

Social security systems in low income countries: Concepts, constraints and the need for cooperation

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Abstract:

This paper describes existing systems of social security in developing countries and analyses their institutional strengths and weaknesses. To this end, the paper identifies four main providers of social security, namely the state, the market, member-based organisations, and the private households. Given the weaknesses of each system, the paper explores the possibilities of a public-private partnership which should be based on local information on the one hand, while profiting from possibilities of risk pooling, reinsurance and better access to risk capital on the other.

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 is 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 risks². 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 market-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.

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

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² See van Ginneken (1999) for more details on coverage rates across continents.

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 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 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: After having introduced a classification scheme for social security systems, Section 2 presents an overview of the importance of state, market, community and private household based systems in the developing world. Following that, Section 3 analyses the implications 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 discussed in Section 4. The paper closes in Section 5 with reflections on further research needs.

2 Social security systems in developing countries

2.1 Changing concepts and understandings of “social security”

The western concept³ of social security has greatly influenced the discourse about social security. The ILO was for a long time the only international agency with academic capacities as well as field experience in designing state organised social security systems and had thus dominated the international debate. In fact, the understanding of social security as referring to mainly specific 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). The ILO-definition (ILO 1984) indicates the main stream understanding of social security 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 enumeration of risks as done in the ILO definition (ILO 1984) refers to a specific ecological and socio-economic setting in Western countries. It does not cover risk insurance against environmental and medical contingencies as drought, earth-quakes, floods, epidemics (Leliveld 1991). **Whereas this understanding has been dominated to a large extent the policy debate on social security in the 70s and 80s, recently a change can be observed: The international community has become increasingly aware of the need to broaden the concept of social security and to have a specific look for self-employed and informal sector workers.**⁴

In the following, social security refers mainly to the protective aspect⁵. 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

³ With “western concept” we refer to the Bismarckian/Beveridge model of social security which relies mainly on the government to provide retirement income, health care and protection against income, broadly called “social insurance”.

⁴ ISSA has recently edited a special issue of the *International Social Security Review* (1/99) with the focus on self-employed and informal sector workers in developing as well as in developed countries.

⁵ 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,...).

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 discussions on social safety nets which generally focus on state-financed activities⁶.

Furthermore there is no consensus in the literature on the definition of social security; no clear classification raster of social security systems exists which is widely accepted in the international community. Especially German authors often use an approach which classifies social security systems as “formal” or “traditional”, sometimes including a third category “informal”. Other authors use categories 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). Jütting (1999) criticises three basic points of this “conventional approach” to classify social security systems. First, a quasi automatic development from traditional to formal systems in the developing world following a sort of path-dependency is assumed, but cannot be observed, even in developed countries. Second, it is difficult to distinguish between “traditional” and “informal”. This is shown by the example of the “informal” saving and loan groups which exist in several Latin American countries since the 18th Century. Additionally, “private” systems may be for-profit or non-profit, therefore including elements from the traditional systems. Third, a theoretical underpinning and a relation to incentives and actions which drive the foundation of social security providing institutions is lacking. Jütting (1999) therefore proposes a new classification system which is built on institutions.

2.2 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

⁶ Social safety nets involve targeted social services and benefits as well as project-based social funds.

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 backbone of social security systems in developed countries.

In the following we will focus on member-based organisations (MBO's) 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 level⁷. 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”.

From an institutional perspective, the main difference between the state, the market and civic 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, MBO's are bound together by self-interest, local affiliation and solidarity and the private household essentially by social norms and values (Table 1).

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).

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

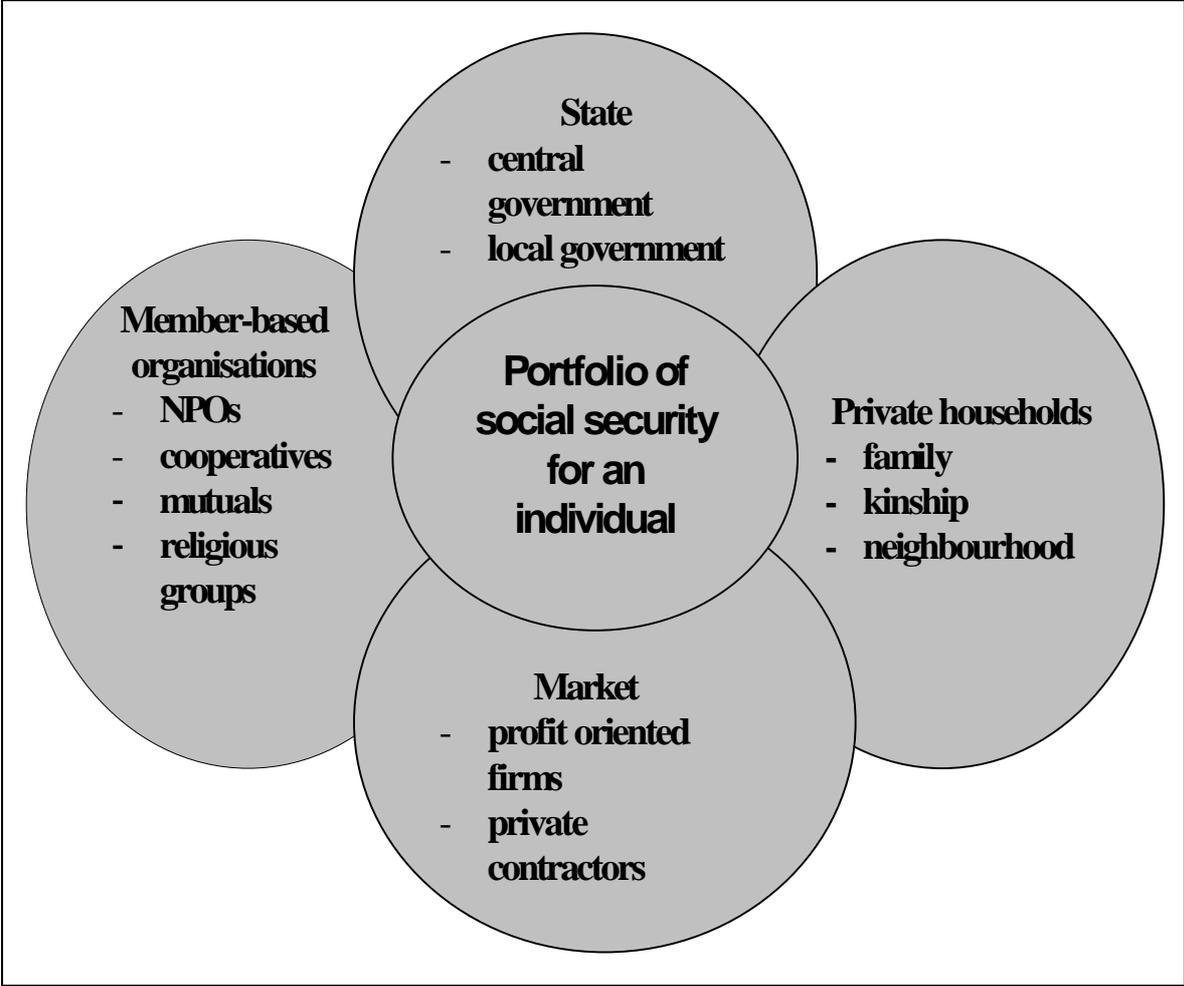
Source: Jütting (1999)

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 for this are MBO's which have a formal corporative relationship with the state in the form of the

local government. Moreover, the existence and the importance of MBO's 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: Jütting (1999)

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.

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.

2.3 Spread and coverage of social security systems in developing countries

State based systems

Social security is a world-wide phenomenon, which is not restricted to developed countries. Today, state based social security in form of social security programs exists in 172 countries (US SSA 1997). However, 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). While social security provided by the state or state initiated organisations covers most of the labour force in the organised sectors of the public and industrial employment, the vast majority of the unorganised rural population and people in the informal urban sector are left out (Jenkins 1993 for Africa; Singh 1994 for Asia and the Pacific; Mesa-Lago for Latin America 1991).

Beside low coverage rates, state based systems face serious 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 able is the organised, formal sector to finance social security for it. The alternative, to use the tax base – personal, enterprise income taxes and indirect taxes – 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 the effectiveness and efficiency of the organisations, which are in charge of collecting contributions and paying benefits, are often criticised. The administration of the social security system is highly complex: Keeping the records, ensuring the compliance of employers and employees, organising an effective control of the agencies and in terms of the regulatory structure demands a well functioning administrative structure. In many developing countries, however, these arrangements are far from functioning properly (Gillion 1997).

Looking at the current situation of state based social security systems a changing economic and social environment and the growing old of the population are heavy tasks which developing countries face. The economic and financial crisis in which several developing countries were found 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 about 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 has come up. Taking the world as a whole, the proportion of the population over 60 will increase from approximately 9 % in 1990 to just over 16 % by 2030. This has different 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 in discussions on the reconstruction of the whole economy. In this context there is a heated debate, whether a revision of the common social security type in Europe – 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 of state based social security schemes in the whole clearly demonstrates the need to look for alternatives. We will therefore investigate, if 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 centers 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.⁸

In addition to the discussion on state-based pension systems in developing and developed countries, there have been discussions on the extent to which market elements can be introduced in the health sector. With regard to developing countries, a study by Berman

⁸ 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).

(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. They act as complements or as substitutes for the government and the private sector (Lam 1996, Ostrom 1996, Uphoff 1993, Thorbecke 1993).

Member organisations based systems

The specific attributes of MBO's are that their size is small to medium varying between 10 to 500 members. The members are usually based in one community, so that they face a similar socio-economic background and the organisation operates in a decentralised way. It is a voluntary association and the purpose is to serve member interest or the collective rather than maximising profit. Although data on the role of MBO's in social security provision on a world-wide level are not available, their role can hardly be underestimated. MBO's are involved in the financing and 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 scheme⁹. 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

⁹ Dror and Jacquier (1999) present on the basis of several pilot cases a promising concept of group based health insurance schemes and explain its rationality as well as its components.

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 MBO's 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 in general MBO's 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 to mobilise resources or to demand services from the state. MBO's not only provide health facilities and disease prevention and are engaged in social welfare activities, as care for vulnerable groups or support activities such as training and the procurement of drugs, but 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).

Apart from health care providing organisations, credit and saving associations play a very important role for individuals 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 are based on accumulate savings which is 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: The Burkinabé Caisse Villageoise d'Epargne et de Crédit den Bangh in Burkina Faso, the Grameen Bank and the Rural Advanced Committee in Bangladesh as well as village banks in The Gambia, Madagascar, Mali and Senegal serve the demand for insurance and combine lending operations with the clients' need to ease personal emergencies. These insurances 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 system can – to a certain extent – cope with major risks affecting peoples' lifes (e.g. Townsend 1994, Morduch 1991, Paxson 1992, Jacoby and Skoufias 1995). A relatively smooth consumption behaviour

of poor households is a strong hint that poor people use 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. 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 state-contingent transfers and loans, remittances, long term labour contracts, share tenancy and crop insurance (Alderman and Paxons 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, Abraham and Platteau 1995, Fafchamps 1992). In addition, further studies (e.g. Rosenzweig 1988) show that intra- and interhousehold transfers between related or proximate individuals are appropriate measures to deal with information asymmetries and resource constraints, which often prevent market institutions to develop or to work 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).

To which extent private households can insure their members sufficiently against risks is debatable. It has been recognised that community 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.

3 Institutional aspects of social security systems in rural areas

3.1 Constraints to the formation of state and market based systems in rural areas

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 the information-flow 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.

3.2 Limits of community and private household based systems in rural areas

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, MBO's can handle the information problem quite well due to the social cohesion among the members. However, MBO's 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 MBO's 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 MBO's 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 MBO's work with poor people and disadvantaged communities (Pachauri 1994 for India). However, as the common bond of MBO's is often formed along religious or ethnic lines, 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 MBO's. 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 MBO's. 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 Towards a public-private partnership to provide social security in rural areas

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 MBO's 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 2 summarizes 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 MBO’s or private households since it largely depends on the type of risk involved. MBO’s 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 2: Strengths and weaknesses of social security-providing organisations

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

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

* insurance universal

** insurance not mandatory

Source: Jütting (1999)

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.

In the literature many examples for successful cases of a public-private partnership (Taal 1993, Clark 1995) can be found, however, 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 MBO’s. 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 MBO’s, 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) on private health care provision in India is enlightening in 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. 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.

Policy, technical cooperation and research has too long focused on different aspects of the „formal systems“, meaning state based systems as compulsory social insurance schemes, for a long time. It is now high time to broaden the concept of public-private partnership, to take into account the variety of civic organisations engaged in the provision of social security and to formulate and evaluate pilot projects which experiment with different forms of partnerships (van Ginneken 1999)

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