The effect of health insurance on reducing child labor in Pakistan

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Sector(s): Health, Labor Markets, Education

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Location: Hyderabad, Pakistan

Sample: 13 branch offices of NRSP

Partner organization(s): National Rural Support Programme

As of 2016, an estimated 151.6 million children aged 5 to 17 were engaged in child labor globally. For low-income households, economic shocks such as expensive accidents or illness are important determinants of child labor, as parents might have to send children to work for additional income. Researchers partnered with the National Rural Support Programme Insurance in Pakistan to introduce expanded health insurance services and evaluate the impact of insurance on child labor. The expanded insurance package reduced both the likelihood that children were working in a hazardous occupation and child labor earnings, especially for boys.

Policy issue

As of 2016, an estimated 9.6 percent of children aged 5-17 – 151.6 million children – were engaged in child labor globally.[1] Previous research has shown that child labor has significant negative effects on education, wages in adult life, and even long-term health. For low-income households, economic shocks such as expensive accidents or illness are important determinants of child labor. After such an event, parents may need to send children to work for additional income. Insurance may protect families from these economic shocks. For example, accident and health insurance can help pay for expensive medical care or disability. Despite its potential to reduce child labor, there has been little rigorous research on the effect of insurance on child labor.

Context of the evaluation

This study took place in the urban district of Hyderabad, Pakistan. According to a 2012 World Bank report, 22 percent of Pakistanis lived below the poverty line of US$1.25 per day. The Rural Support Programmes Network 2008 survey of Hyderabad also found the district had a particularly high prevalence of child labor, especially in the hazardous glass bangle industry.

While there are free public medical facilities in Pakistan, they are often of poor quality. For many Pakistanis, the alternative is to seek expensive private medical care. Seventy-five percent of health expenditures in Pakistan are paid by patients out of pocket, and less than two percent of Pakistani households use any kind of formal insurance. Consequently, low-income Pakistanis rank health shocks as a significant economic risk.

Researchers collaborated with the National Rural Support Programme (NRSP), a Pakistani microfinance institution that serves over two million households throughout the country with microfinance services and client training. Because NRSP serves low-income clients, they were well-positioned to reach the most vulnerable households. NRSP microloans include mandatory accident and health insurance for all nuclear family members, including the clients, their spouses, and children under eighteen. NRSP

reimburses healthcare costs after clients contact the field officer and submit bills or other relevant documentation.

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Details of the intervention

Researchers partnered with NRSP to conduct a randomized evaluation of the impact of offering expanded insurance services on child labor. In 2009, NRSP introduced two additional components to its health insurance program:

1. Optional coverage for more household members: NRSP offered voluntary insurance to additional household members, including adult household members such as parents, adult children, aunts, cousins, etc., which costs 100 Rupees (approximately US$1 at the time of the evaluation) per adult per year.
2. Monthly visits from a field officer: During these visits officers asked clients whether they had incurred any medical costs and if they needed assistance with filing claims to get reimbursed.

The expanded health insurance package was introduced in nine randomly selected NRSP branches. Four randomly selected branches served as a comparison group and only received the mandatory insurance. The nine treatment branches contained 1,320 households and the four comparison branches contained 777 households.

Households were surveyed between September and October of 2009, just before loan disbursement. Four follow-up surveys were conducted every 6 months afterward, ending in November of 2011. Surveys focused on insurance take-up, reimbursement for medical costs, child labor incidence, hours worked, child labor earnings, and school attendance. When reporting the impact on child labor, researchers averaged the results across the four follow up surveys.

Results and policy lessons

The expanded insurance package reduced both the likelihood that children were working in a hazardous occupation and child labor earnings, especially for boys.

Health Insurance Coverage and Use: Health insurance coverage to additional household members was higher in areas that were offered expanded insurance. In treatment branches, 68.5 percent of non-nuclear family members were insured through voluntary insurance after six months while zero percent of non-nuclear family members were insured in the comparison branches. Households who received the expanded insurance services also sought more reimbursements for medical expenses. Within twelve months of the insurance start date almost five percent of households in treatment branches reported filing an insurance claim.

Child Labor: The combination of offering additional insurance and assistance with claims reduced the prevalence of child labor in a hazardous occupation and reduced child labor earnings. The likelihood of child labor in a hazardous occupation was 4.6 percentage points lower in treatment branches, a 44 percent decrease relative to the 10.4 percent likelihood of child labor in a hazardous occupation in comparison branches. Furthermore, monthly child labor earnings decreased by 142 Rupees (approximately US$1.65 during the time of the evaluation), a 33 percent decrease from the 427 Rupees (US$4.95) average child labor earnings in branches that did not receive the expanded insurance. However, there was no strong impact on the weekly hours of labor, school attendance, or days missed at school per month on average. This may have been due in part to the small sample size of the study.

Impacts by Gender: The expanded insurance package was particularly impactful for boys, even on outcomes for which there was no impact among the pooled sample of boys and girls. For example, boys whose households received expanded insurance services worked on average 4.4 hours less per week than boys in comparison areas (a 35 percent decrease from the comparison group average of 12.5 hours per week). Boys in treatment branches also had a lower likelihood of working in a hazardous occupation, less hours worked, and less earned income from child labor. However, girls in treatment branches experienced no changes in child labor incidence or hours worked. These differential results are likely in part because boys were engaged in child labor more often than girls in this sample.

Landmann, Andreas, and Markus Frölich. "Can Health-insurance Help Prevent Child Labor? An Impact Evaluation from Pakistan." *Journal of Health Economics* 39 (2015) 51–59.

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1. International Labor Organization. 2017. “Global Estimates of Child Labour: Results and Trends, 2012-2016.”