cooperation, the government has tried to set up a national universal health system in which there is no place for private providers. However, as Berman concludes, the state has been unable to compete against the much more

extensive system of private providers. Given this outcome, there are major opportunities for a public-private partnership in the Indian health sector. Berman mentions, among other points, the integration of private providers in national disease control programmes and health care planning at the local level, the training of private providers in standard treatment and referral practices, the use of public funds to finance private provision and to support new local health care financing initiatives. The Indian situation is not unique. A similar situation can be observed in several developing countries. It becomes quite clear that a necessary pre-condition for a cooperation between different providers of social security is that the state accepts that it cannot do the job alone and has to withdraw and give up some of its activities.

5 Conclusion on Policy Action and Research Needs

Policy action

Our literature survey on social security systems in rural areas has shown that it has proven to be non-feasible and economically inefficient to provide social security exclusively by public authorities. Yet, given the various institutional difficulties, market, member and private household-based systems cannot, on their own, provide social security to a sufficient extent either. For policy action, one should set priorities according to the level of the hypothesised size of information problems and the estimated level of social capital in a specific region or community. The greater the information problem and the lower the stock of social capital, the smaller is the scope for private engagement and public-private partnership. Or, put the other way round, in relatively well-integrated regions with plenty of associational activity, private engagement in the provision of social security is easier to initiate.

Moreover, policy interventions which lower transaction costs for private insurance companies, such as the support for modern information and communication technologies, are helpful in improving the supply of social security. Dealing with the information problem is essential, as the experience of the developing countries shows. An interesting example in this respect is the beginning of the cooperative movement in Germany, associated with the names of Raiffeisen and Schulze-Delitsch. The institutional strengths and weaknesses of the cooperatives in their initial phase are quite similar to those currently faced by MBOs in developing countries. Hence, it is worthwhile considering policy measures which would facilitate coordination and cooperation between organisations or within organisations at different levels, such as community, district, regional and national level.

In regions with a more advanced physical infrastructure, the state and the international community should put emphasis on the establishment of an enabling environment that fosters the activities of profit and non-profit organisations. The tight restriction by governments on the role of private engagement - as seen in the case of the health sectors in Africa or India - should be relaxed. On the contrary, governments should be helping private companies and MBOs to engage in the provision of insurance and basic social services. For the profit sector, this can be done by integrating private activities into public policy. In the case of health care provision private providers could contribute to problem identification, screening, treatment, patient monitoring and community assessment and evaluation. For non-profit organisations these might include tax concessions,

simplified administrative procedures, additional sources of funding, and opportunities for training and further education.

In addition to greater political commitment to accepting other providers of social security, balanced decentralisation and the principle of subsidarity are important elements in the general framework needed achieve better access to insurance and basic social services. The international community could help build this framework by providing expertise based on its own experience.

Research needs

Research has too long focused on different aspects of the "formal systems", in the sense of state-based systems offering compulsory social insurance schemes. With the growing financial crisis in developing countries at the end of the 80s, the discussion has concentrated on the reform of state-based health and pension schemes to reduce costs and to relieve the public purse. Increasing attention has also been given to the impact of social security systems on the economy as a whole and on the question of how to manage and design specific schemes to achieve cost-effective coverage of the population. Another strand of the literature has focused on the role, functioning, and limits of "traditional" systems. Moreover, the literature has paid a lot of attention to investigating whether rural households can completely smooth consumption and income.

By contrast, only very limited attention has been given to the institutional design of insurance arrangements for helping households and individuals to cope with major risks. Innovative institutional arrangements such as the various health insurance schemes operating at community level in several African countries would be a very interesting subject for case studies, since they have shown their potential benefits, including the regularisation of health expenditures of members and improvement in quality of health services (WHO 1998). A promising line of future research would include comparative studies in different countries to open up the "black box" of insurance contracts and derive lessons that would help policy advisors to improve existing systems. The major components of a research agenda should include the following four aspects:

1 Estimating the effective demand for social security

Research has shown that the demand for social security is especially large in rural areas, in particular by poor people. Despite this fact, we are still far from identifying practical solutions to bring demand and supply into an equilibrium (Zeller et al. 1997). In order to formulate useful and practical policy recommendations, however, much more information on the demand side is needed. Questions such as "What kind and what type of social security do people want? How much are they willing to pay for it?" have to be addressed.

2 Optimal institutional design of a social security system

In order to tackle the question of an "optimal" design of social security systems properly, we need more comparative case studies which highlight the institutional mechanism of risk management in different socio-economic settings and agro-ecological zones. The question here is how well the design of social security system responds to local conditions. This provides a basis for more detailed research on how these systems function in times of a changing environment. Factors driving a changing environment might be different in the cases studied and will have to be identified, but it is often market penetration, migration and exogenous shocks, such as disasters and violent conflicts, that play a major role. New forms of insurance contracts should bear in mind their effects on the existing systems.

To improve the situation of the rural poor in terms of better access to efficient insurance arrangements, one should start by thinking about mechanisms to deal with the problem of covariate risks. Insurance for those "in-between risks", like natural disasters, exist in the developed world. These insurance arrangements are based on the idea of reinsurance, which means that, at certain levels of risk, the primary insurance passes to the international reinsurance market or to the government. The provider of this reinsurance could either be the state, through subsidies, or the market. Research could contribute to a evaluation of the possibilities of reinsurance in rural areas of developing countries.

In this context, a very important research focus is the analysis of how MBOs, private companies and public authorities could interact and produce synergies. Every organisation has its specific comparative advantages, so a properly designed combination might well succeed in lowering transaction costs by exploiting local information, on the one hand, while enhancing the possibilities of risk pooling and fostering a better access to risk capital, on the other. Part of this task is to carefully specify the factors – both favourable and unfavourable – which favour synergy. This analysis of the prospects of a public-private partnership requires a careful look at the state of social capital and the extent of the information problem.

3 Economic impact of introducing insurance schemes

The introduction of insurance schemes in rural communities has various economic impacts. It is assumed that the risk-reducing effects of insurance lead to higher incomes as people alter their investment and production behaviour. So it would be interesting to know how the demand for insurance and the supply side interact as new markets are created. In the case of health insurance, it cannot be taken for granted that the providers will immediately respond by offering more and better services.

4 Policy level

At the policy level, research could create some insights into the ways in which public organisations might contribute to facilitating private engagement in rural areas. Research in this context could highlight examples of public organisations that have contributed to a substantial reduction of transaction costs for private firms. It would also be interesting to consider which services or insurance schemes should be entirely left in the hands of a MBO and which areas would be best served by cooperation between public authorities and private companies.

Empirical case studies in different socio-economic settings and agro-ecological zones are necessary to obtain a deeper insight into the mechanisms needed to establish efficient social security systems in developing countries. An essential element in such studies is the identification of factors which promote partnership between the state, the market and MBOs. These factors can then serve as important reference points for the formulation of policy measures designed to improve the social situation in rural areas.

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