

# Extending social insurance to informal workers

## A gender analysis

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### Abstract

Informal workers face high levels of risks yet the majority are not covered by social insurance. Meanwhile, women informal workers face specific and heightened risks, yet more women than men are excluded from insurance schemes. Increasingly a number of countries are extending social insurance to informal workers, but, with only some exceptions, most policies remain gender-blind or gender-neutral. Gender-responsive reforms can ensure increased coverage of women, including of female informal workers, to address the risks they face. These include; (i) legislation in the labour market; (ii) recognition of the care economy; (iii) innovative policy design in payment options and simplified administrative processes; and (iv) investment in gender-sensitive delivery capacity

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# Preface

This paper is part a series of literature review reports which assess the barriers to participation in social protection schemes of female informal workers and internal migrants. The first review focuses on the participation of female informal workers in social protection programmes. The second review examines the extension of social insurance to female informal workers. The third review discusses internal migrants' participation in social protection programmes. Each paper in the series assesses to what extent these population groups participate in social protection schemes, and discusses the policy implications for extending social protection programmes to these groups.

- Ulrichs, M. (2016) 'Informality, women and social protection: Identifying barriers to provide effective coverage', ODI Working Paper April 2016. London: ODI.
- Holmes, R. and Scott, L. (2016) 'Extending social insurance to informal workers – A gender analysis', ODI Working Paper April 2016. London: ODI.
- Hopkins, E., Bastagli, F., and Hagen-Zanker, J. (2016) 'Internal migrants and social protection: A review of eligibility and take-up', ODI Working Paper April 2016. London: ODI.

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# Abbreviations

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
CSMBS	Civil Servant Medical Benefit Scheme
GVA	Gross Value Added
HISRO	Health Insurance System Research Office
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
INWORK	Inclusive Labour Markets, Labour Relations and Working Conditions Branch
MWS	Medical Welfare Scheme
NGO	Non-Governmental Organisation
NHIS	National Health Insurance Scheme
OECD	Organisation for Economic Co-operation and Development
SEWA	Self-Employed Women's Association
SHI	Social Health Insurance
SSS	Social Security Scheme
SWaCH	Solid Waste Collection and Handling
UCS	Universal Coverage Scheme
UHI	Universal Health Insurance
VHCS	Voluntary Health Care Scheme
WHO	World Health Organization
WIEGO	Women in Informal Employment Globalizing and Organizing

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# Executive summary

Social protection policies are an important component of strategies to tackle poverty and the ‘leave no-one behind’ agenda. However, recent years have been somewhat of a paradox in social protection. On the one hand, social protection expenditure has been subject to contraction, through fiscal consolidation and adjustment measures in the context of global financial crises. Worldwide, approximately 73% of the population remains uncovered by adequate social protection schemes (ILO, 2014), and contributory social insurance schemes continue to cover only a fraction of the working population – typically only formal sector workers in most low-income countries. On the other hand, there has been a global trend in the extension of social protection, with particularly notable experiences of countries expanding social assistance (non-contributory, means-tested or categorically targeted programmes for vulnerable groups) to the poor as well as extending social insurance schemes (state-led contributory schemes that protect beneficiaries from certain risks and catastrophic expenses) to workers in the informal economy.

This paper concentrates on the extension of social insurance coverage to female informal workers. The focus was chosen because in many countries women are overrepresented in the informal workforce, and in almost all countries they are overrepresented in the worst, and most invisible, forms of informal work. Meanwhile, a higher proportion of women relative to men are excluded from social insurance programmes and face gender-related risks that exclude them from participating in and benefiting equally from social insurance programmes. Social insurance is seen as a particularly important instrument to provide protection from risks, given fiscal restrictions on the widespread coverage of social assistance and the need to design and implement contributory schemes to cover an informal workforce that, in most low- and middle-income countries, makes up the majority of the working-age population.

Specifically, we apply a gender lens to examples of where social insurance programmes have been extended, asking to what extent **gender gaps in coverage** have been reduced, and whether programmes **adequately address women informal workers’ needs**. We examine country examples where the state has spearheaded extension of coverage in contributory pensions, social health insurance and (to a lesser extent) maternity insurance. We focus, in particular, on the experiences of Brazil, Chile, China, Ghana, Rwanda, South Africa and Viet Nam. In doing this, we look at four questions: 1) How do social insurance schemes cover different risks across the lifecycle? 2) How do insurance schemes take account of gender inequalities in the labour market? 3) How does an unequal division of labour affect access to, and benefits from, social insurance? and 4) How are social insurance schemes affected by gender inequality at the intra-household and wider society level?

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# 1 Introduction

A renewed focus on women and girls' empowerment and ending gender-based discrimination is increasingly becoming a top policy priority. This has most recently been demonstrated through strengthened international commitments such as the advancement of the Sustainable Development Goals agenda, and the first UN High Level Panel on Women's Empowerment.

Recognition of the importance of gender-based inequalities has not only highlighted again the role of inequality and discrimination in men and women's experiences of poverty and vulnerability, but also goes hand-in-hand with the need to design and implement gender-responsive poverty reduction strategies.

Social protection policies are an important part of this wider strategy to tackle poverty and the 'leave no-one behind' agenda. A coordinated package of social assistance, social insurance, labour market and care programmes prevent individuals and their families from falling into or further into poverty, promote access to basic services, contribute to economic growth by raising labour productivity and can strengthen social relations (Tessier et al., 2013).

However, recent years have been somewhat of a paradox in social protection. On the one hand, social protection expenditure has been subject to contraction, through fiscal consolidation and adjustment measures in the context of global financial crises. Worldwide, approximately 73% of the population remains uncovered by adequate social protection schemes (ILO, 2014) and contributory social insurance schemes continue to cover only a fraction of the working population – typically only formal sector workers in most low-income countries. The informal economy is large, however, and in some countries continues to grow, with millions of people working in it (ILO and WIEGO, 2013). In particular, women are highly represented in the lowest paid and most vulnerable forms of informal work.

On the other hand, there has been a global trend in the extension of social protection. There have been particularly notable experiences of countries expanding social assistance (non-contributory, means-tested or categorically targeted programmes for vulnerable groups) to the poor as well as extending social insurance schemes (state-led contributory schemes that protect beneficiaries from certain risks and catastrophic expenses) to workers in the informal economy. This paper focuses on the latter, drawing on experiences from Brazil, Chile, China, Ghana, Rwanda, South Africa and Viet Nam where rapid extension or reforms of social insurance have taken place, and expanded the reach of schemes to informal workers. For instance:

- Brazil and South Africa have extended social insurance schemes to domestic workers, which now entitle them to unemployment insurance (South Africa) and maternity provisions (both countries). In Brazil, the proportion of domestic workers contributing to the Social Security Institute increased from 18% in 1993 to 30% in 2007 (Addati and Cheong, 2013).



- Chile introduced pension reforms in 2008, including top-ups for workers with low pension contributions and child credits – particularly beneficial for women workers (UN Women, 2015).
- China has seen rapid expansion across its various social insurance schemes. For example, in rural areas, the new social health insurance scheme, the Rural Medical Cooperative Scheme, had enrolled more than 830 million people by late 2009 (Jones and Stavropoulou, 2013).
- Ghana's National Health Insurance Scheme (NHIS), introduced by the government in 2003, aims to attain universal health insurance coverage and ensure equitable health care. In 2010, 66% of the population was registered with the NHIS.
- Following a pilot project in 1999/2000, Rwanda's Mutuelle de Santé scheme (community-based health insurance) covered 90% of the population in 2012.
- Viet Nam aims to achieve Universal Health Insurance (UHI) coverage through mandatory insurance. By 2014, 72% of the population had health insurance.

The extension of social insurance schemes to include informal workers, as well as the development of new schemes to cover this previously excluded group, represents positive progress towards reducing poverty and vulnerability for the poor. This is especially important given high rates of poverty and vulnerability among informal workers, and the sheer size of the informal economy (ILO and WIEGO, 2013).

This Working Paper focuses on the extension of coverage of social insurance to female informal workers. It looks at the barriers and gaps in coverage, and highlights instances where progress has been achieved. Where appropriate, it also draws on innovations in micro-insurance<sup>1</sup> that have proven particularly successful in extending insurance to low-income populations and specifically responding to their needs. For an overview discussion of the barriers to, and successes in, extending social protection, both social assistance and social insurance, to female informal workers, see Ulrichs (2016).

This paper concentrates on the extension of social insurance coverage to informal workers, given fiscal restrictions on the widespread coverage of social assistance and the need to design and implement contributory schemes to cover an informal work force that, in most low- and middle-income countries, makes up the majority of the working-age population. In some contexts, non-traditional and informal work is even growing, partly because of the contraction of the formal sector in many developing countries (van Ginneken, 2009), as well as in some developed nations following the global financial crisis (Chen, 2012). In many countries, women are overrepresented in the informal workforce; in almost all countries, they are overrepresented in the worst forms of informal work: they receive low wages and are employed in casual work and risky work environments (ILO, 2012a).<sup>2</sup> At the same time, however, women are less likely to be covered by social insurance schemes, despite the recent extension of coverage in some countries (ibid.).

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<sup>1</sup> The definitions of micro-insurance vary: in some countries it is defined as insurance for the low-income population; others define the 'micro' according to the level of society the insurance operates at (community-based groups as the insurers and/or the consumers of insurance); and in others it is defined as the product itself. Many organisations, countries and academics incorporate a combination of definitions of micro-insurance (defined by Churchill, 2006), which meet the needs of the low-income population and is affordable (e.g. have low premiums) (Ingram and McCord, 2011). In contrast with state-led strategies extending social insurance, the advances of micro-insurance schemes in delivering social insurance tend to be through non-state actors.

<sup>2</sup> See also <http://www.oecd.org/gender/data/womenandinformality.htm>

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The unequal access, coverage and provision of social insurance for women is a critical concern for reducing poverty and inequality. Not only do experiences of poverty and vulnerability differ for men and women, but also women face specific lifecycle risks, which require particular attention and coverage from social insurance schemes (e.g. to reduce the risks associated with childbirth). Moreover, there are important indirect implications of unequal coverage, including increasing women's participation in informal work and exacerbating care work burdens.

The objective of this paper therefore is to examine experiences of extending social insurance to women informal workers.<sup>3</sup> Specifically, we apply a gender lens to examples of where social insurance programmes have been extended, asking to what extent **gender gaps in coverage** have been reduced, and whether programmes **adequately address women informal workers' needs**. We examine country examples where the state has spearheaded extension of coverage in pensions, health insurance and (to a lesser extent) maternity insurance. It is important to note that the evidence on gendered insurance schemes and systems is much thinner than that on social assistance programmes. This paper should be seen as a contribution to examining the status of this evidence base, and identifying areas of future research to strengthen knowledge on gender and social insurance.

In the next section, we look at recent trends in women's labour force participation and develop a conceptual framework for analysing social insurance from a gender perspective. Section 3 then discusses the reasons why a gender gap in social insurance coverage exists and looks at the barriers that persist in creating unequal coverage and inadequate benefits for women. Section 4 examines how social insurance is being extended to informal workers, and, drawing on country-specific examples, analyses the extension of social insurance experiences using a gender lens. We ask 1) whether extension mechanisms are inclusive of women informal workers (e.g. coverage) and 2) whether they respond adequately to women workers' needs.

Finally, we conclude by summarising the main findings, and draw lessons from these experiences to offer policy implications to inform the design and implementation of social insurance to benefit female informal workers.

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<sup>3</sup> This paper builds on Ulrich's (2016) review of social protection to female informal workers.

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## 2 Trends and concepts: Gender dimensions of informal work and social insurance

Understanding the ways in which women and girls experience poverty, vulnerability and risks differently from men and boys is critical to developing appropriate gender-responsive poverty reduction policies. All too often, however, these are still overlooked. Here, we provide an overview of recent trends in women's participation in the informal labour market. We then look at how social insurance is conceptualised in the literature, and ask what the key questions to consider are when analysing social insurance using a gendered lens.

### 2.1 Women's participation in the informal labour market

Over the past 30 years there has been an increase in women's labour force participation. Latin America, the Middle East and North Africa and Sub-Saharan Africa have all experienced relative increases in women's labour force participation rates (Razavi et al., 2012). This has been the result of multiple factors, including growth in economic sectors such as manufacturing trade and export processing as well as agricultural export crops, which have employed a significant proportion of women. Social and political factors have included increased education of girls, a reduction in fertility rates and changes in social norms around the acceptability of women in work (ibid.).

At the same time, however, the terms on which women have entered the labour force, and the types of work in which they are employed, vary widely. Women represent a high proportion of the millions earning a living from the informal labour market.<sup>4</sup>

Informal employment refers to all work in unregulated jobs that have little or no protection by labour standards, where workers are denied labour rights and social security legislation (such as maternity leave, health insurance or unemployment insurance) and that lack organisation and representation (ILO and WIEGO, 2013; Razavi et al., 2012; Tessier et al., 2013). Informal workers earn less than formal workers, and the types of jobs they do often put them in hazardous, precarious and vulnerable working situations (ibid.). They have little or no protection against the risks or uncertainties in their work (such as late payments, safety of their workspace, etc.) or against common contingencies of illness, disability, property loss and death (Chen, 2012). An extreme example of this was highlighted by the collapse of Rana

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<sup>4</sup> ILO and WIEGO (2013) find that, in more than half of the 47 countries included in their study, more than 50% of people work in informal employment in non-agricultural activities, and in about a third of the countries informal employment accounts for at least 67% of non-agricultural employment.

Plaza in Bangladesh in 2013, which killed and injured hundreds of garment workers – yet millions of informal workers continue to work in hazardous environments every day. For instance, agriculture is one of the most dangerous industries to work in,<sup>5</sup> with a high fatal accident rate and high risks of exposure to pesticides and chemicals.<sup>6</sup>

Informal employment can be categorised according to employment in the informal sector and in informal employment outside the informal sector (see Box 1).

### Box 1: Categories of informal employment

Employment in the informal sector:

- employers in informal enterprises
- employees in informal enterprises;
- own-account (self-employed) workers in their own informal enterprises
- contributing family workers working in informal enterprises and
- members of informal producers' cooperatives

Informal employment outside the informal sector:

- employees in formal enterprises not covered by social protection through their work
- paid domestic workers not covered by social protection through their work; and
- contributing family workers working in formal enterprises

Source: ILO and WIEGO (2013).

The informal economy has significant gender differences. An International Labour Organization (ILO) and Women in Informal Employment Globalizing and Organizing (WIEGO) study in 2013 found that, in 30 out of 41 countries reviewed, the percentage of women in informal non-agricultural employment was higher than that of men. In a number of countries, the gap is large: in Zambia, for example, 80% of women work in informal employment compared with 63% of men; in Mali it is 89% versus 74%; in Sub-Saharan Africa and South Asia, the proportion of women as contributing family workers in total employment reached 40% and 39%, respectively, of working women, compared with 10% and 11% of working men.

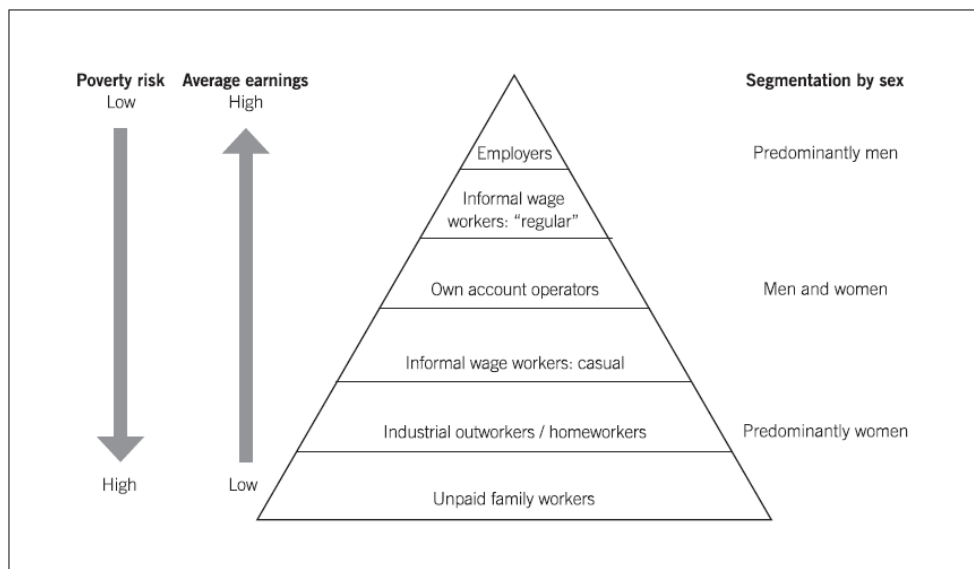
In other countries, the gender gap is much smaller: in India, for example, 85% of women work in informal employment compared with 83% of men; in Indonesia it is 73% versus 72% of men (ILO and WIEGO, 2013). There are not only gender differences in the number of women and men working in the informal economy, but importantly, also differences across sectors. In the majority of countries, more women than men work in **informal non-agricultural employment jobs outside the informal sector**, but more men than women work in **non-agricultural informal sector employment** (ibid.). As Figure 1 and Box 2 below show, women are concentrated in more precarious forms of employment with low and unstable wages, and high risks of poverty – women tend to be overrepresented in domestic work, in home-based work, as street vendors and as unpaid contributing workers in agriculture (Chen et al., 2005; ILO and WIEGO, 2013). Much of this work is invisible and, with

<sup>5</sup> Agriculture, mining and construction are the three most hazardous sectors of activity.

<sup>6</sup> [http://www.ilo.org/safework/areasofwork/hazardous-work/WCMS\\_110188/lang--en/index.htm](http://www.ilo.org/safework/areasofwork/hazardous-work/WCMS_110188/lang--en/index.htm)

only a few exceptions, within employment categories women's earnings are lower than men's (Chen et al., 2005).

**Figure 1: WIEGO model of informal employment – hierarchy of earnings and poverty risk**



## Box 2: Key statistics on domestic workers, home-based workers and street vendors

### Domestic work

- Women accounted for about 83% of the 53 million counted domestic workers in 2010 (almost 44 million).
- These figures do not include the estimated 7.4 million children below the age of 15 years who are engaged as domestic workers.
- The estimate of 53 million is equivalent to 3.6% of global wage employment, and represents a far higher share in regions such as Latin America (11.9%) and the Middle East (8%), where one in four women wage employees and one in three, respectively, is a domestic worker. Domestic work is also a major employer of women in Asia and Africa.
- Many of the 44 million women domestic workers are migrants. Women are concentrated in cleaning and care services, whereas male domestic workers tend to have better-paying jobs as gardeners, drivers or security guards.

### Home-based workers

- The vast majority of home-based workers are women – for example 62% in South Africa, 70% in Brazil and 88% in Ghana.
- In India, home-based workers represent 18% of the share of urban employment; in South Africa this is 6% and in Buenos Aires it is 3%.
- A significant proportion of home-based workers are to be found in manufacturing and trade. In India and eight cities in Africa (excluding South Africa), the majority of home-based workers are self-employed, mainly as own-account workers.

### Street vendors

- In many countries, especially in Africa, the majority of street vendors are women: 63% in Kenya, 68% in South Africa and 88% in Ghana. In Buenos Aires, by contrast, only 29% of street vendors are women.
- Street vendors constitute a significant proportion of urban employment in Africa, including South Africa (15%), but less so in India (11%) and even less so in Latin America (3% in Brazil).

### Smallholder farmers

- Half of the world's population works in agriculture: 60% are self-employed as farmers, mainly as small farmers.
- In most African countries, agriculture accounts for 70% of the labour force. Women often provide much or most of the labour.
- Unpaid work on family farms accounted for 20% of women's informal employment in Ghana, 34% in India, and 85% in Egypt.

Source: Chen et al. (2005); ILO and WIEGO, 2013

The scale of informal employment cannot be underestimated: millions of individuals work in the informal economy and its economic contribution to gross value added (GVA) and household income is significant (Chen, 2001; ILO and WIEGO, 2013). ILO and WIEGO report that the number of domestic workers increased from 34 million in 1995 to 53 million in 2010. Women represent 83% of this 53 million. However, because informal work operates outside of regulations and protection, informal groups remain largely invisible in official statistics. Domestic work is an exception here as it is often identified in official national statistics, although workers are often undercounted and misclassified (ibid.). As such, even the estimated 53 million domestic workers in 2010 is likely an underestimate. The recognition and thus visibility of this employment has significant implications for policy, however, as Section 4 discusses further.

The share of the informal sector, excluding agriculture, in non-agricultural GVA is significant. In Benin, Niger and Togo in West Africa, for instance, the informal sector, excluding agriculture, accounts for more than 50% of non-agricultural GVA. In India, the contribution of the informal sector to the economy, excluding agriculture, is also very high, at 46% of non-agricultural GVA in 2008 (ILO and WIEGO, 2013). According to components of the informal economy, women's share is higher in informal employment outside the informal sector than within the informal sector (30.6% compared with 26.5%) (ibid.).

The rise in women's labour force participation rates in the informal sector and inequalities within the informal sector owe to a number of interrelated factors. Women's lower levels of education, skills and resources all contribute to their working in informal labour markets as well as explaining wage differentials (Tessier et al., 2013). Razavi et al. (2012) argue that women coming to the labour market with different types of skills and experiences to, as well as less capital, contacts and other resources than, men is itself a reflection of broader societal structural discriminatory forces, including care-related interruptions in paid work.

Domestic work and care responsibilities shouldered by women result in significant time poverty for women, making engagement in paid work a challenge (Tessier et al., 2013). For instance, in some countries, women take on an extra ten or more weeks per year of unpaid care work (based on a review across 66 countries), and on average

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spend 45 minutes more than men daily on paid and unpaid work – and over two hours more in the most unequal countries (Samman et al., 2016). Women’s employment is likely to be interrupted or reduced, for example when children are very young or a family member is sick, and they may prefer more flexibility in terms of the physical location or timing of activities (such as informal industrial outwork) that pay less well. While this ‘reproductive work’ is indispensable to the functioning of the ‘productive economy’, it remains invisible, and women are penalised for this work in terms of their earnings, occupations and social insurance benefits (Elson, 1999).

Moreover, social norms around the religious and cultural acceptability of women’s paid work outside the home, women’s own status within the home and household decision-making on who works affect women’s participation in the labour market and how earnings are spent. For example, in male-headed households, women have less autonomy over how they use their earnings, and paid work does not automatically translate into greater decision-making power, control over own earnings or a reduction in unpaid care responsibilities (Domingo et al., 2015; Razavi et al., 2012).

Bias within the structure and operation of the labour market is another factor affecting women’s higher representation in informal employment, as it tends to reflect unequal gender norms from the society and economy in which they operate (Razavi et al., 2012). For example, choice of work for women may be limited to culturally acceptable jobs. Opportunities for payment and promotion can remain biased towards men, with the wage gap between men and women remaining high across the world (INWORK, 2014).

The macroeconomic environment, including the increasing pressure on public employment and the effects of economic crises, has also played a part in pushing women to take up low-paid casual employment. The recent global financial crisis, for example, pushed more women out of the formal market and resulted in more women taking up informal jobs (Razavi et al., 2012). Jones and Stavropoulou (2013) find that the crisis exacerbated women’s position in informal employment in South-East Asia. In Indonesia, the crisis has been responsible for moving 2 million workers into the informal economy (ILO, 2012c).

## 2.2 Social insurance

Insurance is a risk management strategy to protect individuals against shocks. *Social insurance* has defined characteristics, although these vary according to different authors and institutions. The Organisation for Economic Co-operation and Development (OECD) defines it as ‘schemes in which social contributions are paid by employees or others, or by employers on behalf of their employees, in order to secure entitlement to social insurance benefits, in the current or subsequent periods, for the employees or other contributors, their dependants or survivors’.<sup>7</sup> Connolly and Munro (1999) refer to it as the role of governments taking the lead in directly providing forms of insurance or indirectly organising and regulating the voluntary sector. They further suggest that social insurance:

- offers protection against risk that the private sector will not cover.
- has aims beyond private sector objectives, including building ‘social unity’ and redistribution.
- is often compulsory, requiring contributions from individuals.
- often coexists with other forms of benefits, including social assistance.

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<sup>7</sup> <https://stats.oecd.org/glossary/detail.asp?ID=2490>



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Social insurance typically takes two broad forms:

- quasi-actuarial contributions, related to the average risk – a ‘pure pooling equilibrium’ (Barr, 2004). Pooling reduces individual uncertainty over the costs of risks, and provides a rationale for insurance companies being willing to take on risks (Connolly and Munro, 1999)
- income-related contributions (Barr, 2004).

Common types of risks covered by social insurance include unemployment, ill health, old age, disability and maternity. However, many low- and middle-income countries do not provide comprehensive coverage of all types of schemes. Moreover, such schemes typically cover only formal sector workers. In this paper, we limit our focus to the extension of three types of *contributory social insurance schemes* that may be provided by the state and/or employers with state and employee contributions: contributory pensions, maternity provision and social health insurance (SHI). Box 3 discusses some of the key conceptual and design issues of each.

### Box 3: Key conceptual and design issues of pensions, maternity and health insurance

**Pensions** (Arza, 2015): Globally, the most common type of pension are social insurance pensions. These are contributory pension schemes, administered by the state, which provide earnings-related benefits for workers who have contributed over a specific period of time. Other forms of contributory pensions include minimum contributory pensions (which aim to provide a minimum level of income security in old age) and individual pensions accounts.

The first key design feature of contributory pensions is related to a person's entitlement to receive a pension and is the number of years of contributions required to get a pension. The second is the benefit formula, or the rules that specify how benefit levels are calculated for each pensioner. Benefit formulas that closely reflect earnings and contributory histories tend to generate lower benefits for women than they do for men, while benefit formulas including flat or redistributive components favour women on average. Individual pension accounts, for instance, introduced in some Latin American countries in the 1980s and 1990s (including in Chile, Colombia and Mexico), are mandatory and fully funded by an individual's contributions. This can mean substantially lower benefits for people with limited or interrupted contributory histories. The third key design feature is the mechanism for benefit indexation, which is essential to maintain the real value of pension benefits during retirement. This is especially important for women, who face higher risks of benefit depreciation owing to their higher life expectancies.

**Health insurance:** SHI can be one component in ensuring universal coverage of health care. It is a model of health financing whereby a person's entitlements to health care derive from earnings-related contributions (Wagstaff, 2010). Including the informal economy within SHI can take several forms, including allowing informal workers to contribute to schemes designed for formal workers; requiring informal workers with sufficient means to contribute to formal sector schemes; and establishing separate voluntary schemes for people outside the formal sector.

Across countries that have adopted SHI, the share of total health care spending financed through SHI contributions, as opposed to through general government revenues, varies markedly. For instance, the share in Colombia is 60%, whereas in Viet Nam it is less than 10% (Wagstaff, 2010). Certainly, ensuring the financial sustainability of a SHI programme is crucial. Key design considerations for a SHI scheme are the level at which premiums are set,



whether they should be flat or tiered, whether they are to be subsidised for certain groups and whether co-payments are required. On the delivery side are key questions around whether the health care offered is to be comprehensive or focused on particular risks, and which health care providers those enrolled in the scheme can use.

**Maternity benefits (ILO, 2010):** In 1919, the ILO first adopted a convention on maternity protection. The three key aspects of maternity protection are duration of maternity leave; benefit paid; and source of funding. The 2000 ILO Maternity Protection Convention (No. 183) states that member states must provide for at least 14 weeks of maternity leave at a rate not less than two thirds of previous earnings. This should not be paid for solely by the employer – that is, public funds or social security must cover some of the costs. In 2010, ILO estimated that 30% of all member states met these three requirements.

Particularly in contexts of irregular earnings, further design decisions need to be made, for instance around the definition of 'previous earnings'. In Senegal, this is applied to the daily wage received on the last payday. In Peru, it is based on the average daily wage in the previous four months. Some countries also have in place a minimum period of employment or of contributions before women are eligible to claim maternity cash benefits, which can penalise part-time workers and those who have insecure jobs and undertake each job for a short period of time.

## 2.3 Gender and social insurance

Social insurance schemes are rarely designed and implemented taking into account the different experiences of poverty and vulnerability women and men face. As we discuss in more detail below, not only does this result in lower coverage of women in social insurance schemes, but also the benefits give them inadequate protection from the risks they face. Why do social insurance schemes find it more difficult to reach women and to cover the risks facing them? There are a number of reasons for this, related to both gender-specific risks (affecting only women) and gender-intensified risks (where women and men face the same risk and vulnerabilities but they affect women more severely) (Sabates-Wheeler and Kabeer, 2003). Quite simply, *eligibility* is the most constraining factor. Women are less likely to work in the formal sector (Floro and Meurs, 2009) and highly represented in informal work (ILO and WIEGO, 2013), and therefore not covered by social insurance schemes. In cases where social insurance has extended coverage so that categories of informal workers are eligible, they still may not be able to *participate*. Women are concentrated in the lowest-wage and most casual types of jobs, resulting in low capacity to contribute regularly to social insurance schemes. *Contributory capacity* is associated not only with low income but also with the regularity of that income. Women's employment in both formal and informal work is typically characterised by time taken out of the workforce for care and domestic responsibilities.

Social insurance schemes also find it more difficult to cover women because of the specific *lifecycle risks* women face: women have greater need of health services for reproductive health, for example, but social insurance may not include such services in health insurance. Meanwhile, the fact that women live longer results in unequal pension benefits.

In addition to these three main difficulties (of eligibility, participation and types of risks), other factors also interact to influence women's take-up of social insurance schemes. These include women's status and decision-making capacities at the *intra-*

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*household and community level*, which, for example, influence decisions to use services (e.g. health services) or women's mobility to access insurance services. The design of social insurance is therefore of critical importance, but many insurance schemes continue to be biased against women because they are based on the '*breadwinner model*' – a social welfare policy model<sup>8</sup> that assumes a nuclear household whereby women are economically dependent on men, men bring in wages to the household and women's domestic and reproductive work goes unrecognised (Folbre, 1994, cited in Holmes and Jones, 2013).

Drawing on these factors, which influence the take-up and benefits of social insurance for women, applying a gender lens to social insurance requires examining the dimensions of individual experiences of risk as well as women's differential position in the household, community and labour force. Drawing on Holmes and Jones (2013), MacDonald (1998) and Sabates-Wheeler and Kabeer (2003), we identify four key questions it is necessary to ask in order to analyse the extension of social insurance schemes from a gender perspective:

1. **How do social insurance schemes cover different risks across the lifecycle?** Women and men face a range of distinct health risks, as a result of both biological and social factors (Sen et al., 2007). Reproductive health is an obvious biological factor, but so too are risks of infectious diseases such as HIV and different types of violence and related health effects. Occupational risks are also gendered. For example, women may be more vulnerable to musculoskeletal disorders because of the monotonous rapid-pace work they are engaged in (ILO, 2004 cited in Lund and Marriott, 2011). The likelihood of a woman being widowed is also higher than that of a man becoming a widower, because of the longer average lifespan of women and also because in some cultures women marry men who are many years older than them (Holmes and Jones, 2013).
2. **How do insurance schemes take account of gendered inequalities in the labour market?** As discussed above, while women's participation in the labour force has increased, the latter's characteristics are highly gendered. Women are typically paid less and are overrepresented in the worst forms of work informal economy. When eligibility for social insurance programmes is based on male work patterns of continuous and full-time employment, women's access to social insurance benefits is restricted (Holmes and Jones, 2013).
3. **How does an unequal division of labour affect access to, and benefits from, social insurance?** Most insurance programmes based on a male breadwinner model fail to consider the effects of women's domestic and care responsibilities, providing only minimal compensation for their reproductive labour (Holmes and Jones, 2013). Maternity leave exists in many countries but mainly only for formal economy workers. Paternity leave is less common, thus reinforcing the traditional gender division of labour. Moreover, as mentioned above, interruptions in labour force participation for domestic and care work also reduce women's contributory capacity in relation to pension and other insurance schemes.
4. **How are social insurance schemes affected by gender inequality at the intra-household and wider society level?** Insurance schemes may reach women as wives or mothers rather than as individuals or workers, yet individual entitlement to social insurance is very important. If women's access to social insurance comes through their husbands, this may provide protection within the family but not female autonomy (Arza, 2012). This raises another

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<sup>8</sup> A model particularly influencing the design of pensions and family allowances in post-war northern Europe at the time of developing the welfare state.

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issue – that insurance policies may treat the family as a unit, with assumptions that incomes and benefits are shared within the family. However, because women often have lower status and less control over decision-making, such an approach risks reinforcing women’s disadvantageous position. At the community and broader societal level, socio-cultural norms may restrict women’s movement outside the home, or result in lower levels of education and skills. This can limit women’s access to applying for schemes, or limit their knowledge of application processes, claims and benefits.

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# 3 Gender inequality in social insurance coverage and benefits

The existing status of social insurance systems and coverage of social insurance programmes vary widely by region and country (see Box 4). A comprehensive social insurance system typically includes schemes covering sickness, maternity, old age, invalidity, survivors, family allowances, employment injury and unemployment. However, few low-income countries have such extensive systems (covering just a few of the risks), and most schemes are restricted to small populations – mainly urban higher-income civil servants and formal sector workers. As such, most schemes exclude the majority of informal workers, including a disproportionate number of women (Jones and Stavropoulou, 2013; Ulrichs, 2016). However, there are exceptions, and, as the examples in Section 4 demonstrate, important strides have been made in some countries to extend social insurance to the population, including informal workers. In particular, this progress has been made specifically in extending coverage of SHI schemes. The rest of this section, however, examines the extent of the gender gap in coverage and benefits of social insurance, and identifies what the main barriers are for women to be covered on an equal basis to men.

## **Box 4: Regional and country trends in the coverage of social insurance**

In Sub-Saharan Africa, social insurance covers only 5–10% of the population, principally in the form of pensions for civil servants and employees of large, formal private sector enterprises (van Ginneken, 2009). There are, of course, huge variations between countries. Rwanda and South Africa, for example, have made important strides: in Rwanda, health insurance now covers 90% of the population (Ubwuz Mabwacu, 2012); South Africa has extended the reach of its unemployment insurance to domestic workers. The main challenges to expanding coverage in the region are 1) the high proportion of the population in informal employment; 2) informal workers prioritising health insurance over pensions (van Ginneken, 2003); and 3) informal workers' low capacity to contribute to formal insurance schemes (van Ginneken, 2009).

In Latin America and the Caribbean, coverage of contributory social insurance schemes is highly unequal, ranging from 30% in the lowest-income countries to 60% in high-income countries (van Ginneken, 2009). Levels of affiliation continue to be one of the key challenges. Argentina, Ecuador and Uruguay have seen achievements in extending social insurance schemes. In Uruguay, for example, the number of workers contributing to the national Social Insurance Bank grew by over 35% between 2004 and 2008 as a result of improved flexibility in the retirement system, reforms to the health insurance and unemployment insurance systems and introduction of a single tax payment (monotributo) that allows workers to contribute a single amount on their income generated from their productive activities (ibid.).

In Asia and the Pacific, coverage of informal workers has seen notable success in a few countries, particularly health insurance in China and Viet Nam (van Ginneken, 2009). Poor compliance remains a key barrier (ibid.), and less than 20% of the working-age population is legally covered by a contributory old age pension (ILO, 2010b, cited in Jones and Stavropoulou, 2013). In China, however, the New Rural Medical Cooperative Scheme had enrolled more than 830 million people by late 2009 (Jones and Stavropoulou, 2013).

Looking specifically at social insurance from a gender perspective uncovers a rather unequal picture. There are three main issues of concern: 1) **gender gaps in coverage** – women are less likely than men to be affiliated to social insurance schemes (Tessier et al., 2013); 2) **low coverage of certain types of risks that women specifically face** – there are significant gaps in maternity coverage, for example (UN Women, 2015); and 3) **unequal benefits from schemes** – women may lose out on benefits from insurance, for example in the case of pensions, owing to interrupted employment as a result of childcare responsibilities. We now look at each of these concerns in more detail.

### 3.1 Gender coverage gaps: Eligibility and participation

Studies show that in the majority of low- and middle-income countries, women are less likely to be covered by different types of social insurance schemes. For instance:

- Women's statutory coverage for contributory schemes is below that of men (ILO, 2014).
- Overall unemployment insurance coverage is generally low (just 8.4% of the workforce in Africa is covered, usually because unemployment benefit schemes do not exist; if they do exist, they typically cover only formal workers), but in the Middle East the law protects only 17.7% of the female labour force, compared with 20.6% of the total labour force. In North Africa, 20.9% of the female labour force is protected, compared with 27% of the overall labour force (ILO, 2014).
- Coverage of employment injury also protects mostly those in formal employment. At the global level, only 33.4% of the total labour force, and only 31.7% of the female labour force, is mandatorily covered by law through social insurance (ILO, 2014).
- In Asia and the Pacific, the gender gap in social insurance alone accounts for over 80% of the gender gap in all forms of social protection. This means that, in comparison with men, women benefit much less from social insurance than they do from social assistance in the region (where the latter is more gender-equitable) (ADB, 2013).

The gender coverage gap for women informal workers can be explained mainly by *eligibility* issues, but it is also partly to do with other factors affecting their ability to *participate* in insurance schemes. Studies show insurance coverage of informal workers is dependent on multiple supply and demand factors. These range from tangible factors, such as eligibility to enrol, contributory capacity, ability to apply through administrative processes and compliance in the payment of contributions, to more intangible factors, including level of trust in programme providers and perceptions of benefits (see Acharya et al., 2012; Adebayo et al., 2015). Some of these barriers apply equally to men and women; however, a number of them have

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specific gender dimensions that can intensify women's exclusion from insurance schemes.

In terms of *eligibility*, women's lower rates of participation in the formal labour market, and overrepresentation in the informal sector, is the most significant factor explaining their exclusion from contributory social insurance (Sabates-Wheeler and Kabeer, 2003). Women informal workers tend not to be recognised at all – working in informal enterprises or being self-employed, by definition, means workers are not provided contracts or have no employer, and so are excluded from social security legislation, which usually requires employer and employee contributions. For example, employers represent less than 9% of the informal workforce in East and South-East Asia and less than 2% in South Asia (Vanek et al., 2014).

In addition, informal work is mainly unorganised and invisible: working in different places and lack of an organised workforce result in limited bargaining and negotiating power with employers and/or governments. ILO and WIEGO (2013) report that the majority of street vendors are informal (e.g. 94% in Buenos Aires), the majority of home-based workers are informally employed (60% in Buenos Aires and 75% in South Africa) and the majority of domestic workers are informal (in eight African cities, excluding those in South Africa, 91–7% of domestic workers are informal; in Buenos Aires, it is 97%). Forty percent of countries around the world specifically exclude domestic workers from labour law (Jones and Stavropoulou, 2013), despite the 2013 ILO Convention on Domestic Workers calling for national policies to promote fair treatment and decent working conditions for domestic workers.

Eligibility is also a key challenge for internal and international migrant workers, as insurance schemes usually require minimum residency requirements and documentation (see Hopkins et al., 2016 and Sabates-Wheeler and Feldman, 2011 for further discussion).

In terms of *participation* in insurance schemes, even where women are eligible many factors influence their ability to take up compulsory or voluntary contributory schemes. One of the key factors is that women in the informal sector have less income and/or less reliability in their income to contribute to schemes, which means premium costs (and associated costs) and the regular payment requirement can be prohibitive for them. For example, as mentioned above, women are less likely to be affiliated with pension schemes than men. One of the main reasons for this is the interaction between gender inequality in the labour market and the design of pension schemes (ILO, 2014). Where pensions do not compensate for gender inequality in the labour market – such as women's lower contributory capacity but also their interruptions in the workforce as a result of care responsibilities – the participation of women in schemes is lower because they cannot build up pension entitlements, and benefits they may receive tend to be lower (see Section 3.3) (ibid.).

Women's participation in insurance schemes is also influenced by the time costs associated with joining and benefiting. Women's domestic and care responsibilities, for example, affect their ability to contribute, not only financially (where it affects participation in the labour force) but also in terms of time and mobility. For example, a study of almost 2,000 informal workers (home-based workers, street vendors and waste pickers) in Bangkok (in Thailand) and Ahmedabad (in India) found that out of the 20% of workers who had reduced their working hours in the previous week, no men had done so to care for children, the sick or the elderly, whereas women across all sectors had reduced working hours to care for these groups (total of 2% for childcare, 3% caring for a sick person, almost 1% caring for the elderly) (Chen et al., 2015). Women may have less access to information on schemes too, as they have different networks to men and disseminating information to women can be more

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difficult because they are more likely to work in private homes (ibid.). Women may have less time to deal with social insurance administrative processes to apply for schemes because of work and care work responsibilities, as well as mobility constraints in some contexts. Nicaragua's extension of health insurance to informal workers on a voluntary basis brought enrolment and payment processes physically closer to informal workers through microfinance institutions, but the scheme still faced low enrolment and retention. Programme costs (subsidised only in the first year) and time costs associated with bureaucratic procedures were cited as the main problems (Thornton et al., 2010).

Gender inequality in the household and in wider societal norms also affects women's individual access to insurance. Evidence from the Indian health insurance scheme, Rashtriya Swasthya Bima Yojana shows that, while health insurance covers over 100 million people (Swarup, 2011, cited in Jain, 2012), only a third of women have been issued with a 'smart card' to access the scheme. This may be because female-headed households are marginalised in the implementation process at the local state level. Also, it may be that household heads need to be present to enrol, so if the male household head does not wish to be enrolled it is difficult for female household members to enrol (Jain, 2012). Other factors affecting women's participation include women's lower access to financial resources (e.g. fewer women have independent bank accounts and access to credit markets), reducing their contributory capacity. Women's different social networks and literacy levels may mean they have less knowledge and awareness of social insurance schemes (including the administrative procedures needed to apply, knowledge about benefits etc.) than men. And, women's lack of trust in providers may make them less likely to contribute to formal schemes (Holmes and Jones, 2013).

### 3.2 Low coverage of female-specific risks

Although data unavailability makes it difficult to present a full picture of the incidence and type of injuries workers incur, informal workers do face specific health risks owing to the nature of their work, in terms of both the place of work and the type of work engaged in. For example, working in environments with inadequate shelter, water, sanitation or electricity heightens exposure to risk for informal workers (Chen et al., 2015). Type of work also affects health risks, with gendered impacts. Men predominate in some particularly hazardous occupations, such as construction and transport, but women are also found in particularly hazardous occupations, such as waste-picking, street-vending and homeworking (ibid.). There is also evidence that women in informal work may be more vulnerable to musculoskeletal disorders than men, given the monotonous rapid-pace work they are engaged in, often in static postures (ILO, 2004, cited in Lund and Marriott, 2011). Few social insurance schemes cover these types of risks for informal workers.

The specific risks women face in terms of reproductive health or heightened vulnerability to other health risks such as HIV and AIDS are not always routinely covered in insurance schemes. According to ILO, maternity protection should be a key part of employment-based social insurance, but in practice provision is low. Only 28% of member states comply with the ILO Maternity Protection Convention, providing for at least 14 weeks of leave at a rate of at least two thirds of previous earnings, paid by social insurance or public funds and not solely by the employer (UN Women, 2015).

Insuring reproductive health for women, especially around pregnancy and childbirth, raises two particular issues for insurers. Some are less likely to offer maternity protection because it is seen as a risk that can be controlled, and as such, if there is no risk-pooling, then maternity or reproductive health coverage may increase



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premiums for women and employers or even cause women to be excluded altogether, because of the increased costs to employers of coverage. Second, there is an adverse selection risk of women knowing they are pregnant and then enrolling in an insurance scheme. In Chile, although the National Public Health Fund (Fonasa) reaches near universal coverage (96%) and includes low-income workers, women have been subject to significantly higher premiums than men of the same age as a result of maternal care (Holmes and Jones, 2013). In one instance, one private insurer's plan was even closed to women aged 18–45 years following the withdrawal of a government maternal subsidy in 2002 (Mesa-Lago, 2008). Similarly, some micro-health insurance schemes are known not to offer maternity benefits, partly on the basis that pregnancy is viewed as a risk women can control and so cannot be pooled like illness or accidents (Ahmed and Ramm, 2006). For example, during negotiations with a state-owned insurance company, the Indian non-governmental organisation (NGO) insurance programme Shepherd was informed the price would double if it included child delivery, and would include a nine-month waiting period to exclude women already pregnant. As such, members decided not to include maternity care; an alternative soft loan scheme was provided instead (*ibid.*).

In some cases, alternatives to insurance are considered more appropriate to cover these 'predictable' costs, such as free access to health care, soft loans or savings (Berkhout and Oostingh, 2008). In other cases, health reforms have included states compensating paid insurers with additional sums according to predetermined risk factors, thus risks are pooled and not individualised. In other cases, including Argentina, Bangladesh, Bolivia, India and Indonesia, countries have introduced or extended non-contributory maternity benefits to informal female workers or poor women in general (ILO, 2014). For instance, Argentina, in 2011, introduced a new programme for female workers: the Pregnancy Universal Allowance for Social Protection (Asignación Universal por Embarazo para Protección Social) – a cash transfer for pregnant women from the 12th week of pregnancy until birth. To receive the transfer, women must either be unemployed, having contributed to social security and not receiving any other benefits, or be working in the informal sector with a salary below the minimum wage (ILO, 2012b). The programme covered 22% of births in Argentina in 2011 (ILO 2015). This raises an important question about the appropriateness of social insurance to respond to specific risks, and the necessity to strike the right balance within a social protection system to provide alternative coverage of risks through social assistance.

Indeed, insurance schemes also need to consider both the demand- and the supply-side barriers that prevent informal workers from seeking and accessing health services. Some of the main demand-side barriers outside of financial constraints include the opportunity costs involved in seeking health services in terms of time spent in transport and waiting in the health service; inability to negotiate registration and complex referral systems; and lack of documentation required for health service registration (Chen et al., 2015). These barriers are often more severe for women, given pressures on their time as a result of additional domestic and care responsibilities and limited education, which reduces their ability to register for or claim insurance in complex administrative procedures. Supply-side barriers are also important. These include inconvenient locations (far from informal workers' place of work) or opening times of health services, lack of female health workers, inadequate dissemination of health information and poor quality of health service provision (including coordination between health facilities, efficiency of health service) (Chen et al., 2015). If such gender-specific supply side barriers are not resolved, there are limits to what social insurance can achieve in addressing and reducing the health risks which women face.



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### 3.3 Unequal benefits

The benefits of insurance schemes may disproportionately favour men. A case in point here is the value of pension benefits. As discussed above, pensions are usually designed according to contributory years and earnings, and with the same vesting period for men and women – without taking into consideration women’s domestic and care responsibilities (which often mean interruptions in working life), their lower pensionable age or their longer life expectancy (Arza, 2015; ILO, 2014). Moreover, if pensions are not indexed to follow inflation rates and wage increases, their levels may be insufficient to allow a decent standard of living (Arza, 2015). Furthermore, gender inequalities at the intra-household also influence how benefits may accrue to household members (Tessier et al., 2013). For instance, women may be dependent on men to access pension benefits (through their husband), but in case of divorce women cannot generally claim the pension (Holmes and Jones, 2013).

The benefits of health insurance schemes can also be highly inequitable, and there are important issues over the quality of care received to consider. At the intra-household level, power dynamics play an important role. For example, where decision-making in the household tends to fall on men, this can reduce women’s access to health insurance benefits. In many countries, women’s autonomy over their own health care is constrained. For example, in Senegal, 69% of women do not make the final decision on their own health care (either a final say alone or jointly with husband/partner or another person). In Bangladesh this is 37% and in Peru it is 20% (UN Women, 2015 based on ICF International data 2010–2013). Indeed, the importance of the interaction between the supply and demand of services cannot be underestimated from a gender perspective. Even if SHI is available, unequal power relations within the household can present barriers to women accessing what services and benefits do exist (Holmes and Jones, 2013).

Cost and quality of benefits can even vary among women within countries, as women are affiliated to different types of schemes. This can result in differences in costs as well as benefits, and it is often lower-income women who pay the higher price and benefit less. In Chile again, for example, women relying on health insurance and a monthly income of \$400 paid more than five times as much from their own pockets as those with statutory insurance, and those with a high income and private insurance paid on average only half the amount paid by statutory scheme members (Holmes and Jones, 2013: 146). In Colombia, differences were found between women affiliated to the contributory scheme and women in the subsidised sector. The latter received lower-quality care and were excluded from paid maternity leave and sick leave (Holmes and Jones, 2013). Ewig and Bello (2009, cited in Holmes and Jones, 2013) report that, between 1998 and 2006, the rate of maternal mortality for women in the subsidised health insurance scheme was on average twice that in the contributory sector. This raises a key question as to the quality of services provided, and the role of SHI as an effective mechanism to produce positive health outcomes of the poor. This is an issue we return to in Section 4.

From an institutional perspective, therefore, extending the coverage of insurance schemes to informal workers, and particularly ensuring extension to women, requires designing, implementing and funding schemes to overcome the barriers women face, in terms of both access to schemes but also provision of appropriate benefits for women workers in the informal economy. Jones and Stavropoulou (2013) argue that few social insurance schemes are informed by a gender lens or a gender vulnerability assessment, and implementation deficits and programme accountability shortcomings result in serious gender-specific constraints to the extension of social security schemes.

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The next section of this paper looks at examples of how social insurance is being extended, and draws out what lessons there are for overcoming such barriers and reaching women in the informal sector.

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## 4 Extending social insurance schemes to women informal workers

It is only relatively recently that formal national social insurance systems have been extended or reformed to reach informal, self-employed and migrant workers, often through specialised arrangements or a ‘group-based approach’ to integrate this previously excluded population (Olivier, 2009, cited in van Ginneken, 2009). Good practice examples can be found in countries including Brazil, Chile, China, Ghana, Rwanda, South Africa and Viet Nam, where national priorities have pushed to cover large sections of the population, interest groups have successfully lobbied for increased coverage of particular groups and there is increasing realisation that a significant proportion of informal economy workers are willing to pay ‘affordable and fair’ contributions (van Ginneken, 2009).

Here, we discuss how governments have extended or reformed social insurance schemes to cover informal workers, applying gender analysis where information is available. We mainly focus on the experiences of Brazil, Chile, China, Ghana, South Africa, Rwanda and Viet Nam due to the availability of data. Box 5 gives more details on the types of social insurance scheme these countries have introduced. We also draw on innovations in micro-insurance to highlight progress in gender-responsive design and implementation features. Specifically, we focus on changes in legislation and the categorisation of workers; changes in financing and contributory arrangements; and implementation arrangements.

### **Box 5: Schemes that have successfully expanded their reach to include the informal economy**

Brazil has focused on improving domestic workers’ access to social insurance since the 1990s. The proportion of domestic workers who contribute to the Social Security Institute increased from 18% in 1993 to 30% in 2007. The institute covers 120 days of paid maternity leave for all insured domestic workers (Addati and Cheong, 2013).

China has seen rapid coverage of the social security system since the 2000s. There are five main social insurance programmes: pensions, health, unemployment, disability and maternity. While these cover mainly formal sector workers, informal workers can make voluntary contributions to pensions and health insurance. There has been notable increased coverage in health care, which grew five-fold between 2003 and 2008 (van Ginneken, 2009). In rural areas, the New Rural Medical Cooperative Scheme had enrolled more than 830 million people by late 2009 (Jones and Stavropoulou, 2013).

Pension reforms in Chile and other Latin America countries (including Bolivia) have introduced contributory or semi-contributory pillars (e.g. non-contributory pensions) to cover informal workers, as well as credits to improve contributory histories, particularly of women (Holmes and Jones, 2013).

Ghana's government introduced the NHIS in 2003. The aim is for universal insurance coverage and equitable health care coverage. The generous benefits package is argued to cover 95% of disease conditions that afflict Ghanaians. Premiums are tiered, with exemptions for certain groups. Membership is mandatory unless alternative private insurance can be demonstrated. Official figures show that, in 2010, 66% of the population was registered with the NHIS.

Rwanda: The Mutuelle de Santé (the national community-based health insurance scheme) is a compulsory scheme that in 2011 covered 90% of the population (Ubwuz Mabwacu, 2012). Democratically elected village committees are responsible for decisions relating to the functioning of the scheme, which offers its members access to a basic health care package. Premiums are tiered, with exemptions for those judged too poor to pay.

The Basic Conditions of Employment Act (2002) in South Africa entitled domestic workers to maternity pay financed through the Unemployment Insurance Fund (Addati and Cheong, 2013).

Viet Nam: Health insurance was first introduced in 1992, in the form of a contributory scheme for public servants and employees. This was followed, in 1994, by a voluntary contributory insurance scheme for workers in the informal sector (especially farmers and the self-employed) and in 2003 by a non-contributory scheme for the poor. With the aim of ensuring 100% coverage of the population and to address financial deficits in the voluntary scheme, the 2008 Health Insurance Law integrated the existing schemes into one national programme with premium exemptions, and reductions in co-payments, for certain groups. At the end of 2014, around 72% of the population had health insurance. The government aims to achieve 80% coverage by 2020.

## 4.1 Legislation and categorisation of workers

Legislative amendments on eligibility for informal workers have occurred through 1) changes in labour laws and the introduction of labour rights for informal workers (specifically domestic workers) and 2) changes in eligibility criteria in insurance programmes.

### *Improving labour laws and rights of informal workers*

There are a number of examples where extending labour rights through statutory adjustments has enabled previously excluded informal workers to be included in social insurance schemes, with important implications for women informal workers (van Ginneken, 2009: 67). An important change has been the adoption of the ILO Convention on Domestic Workers in 2011, which calls for national policies to promote fair treatment and decent working conditions for domestic workers. Although the implementation of such conventions varies across countries, this legal recognition does represent important progress in providing legal labour rights to at least a sector of the informal economy, one in which predominantly women work (an estimated 83% of domestic workers are women).

Indeed, concrete progress for domestic workers has been made through legislative changes at national level. In South Africa and Brazil, for example, approximately a quarter of domestic workers are considered formal because their employers

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contribute to their health insurance or old-age pensions (South Africa), or they have a worker identity card that entitles them to various workers' benefits (Brazil) (ILO and WIEGO, 2013). In South Africa, where domestic work represents a 23% share of urban informal employment (ibid.), legislative changes expanded the labour law and provided workers a legal avenue to prove the existence of an employment relationship (Benjamin, 2008, cited in van Ginneken, 2009). Domestic workers are now covered by the Unemployment Insurance Fund, under which employers must register domestic workers and pay a monthly contribution to a fund (workers also have to make a contribution). Wider legal changes in the regulatory framework have introduced minimum wages, written contracts, paid leave, severance pay and dismissal notes. Although enforcement has not been even across the board in South Africa, emerging findings suggest positive effects for women workers, including raised minimum wages (hourly earnings increased by over 20% within a year), increased written labour contracts (from 7% in 2002 to 36% in 2007) and a larger share reporting unemployment deductions, going from 3% to 32% (Lund, 2006).

In Brazil, a constitutional amendment in 2013 guaranteed domestic workers equal rights with other workers. This law now covers 6.5 million workers, and also includes a provision whereby employers will pay the equivalent of 8% of their monthly salary into a fund that will be made available on compulsory redundancy, death and other contingencies.<sup>9</sup>

Namibia is another country that has explicitly included domestic workers under changing labour laws. Namibia requires all employers to register domestic workers who work at least one day a week so they become affiliated with the Social Security Commission. This includes maternity protection. However, the country has struggled to enforce this legislation and a substantial proportion of domestic workers remain unregistered (ILO, 2013).

### *Changing eligibility criteria of social insurance programmes*

Progress has also been achieved in changing eligibility criteria of social insurance programmes to include informal workers. In some cases, eligibility criteria have been specific to informal workers; in others, notably SHI, informal workers are included as part of a broader attempt to cover the entire population. This has implications for how women workers' specific risks are articulated and covered.

Notable progress has been made in Latin America in providing informal workers (mainly domestic workers but some other informal groups too) with maternity protection. Many countries in the region are making considerable progress in complying with the ILO standard of 14 weeks of paid maternity leave and in ensuring more women, including those in informal work, are eligible (UN Women, 2015). In Brazil, for instance, rural and domestic workers gained the right to maternity leave in 1991. Following a court ruling in 2012, temporary workers are now also eligible. The proportion of domestic workers contributing to the Social Security Institute increased from 18% in 1993 to 31% in 2007, and insured workers are entitled to 120 days paid maternity leave (ILO, 2013). Chile and Costa Rica also grant rights to maternity leave to temporary workers. In El Salvador, the government introduced a national campaign in 2011 to extend maternity protection benefits to uncovered domestic workers, with the aim of covering up to 27,000 domestic workers in five years (25%) (ILO, 2014: module 7 of maternity at work kit). The scheme includes the provision of maternity cash benefits at 100% of the insured salary for 12 weeks, plus access to outpatient health care services for the worker and her/his children up to the age of 12 years. The scheme is organised on voluntary monthly contributions

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9 [http://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS\\_208727/lang--en/index.htm](http://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_208727/lang--en/index.htm)

by both the worker and the employer and provides income tax breaks for employers in order to promote take-up rates (ibid.).

In the case of health insurance, one way national governments have extended social insurance coverage has been to move away from voluntary schemes, which have proved difficult to get people to enrol onto. Thailand was one of the first countries to see the limitations in using voluntary health insurance to achieve universal coverage and switched to a scheme financed through general taxation (see Box 6).

#### **Box 6: Thailand's switch from SHI to universal coverage financed through general revenues**

Thailand's 1997 Constitution enshrined the right of every poor Thai citizen to free health care. In 2002, Thailand achieved universal coverage. The most significant factor in this achievement was a financing reform known as the Universal Coverage Scheme (UCS). Launched in 2001, and financed through general revenues, the scheme ensured the 30% of the population (or 18 million people) not then covered by any form of health insurance were entitled to access free health care.

A main driver of the UCS, therefore, was the failure of previous pre-payment health financing reforms, particularly using voluntary health insurance, over a period of 25 years, to achieve universal coverage. Prior to the UCS, there were four main types of health insurance: the publically subsidised Medical Welfare Scheme (MWS) and Voluntary Health Care Scheme (VHCS) as well as the Civil Servant Medical Benefit Scheme (CSMBS) (for government employees, retirees and dependants) and the contributory Social Security Scheme (SSS) for private sector employees.

Although the MWS provided cover for the poor, the elderly, the disabled and children under 12, access to free health care for the 'near poor', whose access to SHI was designed to be through the VHCS, was far from certain. These were largely informal sector workers, and getting them to enrol onto voluntary health insurance was difficult.

With the 2001 reforms, the UCS covers 75% of the population (including those previously covered by the MWS and the VHCS). The CBMS and SSS continue to operate alongside it.

The UCS has been successful at reducing out-of-pocket expenditures on health care. Impoverishment, or the number of non-poor households falling below the national poverty line as a result of paying for medicines and/or health services, decreased from 2.71% in 2000 to 0.49% in 2009. A key foundation for this successful outcome, though, is the extensive geographical coverage of health care facilities owned by the Ministry of Public Health and the sustained investments in educating doctors and nurses since the 1970s. Meanwhile, progressive taxation in Thailand means the approach to achieving universal coverage through general revenues can be argued to be 'pro-poor'.

*Source: HISRO (2012).*

Other countries have switched from voluntary health insurance to compulsory health insurance. This is the case in Ghana, for instance, where, technically, all citizens are required to be enrolled in health insurance, whether that is the NHIS or a private alternative. However, individuals are not automatically enrolled in the NHIS, and there is no penalty for failing to enrol or enforcement of this (Blanchet et al., 2012). This means that, in practice, many citizens have no coverage of any kind (Brugiavini and Pace, 2016), with the enrolment rate at 66% in 2010 (Alfers, 2012, though this figure is disputed: see Apoya and Marriott, 2011).

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A number of other national health insurance schemes have also made the switch from voluntary enrolment to compulsory membership, given the difficulties of getting people to enrol voluntarily on schemes. In Rwanda, compulsory enrolment is argued to have ‘resulted in rapid expansion in coverage’ (WHO, 2008). Meanwhile, the Viet Nam Health Insurance Law of 2008 envisaged that, by 2014, health insurance would be mandatory and there would be universal coverage (Castel et al., 2011). In 2008, Viet Nam combined the two pillars of its health insurance: 1) compulsory insurance, which covered the formally employed as well as programmes for the poor and children; and 2) voluntary insurance. An important driver of this was limited interest in enrolling in the voluntary scheme, which, as of 2007, covered just 11% of the population, the majority being school children and students (Ekman et al., 2008). A key factor behind people not enrolling in the voluntary scheme was a view that they had no need for it (Castel et al., 2011). Meanwhile, given low levels of enrolment, the scheme was not financially viable, becoming unbalanced in 2005 and recording a record deficit in 2006 (ibid.). Viet Nam had not achieved universal coverage by the end of 2014, though, despite these reforms, with only 72% of the population having health insurance.<sup>10</sup>

For female informal workers, a particularly important question is whether other members of the household also have to enrol in a scheme in order that they can benefit from health service uptake, given their worse health status, higher incidence of chronic health problems and lifetime need for reproductive and related services. For instance, under Viet Nam’s voluntary health insurance, until 2008, when the country’s approach was reformed, enrolment required that all members of the household join – unless an individual joined as a member of a mass organisation, such as the Women’s Union (Castel et al., 2011). This not only increased the financial costs of enrolling but also meant enrolment of women in the household was dependent on the enrolment of men. In China, however, Liu et al. (2009) found compulsory registration of the whole household resulted in higher participation rates of women in the New Rural Cooperative Medical Scheme, even when participation was voluntary.

## 4.2 Financing and contributory requirements

Another key strategy to extend social insurance to informal workers has been for the government to purchase or subsidise insurance premiums or contributions for low-income groups. This is important given that the cost of premiums serves as a barrier for low-income informal workers. Women face additional problems here, especially given their higher concentration in low-income, casual work but also because of time spent out of the labour force in childbirth and care responsibilities.

Governments have reduced the affordability barrier to extend coverage and increase access to benefits for women in a number of ways. One has been to remove the premium costs altogether. In Ghana and Rwanda, the very poorest are exempt from paying premiums. In Ghana, the exemption is extended to pregnant women.

Another popular mechanism has been to introduce a flat premium. Untying premium costs from wages can be particularly beneficial for women, given their lower wages and unpredictability of income in the informal labour market. For example, Argentina and Uruguay have introduced a single tax payment (*monotributo*) to increase affiliation levels to social insurance, whereby registered workers contribute by paying a single amount on the income generated from their work, which counts towards their contribution to social security and the tax system (van Ginneken, 2009).

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<sup>10</sup> <http://vovworld.vn/en-US/Current-Affairs/Vietnam-accelerates-universal-health-insurance/316519.vov>

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Similarly, in the case of health insurance, Rwanda experimented with a flat rate premium cost of \$2 before introducing a stratified contribution system in 2010 to reduce the costs to the poor. In this, higher-income households pay higher premiums than poorer households. In total, there are three contribution groups – one comprising *ubudehe* one and two (these categories encompass locally understood and defined definitions of wealth/poverty), the middle comprising *ubudehe* three and four and the highest consisting of *ubudehe* five and six. For those in the poorest category, the premium is now fully subsidised by government. Today, this national ‘pro-poor policy’ covers about 16% of the population (nearly 1 million people), who are identified by community members at village level. Meanwhile, premiums for everyone else have increased – ranging from \$5 to \$12 per person (Vogal, 2011). By law, it is mandated that only 25% of Rwandans fall under category 1 (where their contributions are catered for by others, including the government; Ubwuz Mabwacu, 2012).

Another popular mechanism has been to introduce top-up systems and credits for women contributing to pensions. This has been a key strategy of pension reforms in Latin America, for example, where changes to contributory requirements through pension reforms represent significant progress in ensuring gender equity in old age for informal workers. Inequality arises when pension benefits are linked to contributions based on a typical male worker in terms of contribution value and consistency, the applied indexation mechanisms and retirement age. When pensions are designed the same for women and men, calculated according to contributory years and earnings with the same vested period, women are discriminated against because of their lower earnings, often interrupted working life because of reproductive and caring responsibilities and earlier retirement age (Arza, 2015; UN Women, 2015).

Reforms in Bolivia and Chile have introduced a solidarity pillar. Bolivia’s 2010 pension reform introduced a semi-contributory pillar that provides better benefit guarantees for workers with low earnings and poor contributory records, most of whom are women. In Chile, the solidarity pillar provides basic social protection to all Chileans aged 65 years or over in households in the three lowest income quintiles, regardless of contributory history (for more discussion on non-contributory pensions, not discussed in this paper, see Arza, 2015). This also tops up benefits of workers with limited contributions and thus low benefits from the contributory system (Holmes and Jones, 2013).

In addition, some countries have introduced care credits, which compensate individuals – usually women – for time lost as a result of time spent out of the labour force caring for dependants. Childcare credits have been used in Chile, Bolivia and Uruguay. In Uruguay, women are credited with one year of contributions per child, up to a maximum of five children. In Chile, the Bono por Hijo child credit is equivalent to 18 months’ contribution on a minimum wage, for every child born alive, to increase their pension entitlement (Arza, 2012). In Bolivia, the introduction of child credits for women with children is equivalent to one year of contributions per child up to a maximum of three years (given women’s very low contributions, these can be used to help women in the contributory system reach the 10-year minimum record for an old-age pension or increase the benefits to which they are entitled) (ibid.; UN Women, 2015).

In many cases, these strategies have been beneficial for women, not only resulting in positive effects in terms of increasing coverage of women in these schemes, but also reducing health expenditure and increasing utilisation of health services in the case of health insurance, and potential equality of benefits in the case of pensions.



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For example, effects of the single tax payment in Argentina and Uruguay show increased affiliation levels. In Uruguay, from July 2007 to March 2009, the number of ‘*monotributo* enterprises’ rose from 4,000 to 12,000. Those eligible include small-scale self-employed workers (including rural workers selling their products) (van Ginneken, 2009), which is likely to include a high proportion of women.

Liu et al., (2009, cited in Holmes and Jones, 2013), report that, in China, low annual premiums (10 yuan per capita) have contributed to increased health service utilisation by rural women, including institutionalised deliveries. Similarly, in Ghana, where pregnant women have received free health care since 2008, women enrolled in the NHIS are reportedly far more likely than the uninsured to give birth in hospital (81% of those who are insured deliver in a hospital, compared with 57% of the uninsured), have their birth attended by trained health professionals (81% vs. 59%) and receive antenatal care (94% vs. 76%), and they experience fewer infant deaths (twice as many uninsured women reported the death of a child under five years of age (Holmes and Jones, 2013: 146)). In Ghana, though it is difficult to draw a causal chain from the changes in 2008, the NHIS has seen positive results in terms of enrolled women accessing maternal health care (World Bank, 2012, cited in Alatinga and Williams 2014). This includes NHIS enrolment positively affecting the probability of formal antenatal check-ups before delivery, the probability of delivery in an institution and the probability of being assisted during delivery by a trained person (Brugiavini and Pace, 2016).

In Rwanda, health insurance is also associated with a reduction in the likelihood of women giving birth at home or in the presence of an unskilled birth attendant (Hong et al., 2011). And in Mexico, the voluntary Seguro Popular provides premium exemptions for people in the five lowest income deciles and the scheme has a focus on female-specific health problems, maternal mortality, HIV and AIDS, cervical and breast cancer and gender-based violence. A study using national statistics found positive effects on health expenditure and usage. It found the scheme reduced catastrophic health expenditure by 23% from the baseline, with the highest overall effect in poorer households and a positive effect in female-headed households (King et al., 2009, cited in Holmes and Jones, 2013). It also found 94% of women now have at least one antenatal appointment, and 93% have a skilled attendant present at birth (ibid.).

Despite these important effects, there are also some drawbacks and trade-offs of amending contributory requirements. The introduction of flat rates – even low payments – can disproportionately affect women. This is because an inability to afford the premiums, or any co-payments for accessing services, is frequently seen as a key barrier to expanding enrolment in health insurance. For example, while Rwanda’s introduction of compulsory health insurance is argued to have enabled rapid expansion, it was also argued to have led to poor households being pressurised to join a scheme they could not afford, with the premiums being a flat \$2 per person per year (WHO, 2008). The government argued that flat fees were initially introduced to ensure the scheme was relatively simple for people to understand when the concept of ‘insurance’ was adopted (Vogal, 2011). However, some argued that this contributed to lower enrolment of female-headed households, compared to male-headed ones, in 2005/06, given their lower mean incomes (Finnoff, 2015). In Ghana, while efforts have been made to facilitate access through low and free premiums, lack of finance is still the most cited obstacle to joining for 90% of non-participants (Mensah et al., 2010, cited in Holmes and Jones, 2013).

Box 7 shows some recent innovations in the micro-insurance sector overcoming these challenges by introducing flexible payment options and covering costs of participation in insurance schemes.

### Box 7: Flexible payment options and reducing costs associated with micro-insurance schemes

Innovations in payment options and renewal modalities can create conducive conditions for women's affiliation. In India, an assessment of a community-based health insurance scheme found local innovations in payment options such as deferred payment plans and discounts for bulk purchases increased take-up (Panda et al., 2013). A micro-pension scheme in India accepts very small voluntary deposits at flexible intervals with no entry fee (Cameron, 2014), and flexible payment options plus coverage of extra hospitalisation costs have also been important in the integrated micro-insurance programme VimoSEWA's coverage of women in India (SEWA is the Self-Employed Women's Association). Clients can pay an annual lump sum with the interest accrued contributing to the premium payment (Sinha et al., 2007a, cited in Holmes and Jones, 2013).

In India, the SWaCH (Solid Waste Collection and Handling) cooperative provides a unique example where the local government subsidises the premiums for social health insurance of waste pickers in Pune, India. Importantly this is a rare example of SHI incorporating *preventive* health care. In Pune, 90% of waste pickers are women, and they face particular health risks. These include vulnerability to skin and gastro-intestinal complications resulting from manually handling garbage, musculoskeletal ailments from repetitive bending down and carrying heavy loads as well as dog bites, hand injuries mainly from broken glass and respiratory diseases resulting from exposure to toxic gases. Thanks to the interventions of the cooperative, every registered waste collector is provided with health insurance, the premiums for which the Pune Municipal Corporation pays. This insurance covers not just comprehensive health care but also access to regular meetings on occupational health and safety and nutrition (Samarth, 2014).

Covering other costs – financial and time – is also an important gender dimension, as distance to facilities such as health centres as well as the indirect costs of health care, such as for transport and medicine, and the opportunity costs of travel are a barrier to women's take-up of health insurance. Some micro-insurance companies have addressed this problem by providing their own health services. For example, in Latin America, Pro Mujer operates a direct partnership with providers and has its own clinics (UNFPA, 2010, cited in Holmes and Jones, 2013). In other cases, policies explicitly cover costs of treatment and related transport. In Jordan, all customers of the Microfund for Women, 97% of whom are women, are enrolled in the Care Giver Policy and receive expenses to cover the costs of medical facilities and related transport (Holmes and Jones, 2013).

## 4.3 Implementation and providers

The implementation of the scheme itself, as well as the implementation of the laws (discussed in Section 4.1), is critical to access to social insurance schemes.

Evidence from China suggests a significant share of the increase in social insurance coverage especially in urban areas between 2005 and 2010 reflects implementation of the 2008 Labour Contract Law (Giles et al., (2013). This law increased sanctions for hiring workers without offering contracts and for failure to enroll employees in social insurance schemes (Giles et al., 2013). Specific progress has also been made in reducing the gender gap in the implementation of the Labour Contract Law. Gallagher et al. (2012), on urban workers, find that in 2001 and 2005 women were 6–7% less likely to have labour contracts compared with in 2010, when there were no significant gender differences in the likelihood of having a labour contract. However, women are still more likely to be concentrated in types of employment and

industries that do not provide labour contracts. Looking at specific groups of workers (local urban resident workers), the same study finds women are 3% less likely to have a labour contract (and thus to participate in social schemes) because of the types of job local urban women are employed in rather than differential treatment within sector and ownership type (Ibid.).

In terms of health insurance, who implements the scheme, how it is implemented and the processes required in order to enrol on it and to continue to benefit are both also important considerations when trying to expand involvement to female informal workers (see Box 8 on lessons from micro-insurance schemes). For instance, in Ghana, educational attainment of women is a strong determinant of enrolment, and as such, those with low education and unable to read are less likely to enrol. Information on the NHIS should be disseminated in ways that reach those with little or no education (based on analysis of GDHS 2014 survey, Brugiavini and Pace 2016).

### **Box 8: Lessons from implementing gender-responsive micro-insurance schemes**

**Trust and personal contact:** Women with stronger links to SEWA are more likely to renew their premiums, and improved awareness-raising campaigns during the annual renewal period raised renewal rates. This is seen as particularly important, as a study in Ahmedabad, India, found lack of face-to-face contact still emerged as the primary (57%) self-reported reason for dropout among more than 17,000 women (Sinha et al., 2007).

**Advances in technology:** These can also facilitate easier payments. For example, the Mbao micro-pension scheme in Kenya covers medium and small micro-enterprises and Jua Kali associations. Mbao members can quickly and easily make payments through the leading mobile transfer services, such as M-PESA and the Airtel money transfer service (Bukuluki and Mubiru, 2014).

**Simple administrative processes:** Submitting claims continues to be a challenge for poor individuals, especially for those with low education and literacy and where submission requires travel to a city or town. Ranson et al. (2006), on VimoSEWA health insurance in Gujarat, show that, while claim submission is equitable in Ahmedabad in India, it is inequitable in rural areas, with the better off more likely to submit claims. Men are significantly more likely to submit claims than women in both rural and urban locations. Ranson et al. find this owes in part to a burdensome claims process. A number of different innovative approaches to address this have been implemented in other countries too, for example funeral parlours offering funeral insurance in South Africa and internet kiosks selling life insurance in India (Lloyds 360 Risk Insight, 2009).

SEWA has also adopted several innovative approaches to help members make claims, including the use of extension agents as well as a barcode scanner system, which allows illiterate or semi-literate members to make a claim by attaching a sticker to a prepaid envelope and sending it to the micro-insurer, who in turn sends a fieldworker to provide support and also encourage policy renewal (Botero et al., 2006). These also help overcome power differentials between often poorly educated, lower-caste, low-income women and the doctors required to support insurance claims, as well as issues of time poverty in travelling to local SEWA offices to submit paperwork.

**Flexibility:** Another innovative approach related to the claims process is the increasing flexibility in choosing beneficiaries. Where women are the holders of life insurance, for example, there is an assumption that husbands will benefit from claims, but many women prefer the freedom to choose friends, relatives or children, to better protect children in the event of their death. For instance,

Cohen and Sebstad (2006) found in Kenya, Tanzania and Uganda that women were increasingly designating their friends as beneficiaries and instructing them to use the money for children's school fees and other necessities, rather than naming their husbands. Policies can also be designed to ensure insurance money is spent on allocated items that are traditionally women's responsibility. La Equidad in Colombia, for instance, provides a policy whereby ongoing payments are made for education as well as a one-off funeral payment (Banthia et al., 2009). And Delta Life in Bangladesh has a savings scheme to benefit the policy-holder's daughter when she reaches 18 years of age. This is marketed as a marriage product, but it could be used for education or other purposes.

*Source: Holmes and Jones, 2013*

However, even where women are aware of the benefits of health insurance, they may choose not to enrol because of a mistrust of scheme managers, poor attitudes of those involved in enrolment and even discrimination. Finnoff (2015) argues that the higher enrolment of female-headed households in the 1999/2000 pilot of community-based health insurance in Rwanda relative to the nationwide programme could have owed to the involvement of church groups in targeting the pilot and enrolling poor households, including widows. In contrast, under the scaled-up *Mutuelle de Santé* scheme, scheme managers are under the Ministry of Health. They are effectively gatekeepers for enrolment and have great power, including to appropriate funds. Female-headed households may be more aware of their vulnerability in this setting and choose not to enrol (*ibid.*).

In Viet Nam, meanwhile, the way health insurance is implemented is argued to matter. The South Central Coast region, which has arguably the most 'client-oriented' approach, has also achieved the highest coverage of people in the informal sector (Castel et al., 2011). Meanwhile, the use of intermediaries, including the Women's Union and the Farmers' Union, to expand enrolment in voluntary insurance among a cross-section of the population and to limit adverse selection into the scheme, meant the number of voluntary insured doubled between 2005 and 2006 (*ibid.*). Since the 2008 reforms, the use of enrolment through intermediaries has been stopped – even though this would seem to have been an important way of encouraging enrolment among informal workers (*ibid.*).

The time taken to enrol onto a scheme is also seen as a particularly important barrier for informal workers, for whom time is quite literally money (Alfers, 2012). The administrative procedures related to enrolling in Ghana's NHIS, for instance, and inefficiencies in these procedures that mean regular follow-up is required by enrolees can deter informal workers (*ibid.*). As an example, to enrol for the NHIS, you must go in person to a District Mutual Health Insurance Scheme office, complete registration paperwork (often after waiting a substantial amount of time) and pay a small annual registration fee meant to cover the photo ID and the administrative expenses of registration (Alatinga and Williams, 2014; Blanchet et al., 2012).

The administrative processes for applying stratified payments or exemptions (discussed in 4.2) can also be burdensome if administrative capacity is low. Often, this means exemptions are not applied in practice, meaning financial barriers to enrolment remain for the poorest. For example, Ghana's NHIS incorporates exemptions from premiums for certain groups, including people classified as indigents (impoverished) based on a means test. However, scheme administrators face real challenges in identifying those individuals, which means that, in practice, they are set at a flat rate at the district level (Alatinga and Williams, 2014; Brugiavini

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and Pace, 2016). Another driver of the flat rate premiums is the requirement that poor people receiving premium exemptions must not exceed 0.5% of the total membership of any scheme – far below the allocation required (Apoya and Marriott, 2011). This means some individuals, including those working in the informal economy, still report the premiums as a key barrier to their enrolment (Alfers, 2012). In addition, there are reports that premiums in urban areas are unofficially set higher than those in rural areas, given the perceived greater ability of urban residents to pay them. This is an assumption that may not necessarily hold for informal workers eking out a precarious living (Alfers, 2012; Blanchet et al., 2012).

Finally, particularly in the health insurance sector, there is also a complex debate, given finite resources, about the trade-offs between the levels at which to set premiums and the levels of investment required to ensure the quality and range of services provided. For instance, it may be that people choose not to enrol, or to re-enrol, particularly if there are no penalties for not doing so, if the quality of health services offered is low or worse than they anticipated (see Jehu-Appiah et al., 2011 for a discussion related to Ghana's NHIS).

UN Women (2015) notes that the experiences of Rwanda and Thailand are successful stories in terms of reducing the financial burden of health insurance for the population. Improvements in health outcomes, particularly for women, are also the result of longer-term investments in decentralised health services and the development of administrative capacity to manage these effectively (*ibid.*). Given that significant subsidies from general taxation or international aid are required to make up for the limited contributory capacity among low-income women and men, UN Women argues that contributory social or community insurance schemes may not be the most effective way to achieve affordable access to health care, particularly in low-income countries where the amount of contributions that can be extracted from informal workers and other low-income groups is usually low. This is reflected in the experience of Thailand (see Box 6 earlier). Here, there are important investment priorities to decide on in the context of scarce resources, where investment is also needed in the extension and operation of public health facilities with the aim of building national health systems that are free at the point of service delivery (*ibid.*).

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# 5 Conclusions and policy implications

This paper has applied a gender analysis to examine the gaps in social insurance coverage and experiences of extending social insurance to women informal workers. Specifically, we have used a gender lens to examine examples of where social insurance programmes have been extended, asking to what extent **gender gaps in coverage** have been reduced, and whether programmes **adequately address women informal workers' needs**. The focus has been on the role of the state in extending contributory pensions, SHI and (to a lesser extent) maternity insurance.

We have focused on informal workers given that, although this group continues to be excluded for the most part from social insurance programmes, there has been progress in coverage. Moreover, we have specifically focused on women informal workers, as a higher proportion of women are excluded from social insurance programmes, are overrepresented in the informal sector and face other gender-related risks that exclude them from participating in and benefiting equally from social insurance programmes.

Given the specific barriers women face, at the beginning of the paper we identified four conceptual questions to consider asking when applying a gender analysis to the extension of social insurance:

1. How do social insurance schemes cover different risks across the lifecycle?
2. How do insurance schemes take account of gendered inequalities in the labour market?
3. How does an unequal division of labour affect access to, and benefits from, social insurance?
4. How are social insurance schemes affected by gender inequality at the intra-household and wider societal level?

Looking at each of these now in turn, we summarise the main findings from across the review, recognising that the evidence base we use to draw these conclusions is currently very thin.

## 5.1 Summary of key findings

### **How do social insurance schemes cover different risks across the lifecycle?**

Women face specific risks cross the lifecycle, including reproductive health risks, a higher risk of being widowed, as well as specific occupational risks. A number of health insurance, maternity insurance and pension schemes have shown progress in covering specific lifecycle events that put women in a more vulnerable position. These include, for example, health insurance schemes that specifically include family planning, cover pregnant women and/or childbirth and/or waive the premiums for pregnant women; maternity insurance for women; and amending the calculation of pension benefits so women benefit even when they live longer on average.



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However, there are still gaps and barriers in coverage. In many social insurance schemes, covering reproductive health risks increases the cost of health insurance. This may serve as a disincentive to covering women or may increase the cost of the premium. The health insurance schemes examined here have all aimed to cover the entire population, and none of the schemes specifically cover the types of occupational hazards and risks that women informal workers face. Other important considerations in SHI are the non-financial demand and supply-side barriers to accessing health services, such as time costs to seek health care (for women and those they care for), and quality of services (particularly gender-responsive services such as availability of female health workers). In addition, SHI, by its nature, encourages a focus on curative care – on helping households manage health shocks when they occur. However, it may be that, particularly for informal workers, who often work in dangerous and unhygienic conditions, preventive services are as important. This raises an important question about investment priorities - in contexts of low resources, it may be that investments in universal health care provision can be more effective in achieving health outcomes for informal workers than the collection of premiums.

Pension reforms that have changed the benefit system, taking into consideration women's longer life expectancy, are few and far between. The provision of maternity insurance is still very low across low-income countries. Although there has been an increase in the number of schemes in which the employer and social security systems share responsibility for paying cash benefits for maternity leave, in 26% of the countries where there are cash benefits for maternity leave these remain solely funded by the employer. This not only limits the possibilities for pooling contributions, but also, in placing undue financial costs on women's employers, is unlikely to contribute to promoting labour market equality between men and women (ILO, 2010). As such, a number of countries are combining contributory and non-contributory schemes to provide maternity benefits especially to low-income working women.

**How do insurance schemes take account of gendered inequalities in the labour market?** Women are overrepresented in informal low-wage, irregular and casual work, often with no employer. Many insurance programmes remain strongly linked to assumptions around formal employment (full-time, formal, life-long employment as the norm), but these implicitly discriminate against women (Razavi et al., 2012). However, a number of recent reforms have made insurance programmes more inclusive of women. Legislative changes have had important positive effects in bringing women into social insurance programmes through formalisation and contract laws, as have changes in eligibility for social insurance to improve access for previously excluded groups such as domestic workers and migrant workers. Compulsory affiliation to social insurance schemes has also increased coverage, for example in the case of some health insurance schemes. Moreover, reforms in the requirements for pension contributions helps overcome financial barriers, such as through the introduction of solidarity pillars. Reducing other financial barriers, for example by introducing flat rates so contributions are not linked to a proportion of income and exemption from premiums for groups of informal workers, has increased coverage in some insurance schemes, although even small premium costs may represent a barrier for low-income households. Lessons from micro-insurance demonstrate the usefulness of introducing innovative payment mechanisms such as flexible payment schemes, eliminating fixed fees, facilitating easy payments through mobile technology and reducing indirect costs including on women's time.

However, financial and non-financial costs (such as time taken to join the scheme) still represent a key barrier for low-income households, and particularly for low-income women and female-headed households. For example, even low-cost flat rates

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may be unaffordable for the poorest and the implementation of premium exemptions or stratified premium costs involves high capacity requirements, which in practice are difficult to deliver. In particular, in the case of SHI, the private costs borne by people to register and annually enrol in schemes should not be overlooked. Time spent in enrolment is particularly important for informal workers. .

**How does an unequal division of labour affect access to, and benefits from, social insurance?** Unequal care and domestic responsibilities have huge implications for accessing and benefiting from social insurance programmes in terms of women's ability to financially contribute to schemes when they are out of the labour market, as well as other issues such as time spent on the application and claims processes. While these examples are few and far between, some insurance programmes – notably pension schemes – have sought to overcome this by introducing top-up systems and childcare credits, for example. These entitle workers to benefits even when they have been unable to contribute to the scheme, particularly benefiting women especially where they are credited with contributions when they have been out of the workforce to have children. While such credits are an important tool to improve women's pension benefits, they are, however, unlikely to close gender gaps in coverage and benefits on their own (Arza, 2015). Moreover, while it is necessary to recognise and value women's reproductive roles, it is also important to support paternity or parental leave (UN Women, 2015). This requires a wider package of gender equality-enhancing measures (Arza 2015, UN Women, 2015). Some insurance schemes, including micro-insurance services, have tried to address women's time constraints by providing their services geographically closer to their end-users, and investing in delivery mechanisms, such as using extension agents and fieldworkers, to support women's application and claims processes first hand.

**How are social insurance schemes affected by gender inequality at the intra-household and wider society level?** Inequalities in intra-household allocation of benefits of schemes as well as women's opportunity to access schemes as individuals in their own right, rather than as the wife of a policy-holder, are important factors influencing the extension of social insurance. Some programmes have made advances in recognising and responding to these inequalities – including insurance schemes that entitle women to insurance as individuals, micro-insurance schemes that specify particular individuals (not necessarily husband or wife) as beneficiaries (e.g. in life insurance schemes) and also amending administrative and delivery processes to promote women's awareness of schemes and trust in implementers. Indeed, some good practices from micro-insurance emerge showing the importance of ensuring policies are accessible, easy to use and renew and thoroughly understood by poor and often illiterate populations, including women. In some cases, this has involved tailored outreach and support mechanisms that take into account women's greater time poverty, mobility constraints and more limited capacity to negotiate with service providers and programme officials (Holmes and Jones, 2013).

However, overall, intra-household issues are not well considered in terms of allocation of benefits, nor are issues of women's status – such as lower decision-making power. For example, while women tend to be responsible for health-seeking behaviours in the home, they also have less power to act. It is therefore important to look at which social insurance mechanisms can support poor households in coping with general and gender-specific health risks, but also whether such programmes help break down male resistance to women's and family health service use (Holmes and Jones, 2013).

In sum, there are some good practice examples emerging where social insurance schemes respond to the specific and intensified risks that women face. This is particularly notable for particular *groups* of informal workers (e.g. domestic workers



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who are more visible because there is better data collection on this group of workers) and particular *types of risks* (e.g. reproductive health). Progress has sometimes been part of broader national legislative reforms in the labour market or changes to design and implementation features to bring more women into schemes and respond to specific risks they face. However, overall, many schemes do not reflect gender differences well, and significant improvements are required to better respond to women's higher burden of care work responsibilities, the effects of informal employment, their longer life expectancy, different reproductive health needs and intra-household inequalities in decision-making and allocation of resources.

Overcoming these challenges requires: a) gender-sensitive changes in the design and implementation of social insurance programmes; b) a combined and complementary social protection package which includes the availability of gender-responsive social assistance (and labour market programmes) to cover risks that are uncovered by social insurance; c) investment in the gender-responsive supply side of services; d) progress towards a more transformative agenda; and d) better collection of sex disaggregated data to inform gender-responsive policy and programming.

With these conclusions in mind, we suggest a number of policy implications to be considered in extending social insurance and to better respond to women informal workers' needs.

## 5.2 Policy implications

**Design and implementation:** A number of specific design and implementation features can improve women's access to, and benefits from, social insurance. First and foremost, social insurance schemes should be informed by a gender poverty and vulnerability analysis to assess the types of risks women and men face and how gender inequality (and other cross-cutting discrimination such as that related to ethnicity, disability, etc.) might affect these risks. Eligibility to participate in insurance schemes is obviously key to ensuring increased coverage. Other design features need to take into consideration different capacities to contribute, in terms of not only direct costs such as premiums but also the indirect and opportunity costs women (and men) face. Pooling risks (rather than them being individualised) may be an appropriate choice for lifecycle events that apply only to women (e.g. childbirth), so that insurance premiums are the same for men and women. Fixed premiums may be more appropriate than premiums as a contribution of salary, because of gender wage differences and time out of the labour force and to allow for compensation for labour market inequalities. However, in other cases, even low-cost premiums remain a barrier for the poorest households. Fee exemptions or the provisions of non-contributory schemes may be the most appropriate (see below on complementarities).

Other design features may include flexible payment options (including grace periods of several months), using price to create incentives for certain behaviours, such as enrolling whole families (Holmes and Jones, 2013).

Gender-responsive design features also need to be backed up with investment and capacity to implement. Building the capacity of those involved in designing, implementing, monitoring and participating in insurance programmes through gender-responsive training will be important. Meanwhile, the involvement of informal workers (including women), and their representatives, in scheme design is important. It cannot be assumed that representatives of formal workers will also represent those in the informal sector. In reality, they will clash and it is likely to be very difficult for one body to represent both groups effectively (Alfers, 2012). Moreover, through implementation processes, insurance providers need to ensure information is accessible and easy to process and to provide support to those who

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need help with documentation for processing claims. The use of extension agents or fieldworkers who have experience of working with informal female workers, and who have their trust, can be an important way of increasing enrolment in national social insurance schemes.

**Complementarities:** Above and beyond the design of social insurance, an important question that emerged from this review is, in which contexts, and when, *is social insurance the most appropriate form of social protection for informal workers?* It may be that, for certain risks, including the risk of poverty in old age, social assistance approaches represent a more viable option to ensure adequate benefits, given the limited contributory capacities of women informal workers.

Indeed, gender-responsive design and implementation features need to go hand-in-hand with broader reforms and regulatory frameworks to extend insurance coverage of informal workers. For example, it is necessary to forge complementarities with other frameworks, institutions and forms of support, including:

- Strengthening labour market regulations to create a more level playing field for women within labour markets, and enhancing women's income security and employability – for example formalising informal work, regulating minimum wage, eliminating discriminatory wages, etc. (Sieverding, 2011). It also includes providing good-quality and accessible care services that can give women the option of engaging in paid work (Razavi et al., 2012).
- Promoting the right to social security and drawing on the existing international human rights frameworks, constitutional protection and national social protection floors to support the extension of coverage of informal economy workers and their families (van Ginneken, 2009).
- Recognising the importance of the 'interplay' between contributory and non-contributory (social assistance) schemes to ensure more equitable access to programmes that reduce women's risks throughout their life course, especially where women are less likely to be covered by certain types of insurance schemes (such as maternity insurance, pensions) (Tessier et al., 2013).
- Strengthening partnerships and improving collaboration and coordination, with actors supporting women's rights and gender equality – for example giving women's representatives a voice in the design of programmes through participatory national dialogues (Tessier et al., 2013), drawing on actors to develop gender-responsive legal frameworks for social insurance (Jones and Stavropoulou, 2013), using gender networks and alliances such as SEWA, WIEGO, StreetNet International, HomeNet Southeast Asia and HomeNet South Asia to pressure, provide information and campaign for gender-responsive insurance programmes (see Bertulfo, 2011).

**Engendering the supply side of services:** The potential of social insurance to reduce risks for informal workers will be limited without investing in the supply side of services, such as health care services and basic infrastructure services. For instance, for health insurance benefits to be effective, it is essential to ensure high quality of health care service provision for all beneficiaries, and to ensure non-discriminatory treatment. This also includes considering gender-specific vulnerabilities and the importance of service delivery, such as reducing financial and non-financial costs associated with accessing health services (time to access health care, travel costs, registration requirements, the availability of female medical staff (Tessier et al., 2013).

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**Supporting a transformative agenda:** Examining the current status of social insurance schemes from a gender perspective highlights that there is a need to ensure social insurance provision meets an adequate standard of living for both women and men (e.g. equality in pension benefits, health insurance to cover women's specific health risks, etc.) but also that a more transformative approach to redressing the significant inequalities women face (inequalities in the labour market, the unequal division of labour) – is necessary. Promoting women's empowerment and economic autonomy is an important part of extending insurance and ensuring the benefits of insurance are equitable. UN Women (2015), for instance, calls for 'radical transformations' in how social protection and services are organised and delivered, arguing that there is a role for social policy to incentivise changes in social norms and persistent discrimination, such as men taking on childcare responsibilities, building capacities of health services to respond to violence against women and empowering women. Such transformations should be seen as part of a wider agenda to strengthening women's agency, voice and participation through feminist research, advocacy, legal action and mobilisation, as well as women's political leadership (ibid.).

**Research on gaps in knowledge:** Significant knowledge gaps on gender exist in the social insurance literature. We know very little about progress made in closing coverage gaps, as well as the impacts of insurance uptake and implementation on women's empowerment, overall household welfare, control of resources and poverty and vulnerability levels (Holmes and Jones, 2013). Part of the problem is that few evaluations collect or analyse disaggregated data; this is an area that could be improved with investment in sex-disaggregated monitoring, evaluation and analysis. Monitoring mechanisms should be designed in a way that facilitates the regular review of the efficiency and effectiveness of insurance and performance of the national social protection system as a whole. This requires the collection, analysis and publication of gender-disaggregated data; the development of gender-responsive indicators; the establishment of an operational information system allowing regular monitoring of beneficiaries according to main characteristics; and the inclusion of questions on main social security programmes in regular household surveys (Tessier et al., 2013). Evaluations should include questions relevant to gender dynamics, including women's economic and social empowerment (Jones and Stavropoulou, 2013).

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