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Willingness to Pay for Private Health Insurance Among Informal Sector Workers: A Contingent Valuation Study

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ABSTRACT

Background: Extending financial protection to informal-sector workers remains one of the central unresolved challenges of universal health coverage, and contingent valuation (CV) has been the dominant empirical technique used over the past three decades to estimate what these workers are willing to pay for voluntary or community-based health insurance. Objective: This case study presents a narrative synthesis of the published contingent valuation and related willingness-to-pay (WTP) literature on health insurance demand among informal-sector workers, drawing together regional findings, determinants, and methodological considerations rather than conducting a new primary survey or a formal PRISMA-governed systematic review. Methods: Published CV and WTP studies of informal-sector and rural populations across Sub-Saharan Africa, South and Southeast Asia, and China were identified through targeted searching of health-policy and health-economics literature and organized thematically by region, determinant category, and elicitation methodology, alongside foundational and systematic-review papers on contingent valuation methods in health economics. Findings: Across geographically and methodologically diverse studies, informal-sector households consistently express a positive but modest WTP for health insurance that, in most settings, falls short of the premium required for full cost recovery of a comprehensive benefit package. Household income and expenditure, education, health status and perceived risk, household composition, and, increasingly, trust in the administering institution and perceived service quality emerge as the most consistent determinants of higher stated WTP. Elicitation format, from open-ended and bidding-game approaches to single- and double-bounded dichotomous choice, materially affects estimated WTP and is subject to hypothetical bias, response inconsistency, and framing effects that complicate direct cross-study comparison. Conclusions: The accumulated CV evidence is best used not to identify a single correct premium but to characterize the scale of the financing gap between informal-sector willingness and ability to pay and the cost of meaningful coverage, a gap that most low- and middle-income settings will likely need to close through general-revenue subsidy, quality-linked enrollment strategies, and mechanisms that mitigate adverse selection in voluntary schemes.

Keywords: *willingness to pay; contingent valuation; health insurance; informal sector; universal health coverage*

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Introduction

Extending financial protection against health-related expenditure to workers in the informal economy remains one of the most persistent unsolved problems on the path to universal health coverage (UHC). Informal sector workers, defined broadly as self-employed traders, smallholder farmers, artisans, and casual laborers who fall outside employer-based payroll and tax systems, constitute the majority of the workforce across most low- and middle-income countries (LMICs) and are almost never automatically enrolled in mandatory social health insurance schemes that rely on payroll deduction [1,2]. Because this population cannot be reached through the contribution-collection mechanisms that finance formal-sector social insurance, governments and multilateral agencies have for three decades experimented with voluntary, premium-based community-based health insurance (CBHI) and national health insurance (NHI) schemes explicitly designed to attract informal-sector enrollment [3]. The persistent gap between the coverage ambitions of these schemes and their observed uptake has made an accurate, ex-ante estimate of what informal workers are actually willing to pay for health insurance a central input into scheme design, premium setting, and subsidy targeting.

Contingent valuation (CV) is the empirical technique most widely used to generate these estimates. Borrowed from environmental and natural resource economics, CV elicits a hypothetical willingness to pay (WTP) for a good that does not yet exist in a functioning market by presenting respondents with a structured description of a proposed health insurance scheme and asking them, through open-ended, bidding-game, or dichotomous-choice formats, to state the maximum premium they would be willing to pay for it [4]. Diener and colleagues' foundational classification of health-related CV studies established the methodological vocabulary, elicitation formats, and validity criteria that the subsequent health-insurance WTP literature has largely inherited, while Asenso-Okyere and colleagues' 1997 study of Ghana's informal sector was among the first applications of CV specifically to health insurance demand in a developing-country setting, and remains a frequently cited methodological and empirical reference point for the field [4,1]. In the nearly three decades since, dozens of CV studies have been conducted among informal-sector populations across Sub-Saharan Africa, South and Southeast Asia, and, to a lesser extent, Latin America, generating a substantial but methodologically heterogeneous evidence base.

This article presents a narrative synthesis of that published contingent valuation literature. Rather than conducting a new primary survey or a formal systematic review governed by PRISMA-style reporting, the objective here is to draw together, thematically, what the accumulated body of contingent valuation research says about (i) the magnitude and range of WTP for private and community-based health insurance among informal-sector workers across regions; (ii) the individual, household, and scheme-design determinants that consistently predict higher or lower WTP; (iii) the methodological considerations, biases, and design choices that shape how CV estimates should be interpreted; and (iv) the implications of this evidence for premium setting, subsidy design, and enrollment strategy in ongoing UHC reform efforts. The article closes with a discussion of the limits of the CV evidence base and a set of policy-relevant conclusions.

Methods

This is a narrative, thematically organized synthesis rather than a formal systematic review, and no attempt is made to exhaustively enumerate every published CV study of health insurance demand or to apply PRISMA screening criteria. The underlying literature was identified through iterative searching of PubMed, Health Policy and Planning, PLOS ONE, PLOS Global Public Health, Health Economics Review, Health Economics, Social Science & Medicine, Frontiers in Public Health, and related health-policy and health-economics outlets, using combinations of the search terms "willingness to pay," "contingent valuation," "health insurance," "informal sector," "informal economy," and "community-based health insurance," together with country- and region-specific terms for Sub-Saharan Africa, South Asia, Southeast Asia, and Latin America. Studies were prioritized for inclusion in the synthesis if they (a) applied a recognizable contingent valuation elicitation format (open-ended, bidding game, single- or double-bounded dichotomous choice) to estimate WTP for a health insurance product, and (b) sampled, or reported separately for, workers in the informal sector or economy. Methodological and conceptual papers on the CV technique itself, and systematic reviews and meta-analyses that themselves synthesize WTP estimates across multiple primary studies, were also incorporated to support the discussion of elicitation formats, bias, and cross-study comparability.

Because the underlying primary studies vary considerably in elicitation format, currency, survey year, proposed benefit package, and premium-setting context, this synthesis does not attempt to pool WTP estimates into a single quantitative summary statistic. Instead, findings are organized thematically by region and by determinant category, and the accompanying table and figure present a qualitative, standardized synthesis of reported patterns rather than a meta-analytic pooled estimate. This approach follows the convention used by prior systematic reviews in this literature, which have similarly concluded that heterogeneity in elicitation method and monetary framing across studies precludes straightforward pooling of point WTP estimates [2,3,5].

WTP Estimates for Health Insurance Among Informal Sector Workers: Regional Findings

The Sub-Saharan African literature on WTP for health insurance among informal-sector and rural populations is the most extensive regional evidence base and spans more than a quarter-century. Asenso-Okyere and colleagues' pilot study of Ghana's informal sector, conducted using open-ended contingent valuation before the country's National Health Insurance Scheme was established, found that the large majority of respondents were willing to pay some positive amount for health insurance, but that stated WTP was strongly constrained by household ability to pay and fell well short of the premium levels needed to achieve full-cost recovery [1]. Two decades later, Njie and colleagues applied a double-bounded dichotomous-choice format to estimate WTP for The Gambia's proposed National Health Insurance Scheme and similarly found that mean WTP, while positive for the majority of respondents, clustered below the premium level the government had provisionally proposed, implying that full self-financing of the scheme from informal-sector contributions alone was unlikely to be feasible without public subsidy [6]. Namuhani and colleagues' contingent valuation study of informal-sector workers in Uganda's Iganga and Mayuge districts reported a comparable pattern for Uganda's proposed national scheme: a high proportion of respondents expressed willingness to enroll in principle, but perceived ability to pay, and hence stated WTP, was substantially lower than the government's proposed contribution level, particularly among lower-income households [7].

Nigeria has generated one of the largest concentrations of informal-sector WTP studies in the region. Ogundeji and colleagues' national assessment of factors influencing willingness and ability to pay for social health insurance found that willingness to enroll was widespread but that actual ability to pay the required contribution diverged from willingness in a meaningful share of households, a gap the authors argued has direct implications for premium design [8]. Akwaowo and colleagues, surveying rural residents of Akwa Ibom State on WTP for a contributory scheme, and Onwujekwe and colleagues, examining willingness to pay for improved-quality services from informal providers in urban slums, both reinforced the finding that WTP among Nigeria's informal and rural populations is sensitive to perceived service quality as much as to price, suggesting that CV estimates elicited without a credible quality guarantee likely understate true demand for a well-functioning scheme [9,10]. Bolarinwa and colleagues' cross-sectional comparison of willingness and ability to pay for healthcare insurance across seven communities spanning East and West Africa (the SevenCEWA study) extended this Nigeria-centric picture, documenting wide between-country and

between-community variation in both willingness and ability to pay even after adjusting for income, underscoring that WTP for health insurance is not a single regional constant but a locally contingent quantity shaped by prior exposure to insurance, health system trust, and disease burden [11].

Illustrative synthesis of reported willingness-to-pay (WTP) patterns for health insurance among informal-sector and rural populations across selected contingent valuation studies, standardized descriptively for cross-study comparison.

Setting	Study	Elicitation method	Reported WTP pattern relative to proposed/actual premium
Wuhan, China (informal sector workers)	Bärnighausen et al. 2007	Double-bounded dichotomous choice	Positive WTP for most respondents, broadly consistent with but somewhat below adopted local premium
Ghana (informal sector, nationwide pilot)	Asenso-Okyere et al. 1997	Open-ended	Large majority willing to pay a positive amount, but well below full-cost-recovery premium
Sierra Leone (informal sector)	Jofre-Bonet and Kamara 2018	Bidding game / stated WTP	Substantial share willing to pay less than the premium proposed for national scheme
The Gambia (proposed NHIS, informal sector)	Njie et al. 2023	Double-bounded dichotomous choice	Mean WTP positive but clustered below the government's provisionally proposed premium
Uganda, Iganga and Mayuge districts (informal sector)	Namuhani et al. 2026	Contingent valuation method (dichotomous choice)	High willingness to enroll in principle; perceived ability to pay and WTP below proposed contribution
Nigeria, national (informal sector)	Ogundeji et al. 2019	Stated willingness and ability to pay survey	Widespread willingness to enroll; meaningful gap between willingness and actual ability to pay
Burkina Faso (households)	Topan et al. 2024	Determinants of WTP survey	Positive but modest WTP, generally insufficient for full self-financing of comprehensive benefits
Cote d'Ivoire (diabetic/cardiovascular patients)	Oga et al. 2019	Single-bounded dichotomous choice	Elevated WTP among chronically ill relative to general population, but below government-set premium for most
South Wollo, Ethiopia (households)	Wagaw et al. 2022	Cross-sectional willingness-to-join survey	Majority willing to join community-based health insurance at modest contribution levels
Rural India (rural poor)	Binnendijk et al. 2013	Engel's law-based WTP estimation	Low absolute WTP as share of expenditure, consistent with share allocated to other risk protection
Kolkata, India (urban slum households)	Delavallade 2017	Randomized experiment (revealed retention behavior)	Quality-of-care improvements causally raised willingness to retain/renew insurance coverage
Indonesia (lapsed informal-sector enrollees)	Muttaqien et al. 2021	Mixed-methods ability/willingness assessment	Meaningful share of lapses attributable to inability, not unwillingness, to continue paying premiums

Elsewhere in Sub-Saharan Africa, Bärnighausen and colleagues' contingent valuation study of informal-sector workers in Wuhan, China, though geographically outside Africa, is frequently cited alongside these African studies as an early methodological benchmark because it was among the first to apply a rigorous double-bounded dichotomous-choice design specifically to informal-sector health insurance demand, finding stated WTP broadly consistent with, though somewhat below, the premium level the local scheme ultimately adopted [12]. Within Africa, Topan and colleagues' analysis of the determinants of households' WTP for health insurance in Burkina Faso, Oga and colleagues' study of diabetic and cardiovascular patients' WTP for Côte d'Ivoire's proposed national scheme, and Wagaw and colleagues' study of willingness to join CBHI among households in South Wollo, Ethiopia, together indicate that WTP is generally positive and non-trivial across West and East African informal-sector and rural populations, but consistently falls in a range that most authors characterize as insufficient to fund a comprehensive benefit package without cross-subsidy from general government revenue or donor financing [13,14,15].

South and Southeast Asian evidence tells a broadly parallel story with some important local variation. Binnendijk and colleagues' widely cited application of Engel's law to estimate WTP for health insurance among India's rural poor found that stated WTP,

expressed as a share of total household expenditure, was low in absolute terms but consistent with the share of income that poor households in India devote to other forms of risk protection, suggesting that low absolute WTP reflects genuine budget constraints rather than a lack of demand for risk protection per se [16]. Delavallade's randomized experiment on quality health care and WTP for health insurance retention among slum residents in Kolkata went a step further, providing experimental evidence that improvements in perceived service quality causally increased households' revealed willingness to renew insurance coverage, directly corroborating the CV-based inference from Nigeria that quality perception, not price alone, drives informal-sector insurance demand [17]. In Indonesia, Muttaqien and colleagues' mixed-methods study of why informal-sector workers who had voluntarily enrolled in the national Jaminan Kesehatan Nasional scheme subsequently stopped paying premiums found that a meaningful share of lapsed enrollees reported an inability, rather than an unwillingness, to continue paying, and that many resumed paying only once they or a family member needed care, a pattern consistent with adverse-selection dynamics that voluntary, premium-based informal-sector insurance is structurally prone to [18].

Table 1 summarizes the reported willingness-to-pay patterns synthesized across a representative subset of these regional studies, standardized descriptively to permit qualitative cross-study comparison despite differences in elicitation method, currency, and survey year.

Determinants of Willingness to Pay Among Informal Sector Workers

Across the geographically and methodologically diverse literature reviewed here, a relatively consistent set of determinants recurs as statistically significant predictors of higher stated WTP for health insurance. Household income or expenditure is the most uniformly reported determinant: virtually every study surveyed here, from Asenso-Okyere and colleagues' original Ghana study through Binnendijk and colleagues' Engel's-law application in India and Ogundeji and colleagues' Nigerian assessment, finds that wealthier households state a higher WTP in both absolute and (to a lesser extent) proportional terms, even though the income elasticity of WTP for health insurance is consistently estimated to be well below one, implying that health insurance behaves as a "necessity" rather than a luxury good in these populations [1,16,8]. Educational attainment is nearly as consistently significant, plausibly operating both through its correlation with income and independently through improved comprehension of insurance concepts and risk pooling, a mechanism explicitly discussed by Njie and colleagues in the Gambia and Topan and colleagues in Burkina Faso [6,13].

A second cluster of determinants relates to household composition and health risk. Household size and the presence of children or elderly members are frequently associated with higher WTP, consistent with a precautionary-demand interpretation in which larger households facing greater aggregate health-expenditure risk value pooling more highly, a pattern reported by Wagaw and colleagues in Ethiopia and Bolarinwa and colleagues across the SevenCEWA sites [15,11]. Self-reported poor health status, chronic illness, or recent illness episodes similarly predict higher WTP in several studies, most explicitly in Oga and colleagues' study of diabetic and cardiovascular patients in Côte d'Ivoire, where the presence of a costly chronic condition was associated with substantially elevated willingness to pay relative to the general informal-sector population, illustrating both the adverse-selection risk facing voluntary schemes and the genuine unmet demand for catastrophic-cost protection among the chronically ill [14].

A third and increasingly emphasized cluster concerns trust, prior experience, and perceived scheme quality rather than purely demographic or economic characteristics. Muttaqien and colleagues' Indonesian study and Onwujekwe and colleagues' Nigerian urban-slum study both identify perceived quality of care, and confidence that a claims and benefits process will actually function as promised, as determinants that operate independently of, and in some analyses more strongly than, income [18,10]. Prior awareness of, or exposure to, an existing insurance scheme is likewise a recurring predictor: Nigeria-focused work by Ogundeji and colleagues and the broader systematic review evidence assembled by Nosratnejad and colleagues and by Bayked and colleagues both note that respondents with prior insurance experience, even in an unrelated scheme, report systematically higher WTP than first-time-exposed respondents, a pattern the authors attribute to reduced uncertainty about how insurance functions rather than to underlying differences in health risk [8,2,19]. Trust in the managing institution, whether government, a community-based organization, or a private insurer, is highlighted across several of the African studies as a determinant that can either substitute for, or undermine, the effect of income and education on stated WTP, particularly in settings with a recent history of scheme mismanagement or benefit-payment delays.

Figure 1 presents an illustrative, narrative-synthesis-level summary of how frequently each of these determinant categories was identified as statistically significant across the body of contingent valuation and related WTP studies reviewed in this article, underscoring household income/expenditure, health status and perceived risk, and trust or prior insurance experience as the three most consistently reported drivers of informal-sector WTP for health insurance.

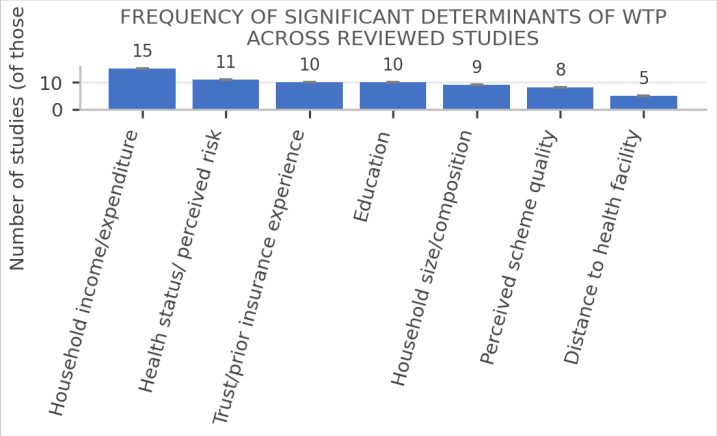
Contingent Valuation Methodological Considerations

The internal validity of any given WTP estimate for health insurance depends heavily on the specific contingent valuation elicitation format employed, and the literature reviewed here spans nearly the full range of formats developed in the broader CV tradition. Open-ended elicitation, in which respondents are simply asked to state the maximum amount they would pay, was the format used in the earliest health-insurance CV work, including Asenso-Okyere and colleagues' Ghana study, but is now understood to be prone to strategic and starting-point bias and to impose a cognitively demanding task that many respondents in low-literacy settings find difficult to answer meaningfully [1,4]. Bidding-game formats, used in early applications including some of the Sierra Leone literature synthesized by Jofre-Bonet and Kamara, mitigate some of this difficulty by iteratively proposing amounts, but are themselves vulnerable to anchoring on the interviewer's starting bid [20].

Single- and double-bounded dichotomous-choice formats, in which respondents are asked only whether they would pay a randomly assigned bid amount (and, in the double-bounded design, are then asked a follow-up bid conditional on their first answer), have become the dominant elicitation approach in the more recent literature, including the studies by Bärnighausen and colleagues in China, Njie and colleagues in The Gambia, and Namuhani and colleagues in Uganda [12,6,7]. Donfouet and

colleagues' methodological analysis of internal inconsistency in double-bounded dichotomous-choice CV, applied specifically to community-based health insurance, demonstrates that the statistical efficiency gains double-bounded designs offer over single-bounded designs can be partly offset by respondents' tendency to give answers to the second bid that are inconsistent with a stable underlying valuation, a finding with direct implications for how confidently point estimates from double-bounded CV studies of health insurance should be interpreted [21].

Illustrative narrative-synthesis summary of how frequently each determinant category was reported as a statistically significant predictor of willingness to pay (WTP) for health insurance across the contingent valuation and related WTP studies of informal-sector workers reviewed in this article. Counts are approximate, standardized across studies with heterogeneous regression specifications, and intended to convey relative emphasis rather than a pooled meta-analytic estimate.



Beyond elicitation format, several broader methodological considerations recur throughout this literature and are synthesized in general terms by Diener and colleagues' foundational review and, for health-services CV specifically, by Steigenberger and colleagues' more recent systematic review of WTP determinants [4,3]. Hypothetical bias, the tendency for stated WTP in a hypothetical CV scenario to exceed what respondents would actually pay when a real payment obligation is introduced, is a persistent concern for health insurance CV given that respondents have a plausible incentive to overstate demand for a good they perceive as beneficial to their community, even without a personal payment obligation. Odihi and colleagues' pilot CV study eliciting willingness to pay for reductions in vaccine-preventable mortality in Bangladesh illustrates the broader methodological toolkit, including debriefing questions and follow-up certainty scales, that has been developed within health-related CV specifically to probe and partially correct for this bias [22]. Framing of the benefit package described to respondents, including the credibility of the proposed provider network and claims process, is a second major source of variation across studies, and several of the papers reviewed here explicitly note that respondents' stated WTP is sensitive to whether the described scheme is framed as government-run, community-managed, or privately underwritten, independent of the objective benefit package on offer.

Policy Implications for Extending Health Coverage to Informal Sector Workers

The accumulated contingent valuation evidence carries several converging implications for the design of health insurance schemes targeting informal-sector populations. First, and most fundamentally, the consistent finding across geographically diverse studies, from Ghana and The Gambia to India and Uganda, that mean stated WTP among informal-sector households falls below the premium level required for full cost recovery of a comprehensive benefit package implies that voluntary, contribution-only financing models are structurally unlikely to achieve both financial sustainability and broad informal-sector coverage simultaneously [1,6,16,7]. This finding underpins the now-widespread policy consensus, reflected in the design of schemes reviewed by Bayked and colleagues across Africa and Asia, that some form of general-revenue or donor cross-subsidy targeted at informal-sector premiums, rather than premium levels alone, is necessary to reconcile the gap between what informal workers can pay and what comprehensive coverage costs [19].

Second, the strong and repeated finding that perceived quality of care and trust in the managing institution shape WTP independently of price, documented by Muttaqien and colleagues in Indonesia and Onwujekwe and colleagues in Nigeria, suggests that premium subsidy alone will be insufficient to sustain enrollment if service quality and claims administration are not simultaneously improved [18,10]. This is consistent with Delavallade's experimental finding from Kolkata that quality improvements causally raised insurance retention, and implies that schemes seeking to convert stated hypothetical WTP into actual sustained enrollment should invest in demonstrable, visible improvements to the provider network and reimbursement reliability alongside any premium adjustment [17].

Third, the adverse-selection dynamics visible in the Indonesian dropout evidence and in the elevated WTP reported among chronically ill respondents in Côte d'Ivoire point toward a design tension inherent to voluntary informal-sector schemes: premiums calibrated to the WTP of higher-risk subgroups price out healthier informal workers, while premiums calibrated to the broader population's lower WTP undermine financial sustainability once enrollment skews toward higher-risk individuals [18,14]. Several of the systematic reviews synthesized here, including Nosratnejad and colleagues and Steigenberger and colleagues, argue that this tension is best addressed through mandatory or automatically enrolled informal-sector coverage financed in part through indirect or transaction-based levies rather than through voluntary premium collection alone, precisely because voluntary CV-elicited WTP systematically understates the socially efficient level of informal-sector coverage once adverse selection and positive externalities from risk pooling are taken into account [2,3].

Discussion

Taken as a whole, the narrative synthesis assembled here indicates that informal-sector workers across Sub-Saharan Africa, South and Southeast Asia, and, more sparsely, Latin America, consistently express a positive, non-trivial willingness to pay for health insurance, but one that in the great majority of studies falls short of the premium levels required to finance a comprehensive benefit package without external subsidy. This basic pattern, first documented by Asenso-Okyere and colleagues in Ghana in 1997 and replicated with more sophisticated dichotomous-choice elicitation methods in settings as varied as China, The Gambia, Uganda, and Burkina Faso, has proven remarkably durable across nearly three decades of

methodological refinement [1,12,6,7,13]. This durability is itself an important finding: it suggests that the WTP-financing gap for informal-sector health insurance is not primarily an artifact of any single study's elicitation design or sampling frame, but a structural feature of informal-sector income constraints relative to the cost of a meaningful health benefit package.

At the same time, the methodological literature reviewed here, particularly Diener and colleagues' and Steigenberger and colleagues' broader reviews of health-related contingent valuation and Donfouet and colleagues' analysis of double-bounded dichotomous-choice inconsistency, counsels caution against treating any individual CV point estimate as a precise, policy-ready number [4,3,21]. Elicitation-format effects, hypothetical bias, and the framing of the proposed scheme's credibility all introduce variance into stated WTP that is not fully separable, within a single cross-sectional CV study, from genuine underlying preference heterogeneity. The consistency of the qualitative pattern, income-constrained but positive demand, sensitivity to perceived quality and trust, and a role for household health risk, across studies using different elicitation formats and conducted in different decades, is therefore more informative for policy than any single study's numerical WTP estimate taken in isolation.

The evidence base also has clear regional and thematic gaps. Latin American CV evidence on informal-sector health insurance demand specifically is markedly thinner than the African and South/Southeast Asian literature reviewed here, reflecting the region's greater reliance on subsidized or tax-financed universal schemes (such as Mexico's former Seguro Popular and Colombia's subsidized regime) rather than voluntary contributory insurance for informal workers, which has meant that CV of hypothetical premiums has been a less central research tool in that regional context. Similarly, few of the studies reviewed here follow respondents longitudinally to compare stated hypothetical WTP against subsequently revealed enrollment and premium-payment behavior, a validation step that only Delavallade's Kolkata experiment and Muttaqien and colleagues' Indonesian dropout analysis approximate within this literature [17,18]. Future contingent valuation research on informal-sector health insurance demand would benefit from greater use of such hybrid stated-and-revealed-preference designs, more systematic reporting of WTP as a standardized share of household income or expenditure to facilitate cross-study comparison, and expanded geographic coverage in Latin America and in fragile and conflict-affected settings that remain underrepresented in the current evidence base.

Conclusion

The published contingent valuation literature on willingness to pay for health insurance among informal-sector workers, spanning Sub-Saharan Africa, South and Southeast Asia, and China over nearly three decades, converges on a consistent narrative: informal-sector households are generally willing to pay a positive but modest amount for health insurance, an amount that is systematically related to household income, education, health status, household composition, and, increasingly, to trust in the administering institution and perceived service quality, but one that in most studied settings falls short of what is needed to finance a comprehensive benefit package through voluntary premiums alone. Methodologically, the field has progressed from open-ended and bidding-game elicitation toward more statistically robust single- and double-bounded dichotomous-choice designs, while accumulating a body of methodological critique, concerning hypothetical bias, response inconsistency, and framing effects, that should temper the precision with which any individual WTP estimate is used for premium setting. For policymakers designing or reforming health financing arrangements for informal-sector populations, the clearest implication of this synthesis is that contingent valuation evidence is best used not to identify a single "correct" premium, but to characterize the scale of the financing gap between informal-sector ability and willingness to pay and the cost of meaningful coverage, a gap that the accumulated evidence suggests will, in most low- and middle-income settings, require some combination of general-revenue subsidy, quality-linked enrollment incentives, and careful attention to adverse selection to close.

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