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LEVERAGING HEALTH MICROINSURANCE
TO PROMOTE UNIVERSAL HEALTH
COVERAGE

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EXECUTIVE SUMMARY

Every member of society has the right to social security, including access to health care (United Nations, 1948). However, 75 per cent of the world's population is not adequately protected and approximately 40 per cent lacks even basic protection (Bachelet, 2011). The International Labour Organization (ILO) is calling for countries to define minimum social security benefits – including those for health – as soon as conditions allow (ILO, 2012). At the same time, momentum for universal health coverage (UHC), or “a system in which everyone in a society can get the health care services they need without financial hardship,” is building in countries as diverse as China, Ghana, Indonesia, Mexico and South Africa (Savedoff et al., 2012).

Many countries are pursuing government-sponsored health insurance as a primary path toward UHC. In these same countries, there are private health microinsurance (HMI) schemes sponsored by community-based organizations, commercial insurance companies or others that share many of the same goals as government-sponsored health insurance schemes.

Reaching informal workers and their families is a major barrier for both types of schemes in providing social health protection. Governments struggle to identify individuals, enrol them and collect premiums. These are functions that HMI providers are well positioned to manage. However, HMI schemes have difficulties in achieving scale and accessing sufficient resources. Governments are better positioned in both respects. These complementary assets open opportunities for collaboration.

This paper reviews country experiences in Cambodia, Ghana, India, Kenya, Thailand, Tanzania and the Philippines. It examines the hypothesis that government-sponsored insurance initiatives should collaborate with private actors to accelerate the expansion of health insurance to informal workers and their families.

Roles for private actors in UHC

The nature of collaboration between the government and private actors changes over time and can differ according to context; nevertheless, there is an on-going role for HMI in supporting government initiatives and improving access to quality healthcare services or financial protection. Our findings suggest four roles in which HMI schemes and other private actors can be leveraged to promote UHC: substitute, foundation, partnership and supplement.

- 1) Early on, HMI schemes, often in the form of community-based health insurance (CBHI), substitute government initiatives that have not yet been designed or effectively implemented. In cases where government engagement remains limited, this substitution may predominate for an indefinite period. In other situations, HMI schemes may substitute government initiatives during the early stage of a country's evolution toward UHC, and diminish as government reforms progress.
- 2) Governments can also leverage the assets of CBHI schemes by using them as a foundation to scale up UHC initiatives. In Ghana, CBHI schemes were consolidated into a government scheme, which is managed at district level. In Thailand, the government incorporated lessons from early CBHI schemes in the design of a voluntary scheme for informal workers. It subsequently merged this scheme with a targeted scheme for the poor to create a single mandatory scheme that has enabled coverage of the entire population.
- 3) Governments can also form partnerships with HMI schemes and other private actors to deliver key insurance functions, such as marketing, identification of eligible clients, distribution of insurance, premium collection and

even claims processing and risk-carrying. This may be an attractive alternative to creating and providing the functions within government and may enable faster, more efficient scale up. In Kenya and the Philippines, the government outsources front-end insurance functions, such as enrolment, to private sector partners; the Rashtriya Swasthya Bima Yojana (RSBY) scheme in India does the same for back-end insurance functions, such as claims administration.

- 4) Even as government initiatives expand benefits, HMI schemes can offer valuable products that supplement government benefits. For example, they can cover outpatient services if these are not provided in the national benefit package, provide additional financial protection against health-related costs for transport, lost wages or child care or provide access to health facilities outside the government network. Examples of the supplementary role of HMI can be seen in India, Jordan, Kenya and South Africa, as well as in more developed countries.

The demonstration effect

HMI schemes can also be “learning incubators” and create a demonstration effect for policymakers. During the early stages of implementing a health financing strategy they can provide valuable lessons to governments on how to reach excluded groups. Thereafter, they can pilot new products or operational models in collaboration with the government.

There are many opportunities to leverage HMI schemes and private actors within government initiatives, but there is no silver bullet to reach UHC. Achieving UHC requires time and resources. Countries that have significantly extended coverage, particularly to individuals in the informal economy, have expanded benefits, increased subsidies and enacted compulsory enrolment, while concurrently improving health care infrastructure. Such policy decisions and the associated mobilization of resources are extremely challenging for most governments.

Though there are advantages to leveraging HMI schemes, their capacity also varies; their ability to perform as government partners varies as a result. In addition, the demonstration effect from HMI initiatives can be valuable, but lessons may not be transferable to other settings. No matter how well designed or funded an HMI or government scheme may be, there are still financial and behavioural constraints that limit and distort demand.

A critical success factor for any form of collaboration between governments and HMI schemes is transparent, ongoing dialogue among all stakeholders in order to align interests and understand each party's strengths and weaknesses. It is important for policymakers to understand and monitor the impact of HMI in their country and to articulate the optimal role of HMI over time. It is equally important that HMI actors advocate for the role they can play in supporting government efforts to achieve UHC.

Despite a lack of clear-cut solutions to achieve UHC, it is evident that HMI can contribute to government efforts to serve large numbers of informal workers, and that collaboration can reduce duplicative or competing models. Governments should look to HMI as a source of innovation and learning, and actively seek partners with experience, fresh ideas and complementary capacities.

ABBREVIATIONS AND ACRONYMS

BPL - Below the poverty line
 CBHI - Community-based health insurance
 CHF - Community Health Fund
 CIDR - Centre International de Developpement et Recherche
 HCHC - Hygeia Community Health Care
 HEF - Health Equity Fund
 HMI - Health microinsurance
 iGroup - Individually Paying Program for Groups
 ILO - International Labour Organization
 KaSAPI - Kalusanga Sigurado at Abot-Kaya sa PhilHealth Insurance
 Ksh - Kenyan shilling
 LMICs - Low and middle-income countries
 MFW - Microfund for Women
 MFI - Microfinance Institution
 MOH - Ministry of Health
 MOLE - Ministry of Labour and Employment
 MOHP - Ministry of Public Health
 NGO - Non-governmental organization
 NHIA - National health insurance authority
 NHIF - National Health Insurance Fund (Tanzania)
 NHIF - National Hospital Insurance Fund (Kenya)
 NHIS - National Health Insurance Scheme
 NSSF- National Social Security Fund
 PhilHealth - Philippine Health Insurance Corporation
 POGI - PhilHealth Organized Group Interface
 PPP - Public private partnership
 RSBY - Rashtriya Swasthya Bima Yojana
 SACCO - Savings and credit cooperative organization
 SMHIS - Self Managed Health Insurance Scheme
 Tika - Tiba Kwa Kadi
 UC - Universal coverage
 UHC - Universal health coverage

1 > INTRODUCTION

Every member of society has the right to social security, including access to health care (United Nations, 1948). The International Labour Organization (ILO) defined minimum standards for health care and eight other areas of social protection in 1952 (ILO, 1952). However, approximately 75 per cent of the world's population – 5.1 billion people – are not adequately protected; approximately 40 per cent lack even basic protection (Bachelet, 2011). A total of 150 million people suffer financial catastrophe annually and 100 million people are pushed below the poverty line as a result of out-of-pocket health-care expenses (World Health Organization, 2010). The recent ILO Recommendation 202 (June 2012) on social protection floors calls for a pragmatic, step-wise approach to social protection. It asks countries to define minimum social security benefits – including those for health – as soon as conditions allow (ILO, 2012).

At the same time, momentum for universal health coverage (UHC), or “a system in which everyone in a society can get the health care services they need without financial hardship,” is building in countries as diverse as China, Ghana, Indonesia, Mexico, and South Africa (Savedoff et al., 2012). Government policymakers are prioritizing UHC as a means of supporting the broad principles defined within social protection standards, and of strengthening their health systems' ability to reduce infectious disease and improve maternal and child health, in line with the Millennium Development Goals. Many governments are pursuing health insurance as a primary path toward UHC, but face significant challenges in making progress, particularly to reach individuals in the informal economy.

In these same countries, there are private health microinsurance (HMI) schemes sponsored by community-based organizations, commercial insurance companies or others that share many of the same goals as government-sponsored health insurance. They want efficient, high quality, effective delivery of health care, at a sustainable cost. They seek to mitigate health-related financial shocks with pre-paid financing mechanisms. They pool risk across large populations and enable access to appropriate use of health-care services. Governments and private actors measure their ultimate impact on health outcomes, though in the early stages their initiatives tend to focus primarily on financial protection against health related events.

Although they have common goals, government and HMI sponsors face different problems in reaching individuals in the informal economy. Governments find it difficult to raise awareness, identify individuals and distribute insurance. HMI schemes struggle to offer broad, sustainable benefits or to include the very poor. This is because they lack access to sufficient subsidies and large, diverse risk pools that can enable cross-subsidizing.

An opportunity exists for governments to consider HMI schemes, as well as other private actors, as allies to reach informal workers. The government's ability to achieve scale and to generate revenues from multiple sources enables government health insurance programmes to pool risk across a larger and potentially more diverse population, and to cross-subsidize sub-populations. Community-based health insurance schemes (CBHI), microfinance institutions, cooperatives and other member-based groups have community ties that can engender trust, facilitate identification of the uninsured and promote enrolment. As an aggregator of informal workers, they can play an active role to market and distribute insurance. Other private institutions, such as commercial insurers, can also perform back-end functions, such as health-care provider management and claims processing. These complementary assets suggest potential for learning, testing new strategies and greater collaboration.

This paper reviews seven country experiences. It examines the hypothesis that government-sponsored insurance initiatives should collaborate with private actors to accelerate the expansion of health insurance to informal workers and their families. Through a desk review of available literature and interviews with key informants from government schemes, HMI schemes and private partners (Appendix I), we identify and describe different models for collaboration. The paper includes a discussion of specific insurance schemes, but it is not a guide for practical implementation; this is an area which will require future work. The paper targets policymakers in the hope that it will stimulate ideas and discussion about new ways of reaching those in the informal economy. The findings and lessons learned should also be valuable for insurers, researchers and the global health community.

The paper begins with a brief background to government UHC initiatives and HMI schemes, followed by a conceptual framework outlining how the roles of private actors can support UHC initiatives over time. The discussion uses real examples to illustrate these roles, including lessons learned regarding strengths and limitations, and seeks to promote dialogue between policymakers and insurers pursuing UHC.

2 > UNIVERSAL HEALTH COVERAGE

Most high-income countries achieved UHC in the middle of the last century, and many middle-income countries have followed in the past few decades. In recent years, a number of low-income countries have made significant progress. Regardless of whether UHC has been achieved, all countries continue to improve quality of health care, make access more equal and contain costs.

The movement towards UHC gained further momentum as a result of the 2010 World Health Report, which stated the key principles and theory behind UHC (World Health Organization, 2010). Since then, numerous academic studies, opinion pieces and reports have been published and the body of research and knowledge related to UHC is growing (Acharya et al., 2012; Garrett et al., 2009; Gwatkin et al., 2010; Lagomarsino et al., 2012; Matul et al., 2010; Spaan et al., 2012). Current evidence about the impact of UHC reforms is mixed; a recent systematic review noted that health insurance may prevent higher levels of expenditure, but there is no conclusive evidence to date regarding an impact on health outcomes (Acharya et al., 2012).

Policymakers and practitioners are sharing their knowledge and experience through platforms such as the Joint Learning Network for Universal Health Coverage, the Capacity-UHC Center in Thailand, the Harmonization for Health in Africa Community of Practice on Financial Access to Health Services and a number of other emerging regional knowledge centres. Global events, such as the 2012 World Health Assembly, Rio+20, the 2012 Prince Mahidol Award Conference and the 2012 Beijing Health Systems Symposium have focused on UHC, as have numerous regional events. In December 2012, the United Nations adopted a resolution recommending UHC as a means of addressing global health challenges (UHC Forward, 2012).

A recent UNICEF study of 52 low and middle-income countries revealed that almost every country is striving toward UHC (O'Connell, 2012). Although only a subset of these countries is focused on introducing reforms, their experiences reveal key lessons about implementing UHC (Kutzin, 2012; Lagomarsino et al., 2012).

- UHC pathways vary: Each country is unique. Countries implementing UHC reforms have very different starting points and country contexts, and their pathways toward UHC are varied and complex. No single UHC pathway is considered best.
- Reaching individuals within the informal economy is a challenge: Countries often start by covering individuals who are formally employed, then follow with targeted subsidies for the very poor and leave informal workers and their families until last. Registration systems in countries also vary. Some have national identification systems, but others lack a mechanism to track the entire population.
- Cross subsidies are essential: Cross subsidies, from the wealthy to the poor, and from the healthy to the sick, are essential to create a system that shares risk across a population and mitigates health related financial shocks.

Box 1. Universal health coverage

This paper defines universal health coverage (UHC) as “a system in which everyone in a society can get the health care services they need without financial hardship.” The underlying theory is that UHC can increase access to essential health services, improve financial protection and ultimately lead to better health outcomes. UHC is measured along three dimensions: breadth – who is covered, depth – what services are covered and height – what proportion of cost is covered.

Source: Savedoff (2012); WHO (2010)

- Fewer, larger risk pools enable cross-subsidy and equity: There is a trend toward fewer, larger risk pools to enable cross-subsidy and scale. In addition, larger risk pools reduce variation across groups, thereby promoting greater equity.
- Government financing is essential to achieve UHC: In countries that have achieved UHC, national governments have played a strong role in financing, shifting to prepaid revenues and minimizing user fees that limit access to care. Taxes have been a core component of revenue generation for all countries that have achieved UHC.
- Improved health-care infrastructure and delivery must accompany financing: The government needs to invest in improving the quality of health care, increasing salaries of health-care providers, reinforcing social security governance and making drugs more available.
- Mandatory membership is necessary for full population coverage: Throughout the world, UHC schemes that rely on voluntary premiums are essentially non-existent. In cases where there are voluntary contributions, these represent a small percentage of overall revenues. Mandatory membership that relies heavily on general government taxes, in addition to secondary sources such as automatic contributions from individuals in formal employment (e.g. payroll tax), have been more successful in achieving full population coverage and expanded benefits.
- UHC is achieved incrementally: Pursuit of UHC is iterative and relies on different types of demand-side financing mechanisms. Most countries that have achieved UHC have done so incrementally, over decades, and most must resolve significant financial, administrative and political challenges along the way.

3 > HEALTH MICROINSURANCE

Microinsurance is traditionally defined as “the protection of low-income people against specific perils in exchange for regular premium payments proportional to the likelihood and cost of the risk involved”(Churchill, 2006). HMI schemes emerged in the late 1980s in Africa and in the late 1990s in Asia to offer financial protection against catastrophic health-care expenditure. HMI schemes often developed in countries where government financing mechanisms to cover health risks were non-existent or inadequate in terms of quality, access or cost.

The majority of HMI products are delivered through microfinance institutions, community organizations, cooperatives, non-governmental organizations (NGOs) or commercial insurers. They target informal workers and their families, using a range of HMI models (Box 2). The products vary, depending on factors that include the scheme's objective and resources, the disease burden of the target population and the type of health-care providers that it contracts. These models vary greatly in their capacity and skills. In order to reduce costs, many CBHI schemes rely on volunteers to conduct some insurance tasks, leading to inefficient business processes, failure to scale up and weak management and insurance capacity. The other models – partner-agent, full service and provider driven – tend to have stronger managerial capacity, but weaker community cohesion.

Box 2. Models of health microinsurance

- Community-based health insurance (CBHI) or mutual model: This not-for-profit insurance is owned and managed by members of the scheme, who pool funds and share risk across the community. Decision-making is more participatory. CBHI is also known as mutual insurance, with an emphasis on social solidarity.
- Partner-agent model: This model involves a private or commercial insurance company that partners with a local agent to sell its products. Common types of distribution channels include microfinance institutions, organized groups and cooperatives.
- Full service/direct agent model: In this model, a commercial insurer assumes responsibility for the entire insurance value chain, selling its product directly to the target population, managing health-care providers and claims and overseeing the scheme.
- Provider driven model: In this model, the health-care providers manage all insurance functions, including sales, financial risk management and provision of health-care services (e.g. BRAC in Bangladesh).

Source: McCord, 2001. Rosner et al., 2012.

The HMI landscape varies substantially across regions. Africa is dominated by CBHI schemes; only 10 per cent of insured individuals are covered through commercial insurers (McCord et al., 2012). Enrolment levels are generally lower (the recent volume *The Landscape of Microinsurance in Africa 2012* cites an average of 5,700 lives per scheme), which results in limited risk pooling and restricted capacity to spread fixed costs. Total HMI scheme coverage in Africa is an estimated 2.4 million lives, excluding government-led schemes. By contrast, Latin America is dominated by commercial insurers. A total of 10 million people are covered through 13 different products, with an average enrolment of 770,000 beneficiaries (McCord et al., 2010). Most of these products supplement existing social insurance schemes with top-up benefits. Coverage in Asia is less well documented, but countries such as India have numerous HMI schemes with substantial levels of enrolment.

Experience with HMI has shown it is possible to target low and middle-income households with customized products that create access to health care and reduce health related financial shocks (Churchill et al., 2012). However, the majority of HMI products are voluntary, and their outreach remains limited.

In a context of limited capability to pay for insurance and limited availability of subsidies to reduce costs for clients, the benefits of HMI products are typically limited. They often cover low-frequency events such as catastrophic hospitalization cases, provide benefits for a defined range of diagnoses and/or services (e.g. female reproductive system cancer prevention and treatment) or simply provide a lump sum payment for each day spent in the hospital (known as “hospital cash”). Nevertheless, some HMI schemes (often CBHI schemes) aim to provide more comprehensive benefits and include outpatient cover, given the equal or even higher financial burden it can place on a low-income family (Dror et al., 2012b; Pott et al., 2013). However, these schemes often face high claims and administrative cost ratios, which limit financial viability.

Innovative products are emerging to combat some of the challenges described above. For example, some products offer discounted prices for outpatient consultations and drugs in order to address the need for outpatient coverage at an affordable price (Pott and Holtz, 2013). New premium collection processes have been developed to overcome client liquidity constraints and difficulties with payments. Innovations include in-kind premium payments (e.g. labour for insurance) and savings-linked arrangements. Technology-enabled innovations show promise in increasing value for clients and enhancing viability of HMI schemes. Examples include the use of mobile phones to collect premiums, transmit policy and claim information between insurers and clients, and to deliver care (i.e. telemedicine).

Reaching low-income households in the informal economy

The informal economy is varied, comprising workers with a range of incomes, both poor and non-poor. Informal workers are employed in diverse areas such as farming, textiles and domestic work, but lack formal employment contracts or other means needed for enrolling in and contributing premiums to social insurance schemes. This challenge can be exacerbated by other characteristics of informal employment, which include:

- Identification: Informal workers may lack a formal identity registration and may not belong to a professional association or organized group.
- Premium collection: Individual contributions cannot be automatically deducted from payroll and the administrative cost of collecting them may even exceed the revenue collected. Incomes may fluctuate according to seasonal harvests or production cycles, as may spending (e.g. for weddings, festivals or education). Even if a family can afford insurance, the timing of premium collection may not align with its cash flow.
- Willingness to pay: The value of insurance may not always be apparent to clients (Dror et al., 2012a; Mathauer et al., 2008). Even those who understand insurance concepts may not purchase it due to behavioural factors (Dalal et al., 2010). They may think that they will not fall sick again, or fear that by purchasing insurance they will be more likely to become ill (Matul et al., 2013).
- Distrust of government institutions and insurers: Trust can also be a challenge, with communities more willing to trust locally sponsored products sold by neighbours (Dalal et al., 2010).

- **Product design:** Health insurance products for informal workers need to reflect the demographics, health status, ability to pay and health-care delivery infrastructure of the target audience. Migration, which is common among informal workers, not only makes establishing their identity and location difficult, but means that products must be portable, so that workers can use them wherever they are.
- **Access:** Insurance alone is insufficient. Informal workers and their families living in rural areas need access to quality health-care services, but may have limited choice. In order for HMI or any type of insurance to be successful, infrastructure and delivery of health-care services must be improved.

Many HMI schemes attempt to address these challenges by marrying technical skills from commercial insurance with knowledge of the context and needs of low-income communities to design relevant products. The schemes have created processes to identify their target market, ensure customer care and settle claims quickly, often by applying innovative or more flexible approaches.

To overcome challenges in identifying eligible clients, HMI schemes often operate locally, either by linking with organized groups in the informal sector (for example, cooperatives and MFIs) or by conducting door-to-door enrolment. Hygeia Community Health Care (HCHC) in Nigeria, which places agents in markets throughout Lagos to conduct enrolment and premium collection where individuals work, and Uplift Mutuals in India, which offers health coverage to microfinance clients, illustrate how HMI can be anchored in the community (Hygeia Community Health Care, 2013; Uplift India Association, 2013). In other schemes, such as in Guinea's Union des Mutuelles de Santé de Guinée Forestière, the premium collection time is adapted to coincide with income availability (i.e. harvest time) (Centre International de Développement et de Recherche (CIDR), 2012).

To create more tangible products, some HMI schemes provide value-added services, either for preventive or therapeutic care. Examples are Swayam Shikshan Prayog, an Indian NGO, which offers discounted access to outpatient consultations and medicines, and SAJIDA Foundation in Bangladesh, which offers access to a dial-a-doctor service (Pott et al., 2013).

Many HMI schemes also facilitate access to services with "cashless" systems that do not require out-of-pocket payment by clients; instead, the HMI scheme makes a payment on behalf of the client, directly to the health-care provider. The case of HCHC in Nigeria is also interesting, as all health facilities involved in the scheme must enrol in the SafeCare programme, which includes a step-wise approach to improve service quality.

Nevertheless, HMI schemes struggle to be viable. Some have strong community engagement, but suffer from weak managerial skills, or vice versa. They typically rely on voluntary contributions from households, with limited subsidies from the government, which constrains their ability to offer comprehensive benefit packages and contributes to adverse selection. While government subsidized schemes can be more affordable, they may provide low client satisfaction, due to limited access to facilities or concerns about quality.

4 > A FRAMEWORK FOR HMI AND UHC

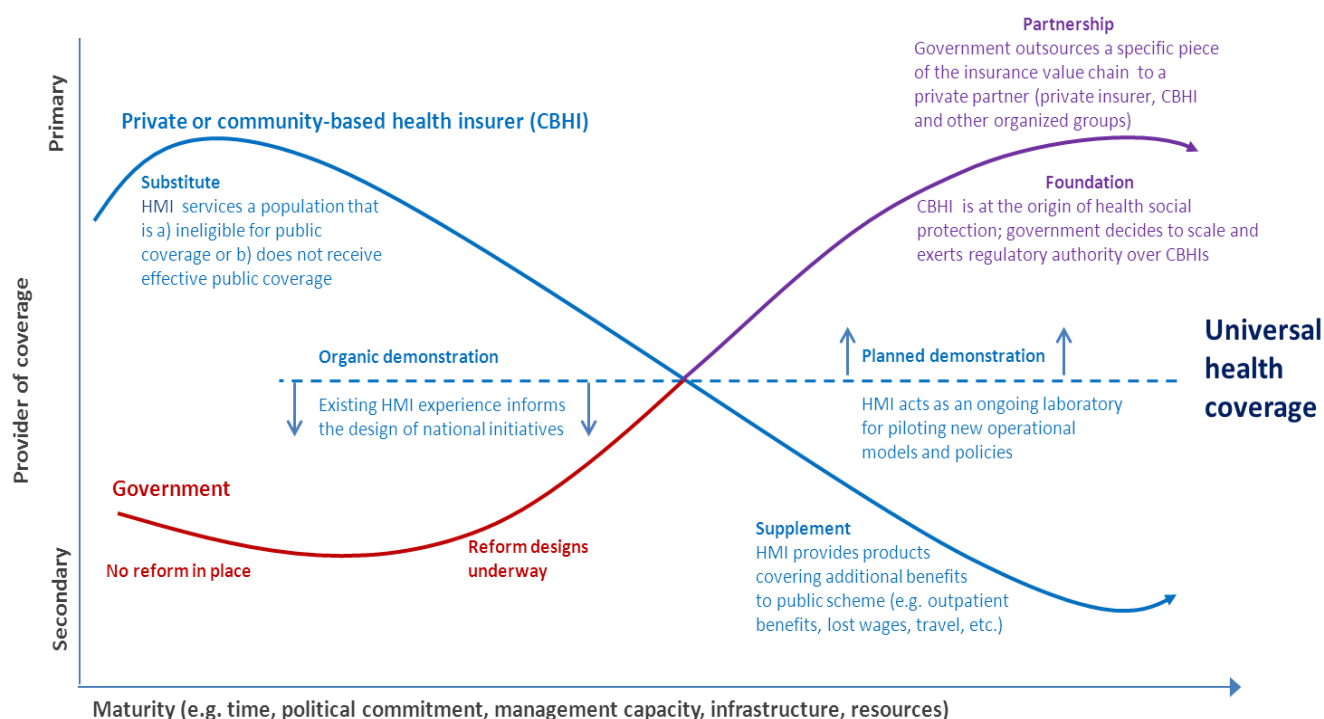
The findings suggest four roles in which HMI schemes and other private actors can be leveraged to promote UHC: substitute, foundation, partnership, and supplement. Figure 1 illustrates these roles as an evolutionary continuum toward UHC. It is important to note that in reality, the evolution is more iterative and multiple roles may apply at a given point in time; the framework represents a simplified understanding of this progression. In addition to these roles, there is an on-going demonstration effect that persists as governments draw upon lessons from HMI experience or turn to HMI schemes as a platform for piloting new models.

Substitute

Early on, HMI schemes substitute government initiatives that have not yet been designed or effectively implemented. Often, this is in the form of CBHI schemes. Before government health financing strategies are in place and operating effectively, HMI may be the only option available to informal workers for providing financial protection against health risks. In cases where government engagement remains limited, HMI may predominate for an indefinite period. In other situations, HMI may substitute government initiatives during the early stage of a country's evolution toward UHC, and diminish as government reforms progress.

In Bangladesh for instance, the government is just beginning to formulate a plan for UHC. In the meantime, private NGOs such as *Gono-Shasthaya Kendra*, *Grameen Kalyan* and *SAJIDA Foundation* are the main providers of health insurance for informal workers. In India, where government insurance schemes specifically target those who fall below the poverty line (BPL), as well as some groups of workers (e.g. textile workers), schemes such as *Yeshasvini*, *Uplift* and *VimoSEWA* provide coverage to the working poor, who may be excluded from government schemes.

Figure 1: Leveraging HMI to promote UHC



Two models for collaboration between the government and HMI are foundation and partnership roles.

Foundation

Some countries have used existing CBHI schemes as the foundation for UHC. In this model, the government scales up CBHI schemes across the country and defines processes and product standards for locally operated schemes. Section VI illustrates the experience of Ghana and Thailand with CBHI schemes using this model. In Ghana, CBHI schemes were consolidated, and they were tasked with managing the national scheme at district level. In Thailand, the government incorporated lessons from early CBHI schemes in the design of a voluntary scheme for informal workers. It subsequently merged this scheme with a targeted scheme for the poor to create a single mandatory scheme covering the entire population.

Partnership

Governments can also form partnerships with HMI schemes and other private actors in order to deliver key insurance functions, such as marketing, identification of eligible enrollees, distribution of insurance, premium collection and even claims processing and risk-carrying. This may be an attractive alternative to creating and providing the functions within government, and may enable faster, more efficient scale-up. In Kenya and the Philippines, the government outsources front-end insurance functions, such as enrolment, to private sector partners; the *Rashtriya Swasthya Bima Yojana* (RSBY) scheme in India does the same for back-end insurance functions, such as claims administration.

Supplement

Even as government initiatives expand benefits, HMI schemes can offer valuable products that supplement government benefits. For example, they can cover outpatient services or provide additional financial protection against health-related costs for transport, lost wages or child care. Examples of the supplementary role of HMI can be seen in India, Jordan, Kenya and South Africa, as well as in more developed countries.

HMI schemes can be “learning incubators” and create a demonstration effect for policymakers. During the early stages of implementing a health financing strategy they can provide valuable lessons to governments on how to reach excluded groups. Thereafter, they can pilot new products or operational models in collaboration with the government.

Basic information about the countries reviewed in this study and the primary government insurance scheme for informal workers is provided in Appendix II. Each country experience is documented in greater depth in separate case studies, found in Appendices III to IX.

The rest of this paper documents experiences of collaboration between governments and HMI schemes (including distribution channels and other partners) to advance UHC. For that reason, we exclude documenting HMI’s role as a substitute for government coverage. Sections VI and VII describe the two hybrid models – foundation and partnership – where government-sponsored health insurance and HMI schemes are collaborating to support a country’s health financing strategy. These two models differ in the type of actors they engage (CBHI schemes for the foundation model, broader private actors for the partnership model), and in the governance of the programme (involving a high level of decentralization in the foundation model and a public-private partnership type of arrangement in the partnership model). Though the models operate differently, the success factors and limitations are similar and these are therefore documented together in Section VIII. Section IX explores the supplement model and Section X examines the cross-cutting demonstration effect.

5 > CBHI SCHEMES AS A FOUNDATION FOR UHC

In many countries, HMI schemes – and especially CBHI schemes – have emerged as a substitute for national coverage, often driven by a social objective for greater inclusion of vulnerable populations. As government willingness to improve access to health financing for informal workers has grown, some countries, for example Ghana and Rwanda, have seen CBHI schemes develop as a key component of their health financing strategy. With this approach, the government mandates a local health insurance structure (district, state or municipality), defines benefit coverage and supports operations to provide insurance coverage. Ghana and Thailand have elements of this foundation approach, leveraging capacity built from earlier community financing schemes, but ultimately have evolved their designs over time. Other countries, such as Cambodia, Mali, Nepal and Nigeria, are considering whether CBHI schemes can serve as a foundation for UHC. The cases of Ghana and Thailand are reviewed below and in Appendices III and IV.

Ghana leveraged CBHI schemes across the nation when the National Health Insurance Act, 2003 (Act 2003) created a “hub and spoke” model for the National Health Insurance Scheme (NHIS), with central management by the National Health Insurance Administration (NHIA) and district level implementation through publicly sponsored District Mutual Schemes.

In the four years prior to the launch of the NHIS, CBHI schemes had proliferated across the country. However, these schemes covered only a small proportion of the population, an estimated 2 per cent in 2003, often providing limited inpatient care, leaving individuals with substantial out-of-pocket expenditure for outpatient care or more extensive inpatient care. In response to demand to reduce out-of-pocket expenditure, the Ministry of Health began to develop a policy for UHC. Ghanaian health reformers saw the advantages of the CBHI schemes’ existing enrolment levels, valuable insurance skills and infrastructure that could be instrumental in helping the country to expand coverage nationwide, including to the poor and informal workers (Box 3).

Box 3. Ghana’s national scale-up

Since the launch of CBHI schemes in Ghana in 1999, coverage in the country has been scaled up in two phases. First, CBHI schemes proliferated organically throughout the country, motivated by community solidarity principles. The CBHI model expanded rapidly, from three schemes in 1999 to 258 by 2003. Although total coverage countrywide was still limited, this fostered a culture of health insurance and laid the foundation for the second phase. After a change in government in 2000, and the passage of the National Health Insurance law, the new government ordered a new health insurance scheme to be set up and administered at district level and offered a standard benefit package. This melding of existing CBHI capacity with a top-down, national framework increased coverage rates 30-fold over a relatively short period of time to reach the present level of 35 per cent. To dissuade existing CBHI schemes from offering duplicative coverage, the government offered them the choice of affiliating with the NHIS and receiving the benefits of a government subsidy and other support, or remaining an independent CBHI scheme and modifying their benefits package. Given the financial incentives, most schemes chose to affiliate with the government’s plan. Those that did not scaled back their coverage to provide exclusively supplementary products, such as medicines or cash for transportation.

Sources: Atim, 2010 and Joint Learning Network, 2012.

Rather than expand the CBHI schemes iteratively, the National Health Insurance law opted for a “big bang” approach and developed a decentralized model with national regulation and local delivery. When the NHIS was launched in 2004, most CBHI schemes relaunched as NHIS district-based schemes, in order to receive government subsidies. Schemes that chose not to join the NHIS were required to modify their benefits so that they did not duplicate the government package.

Other districts without any existing CBHI schemes were required to develop a district scheme. District schemes are charged with handling household education and registration, premium collection, claims management and health-care provider payments. The central government handles overall governance, regulation of the district schemes and fund management. Due to a surge in the volume of claims, and the need to enrol more individuals and collect premiums, the NHIA faced challenges to meet required service standards for scheme operations. To tackle some of these problems, the NHIS is now working to centralize claims processing.

Success factors in Ghana's approach to using CBHI schemes as a foundation for scaling up UHC through the NHIS include:

- Integration of multiple CBHI risk pools into larger, more stable pools;
- Willingness by Ghanaians to participate in the NHIS, due to previous exposure to CBHI schemes;
- Decline in-out-of pocket expenditure, from 50 per cent in 2002 to 27 per cent in 2010;
- Growing client awareness of the NHIS and shifting perceptions and attitudes about health care over time, according to district scheme managers;
- Incremental improvements to operations, including gradual streamlining of enrolment and claims payment processes, regular meetings between District Mutual Scheme managers and central level NHIA administrators and a corporate information platform to facilitate communication across schemes.

Administration of the NHIS has required a significant investment of resources and capacity development over time. However, excluding one-time initial investments, the NHIS currently only spends 5 per cent of total expenditure on administrative costs, a relatively modest investment compared with many health insurance schemes.

In Thailand, community financing began to emerge in the late 1970s and 1980s, alongside government schemes for the formal sector, civil servants and the poor. The CBHI schemes offered narrowly defined benefits, such as drugs or maternity care, but eventually struggled financially. These CBHI schemes evolved into a Voluntary Health Card Scheme (VHCS) in 1983, which offered a supply-side subsidy and was open to individuals who were ineligible for other government programmes (Box 4).

Although the VHCS expanded coverage to more informal workers, by 2000, 30 per cent of the population was still uninsured, most of whom were informal workers. In 2000, the Ministry of Public Health merged the targeted welfare scheme for the poor with the VHCS. The pilot scheme began in April 2001 and was initially called the "30 Baht Scheme" to describe the small copayment required from beneficiaries. This copayment was eliminated in 2006 and the programme was branded the Universal Coverage (UC) scheme, but copayment was reintroduced in mid-2012. Changes in copayment have coincided with changes in political power. The recent reintroduction of copayment is thought to be an attempt to link the new government with the initial introduction of the scheme (Hanvoravongchai, 2013).

Box 4. Thailand's UC scheme

Step 1 (1970s): Emergence of village-based funds to finance health care. Early community-based financing in Thailand made broader use of different community funds for drugs, nutrition, sanitation, health and development. Individual families contributed to these funds and, over time, what began as single purpose funds diversified to become multipurpose funds.

Step 2 (1983): Transformation of HMI schemes into a nationwide voluntary scheme. The Ministry of Public Health (MOPH) launched the Health Card Programme in 1983. The programme grew out of the village health care fund project and covered the near-poor population – those who were ineligible for Thailand's targeted welfare scheme. The programme began as a pilot in seven provinces over 8 months. By 1984, the programme's success had spurred national expansion and an indirect subsidy was initiated through reduced charges at health facilities.

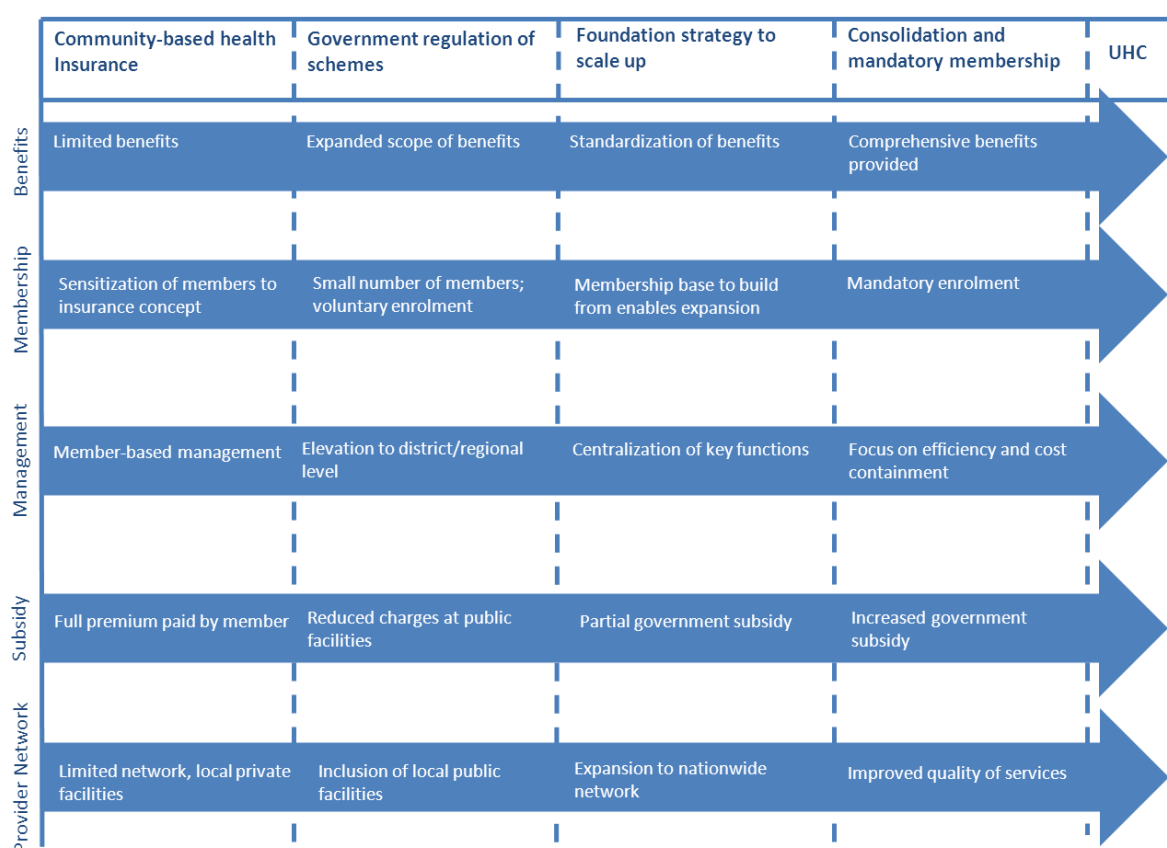
Step 3: Evolution from voluntary scheme to subsidized mandatory scheme. By 2001, there were four different schemes, all operating with different financial arrangements and benefit packages, making the concept of an equitable universal coverage scheme hard to achieve. Approximately 30 per cent of the population (18 million people) was still uninsured, mostly informal workers. The MOPH rapidly combined the beneficiaries of the Medical Welfare Scheme and the Voluntary Health Care Scheme, as well as any additional uninsured people, and brought them under the umbrella of the new Universal Coverage Scheme. This scheme was mandatory, offered a full subsidy and allowed Thailand to quickly scale up coverage so that it virtually covered the entire population.

Sources: Wilbulproprasert, 1991; Supakankunti, 2000, Pannarunothai et al., 2000.

An independent agency, the National Health Security Office (NHSO), manages the UC scheme, and is responsible for defining the benefit package, registering beneficiaries and health-care providers, and paying claims. Uninsured individuals are automatically eligible for the UC scheme, but are required to register at a public health centre, hospital or provincial health office (Hanvoravongchai, 2013). When the UC scheme was first launched, the NHSO used door-to-door campaigns as a marketing tool, leveraging existing identification systems (civil registry, house registration system and national identification numbers) and working with community leaders to identify eligible individuals. The UC scheme remains the primary mechanism for covering informal workers in Thailand and, although improvements are constantly being made, its success highlights the importance of having a solid foundation on which to build.

The cases of Ghana and Thailand illustrate the evolution of the foundation model, taking into account the main factors that define UHC: greater benefits and improved quality of care, increased population coverage and reduced financial burden at the household level (Figure 2). The experiences of both countries suggest that linking with local and trusted institutions may be necessary for early support from the community and to cater to the needs of the informal sector. However, as time moves on, and scale and complexity increase, there is a need for more centralization.

Figure 2: Stage of evolution of the foundation model



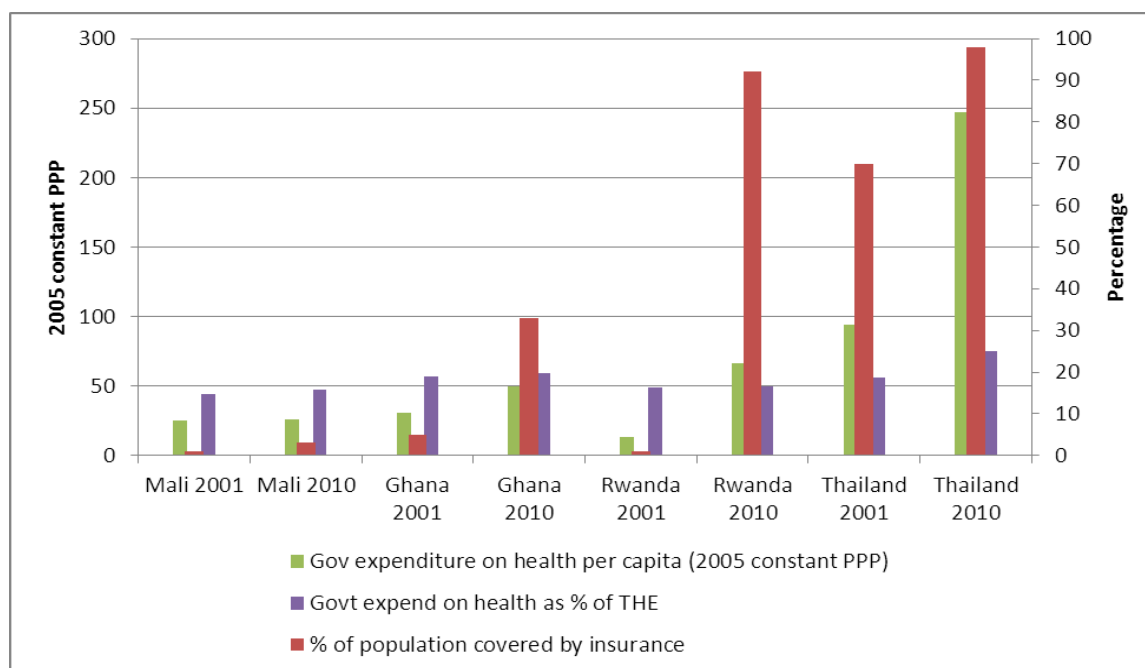
Scheme performance and current challenges

Though Ghana and Thailand share similarities in their approach to using CBHI schemes as a foundation for UHC, they have achieved different outcomes. Ghana currently covers 35 per cent of its population (National Health Insurance Authority, 2010), while Thailand has reached 98 per cent coverage (Hanvoravongchai, 2013). In Ghana, the equity of the scheme is in question since enrolment and benefits have been skewed toward the rich (Ghana National Health Insurance Authority, 2010; Schieber et al., 2012). By contrast, evaluations of the Thai UC scheme show that the poor receive a much larger proportion of public subsidy than the rich (Limwattananon et al., 2012).

Between 2001 and 2010, Thailand increased its public spending on health from 56 to 75 per cent of total health expenditure by reallocating government budgets (National Health Accounts, 2012). Although this enabled funds to be redirected towards subsidies in the case of the UC scheme, it produced the unintended side effect of decreasing available funds for public health promotion and prevention. In the same 10 years, Ghana increased its public spending on health by a much smaller amount, from 57 to 59 per cent of total health expenditure. It did so partly by adding a 2.5 per cent National Health Insurance Levy (NHIL) to value-added tax. The tax increased revenue for the health sector (Ghana Revenue Authority, 2013), and accounts for approximately 70 per cent of the NHIS's resources. The remainder comes from social security contributions (representing 2.5 percentage points of 18.5 per cent of contributions) and graduated premium payments from the informal sector. Figure 3, below, shows how increases in population coverage have been accompanied by increases in public expenditure on health, implying a potential correlation. Though not documented in this

paper, the cases of Mali and Rwanda are also illustrative of the foundation model, and their performance is represented in the graph below.

Figure 3: Insurance coverage and government health expenditure in countries with CBHI schemes as a foundation for UHC



Sources: NHA Global Expenditure Database (2013), UHC Forward Case Studies (2012)

Box 5. Other country experiences using CBHI schemes as a foundation for UHC

Other countries, such as Rwanda, offer additional experience. Rwanda expanded its HMI system in 2003 to a national system (known as “*mutuelles de santé*”), where membership is coordinated at the district and sector level. Some 92 per cent of the total population is now covered, though it is important to note that Rwanda has benefited substantially from donor funding for health. This contributed almost 50 per cent of total expenditure on health between 2001 and 2011, with a low of 33 per cent in 2002, rising to 46 per cent in 2011. Donor forecasting indicates that the percentage will probably remain about the same, or perhaps slow through 2015.

Mali is in the process of organizing nationwide extension of its CBHI system. Cambodia is testing ways of merging its CBHI network with its health equity funds, which exclusively target the poor. As a preliminary step, Nepal and Nigeria have completed an assessment of the current strength of HMI in their countries.

Source: World Bank, 2011.

Thailand benefited from strong political commitment and policy decisions during the preceding three decades to build rural infrastructure and improve benefits. A recent analysis concluded that higher levels of health care utilization, coupled with greater financial protection, was the result of easier access to providers, particularly at district level, as well as a well-functioning primary care system, comprehensive benefits and the elimination of user fees in the wake of high government subsidies (Limwattananon et al., 2012). Thailand's decision to convert from voluntary to mandatory enrolment at the launch of the UC scheme is an important marker in its movement toward UHC. It was able to achieve effective enrolment because it had the financing to support full public subsidies for informal workers and used a national campaign strategy to register enrollees. Thailand's national identification number system facilitated enrolment and, as public confidence has increased over the past three decades, utilization rates have quickly risen.

By contrast, enrolment of informal sector workers in Ghana, especially among the poor, has been an ongoing challenge for the NHIS. Although the district schemes conduct outreach and seek to identify the poor, there is no systematic process for reaching this sector. Major access barriers remain for individuals to join the scheme (e.g. the need to travel for enrolment, a delay of generally several months before membership cards are delivered). The scheme also faces increasing numbers of claims, and central management is testing new provider payment mechanisms, clinical audits and claims processing reform to control costs.

Cost containment issues are common to most schemes as utilization, and therefore costs, increase. In Thailand, the UC scheme deployed a number of cost containment strategies. Separating the purchasing function, led by NHSO, and the provider function, which came under the responsibility of the MOPH, marked a major change in creating greater accountability. In order to control cost, the UC scheme implemented a capitation payment system for outpatient care, and a case-based payment scheme for inpatient care, albeit with a global budget ceiling cap (Hanvoravongchai, 2013). Since it functions as a monopsony, the UC scheme is also able to negotiate better prices from suppliers. These strategies allowed Thailand to maintain reasonable control of claims costs. However, overall scheme costs have continued to rise, largely due to increased compensation for employees of the scheme.

Thailand has been actively reforming its system for a long time and its experience reveals the benefits of a step-wise approach to UHC that other countries should consider. The first major reform took place in 1983 when participation was still voluntary and only partial subsidies were available – a situation comparable to the current position in Ghana. Thailand was eventually able to encourage full participation through mandatory enrolment and full subsidies (with the exception of the 30 baht), but these financing policies were accompanied by strong investments in health-care infrastructure, human resource capacity and the primary care system. The country also centralized insurance functions to achieve greater efficiency.

6 > USING PUBLIC PRIVATE PARTNERSHIPS (PPPS) TO REACH UHC

In the foundation model, CBHI schemes have become semi-public entities, forming the decentralized arm of the government scheme. By contrast, in the partnership model, governments use PPPs to delegate some insurance functions to better positioned partners. A number of government-sponsored schemes, including India's *Rashtriya Swasthya Bima Yojana* (RSBY) scheme, Kenya's National Hospital Insurance Fund (NHIF) and the Philippine Health Insurance Corporation (PhilHealth), have chosen to outsource insurance functions to private partners so as to extend coverage to informal workers (Appendix V, VI, VII).

In Kenya and the Philippines, the NHIF and PhilHealth, government-sponsored schemes for informal workers, are outsourcing some of the same front-end functions – promotion, identification, enrolment and premium collection – to private distribution partners, such as MFIs, NGOs and cooperatives. These partners are often entrenched in communities, enabling them to complement government eligibility data with community knowledge, so that eligible clients can be more easily identified and enrolled. Additionally, partners such as financial institutions which have expertise in financial transactions, offer an efficient channel through which to collect premiums and provide clients with relevant payment options.

Some governments have gone even further. The RSBY scheme in India relies on private insurers for back-end functions such as claims processing, health-care provider management and financial risk. Facilitated by a strong insurance market in India, as well as innovative technologies, it may be difficult to replicate the RSBY formula in other settings.

Further analysis of PPP experiences should evaluate the relative cost-effectiveness of these designs.

Partnering with organized groups in Kenya and the Philippines for insurance distribution

The NHIF and PhilHealth schemes offer two examples of collaboration between government-sponsored insurance schemes and private distribution partners.

Box 6. Characteristics of PhilHealth's iGroup Program

- PhilHealth offers a discounted premium based on group size. The premium rates assigned to each new group are based on group classification, size, policy period, mode of payment and other characteristics.
- PhilHealth stipulates a minimum group size (this was recently lowered in the iGroup Program). At least 70 per cent of each organized group must participate in the programme for it to be eligible.
- Members can make payments at convenient intervals, while groups benefit from the added protection for their members. MFIs have a particular interest in preventing loan defaults.
- PhilHealth recently expanded benefits to include outpatient services. Additionally, the waiting period before an individual can access services has been eliminated.

Source: PhilHealth (2012)

In Kenya, the NHIF has been collaborating with partners such as NGOs, MFIs and savings and credit cooperative societies since 2003 (Appendix V). Partners manage enrolment by collecting enrolment details, taking photographs for identification cards, collecting premiums and delivering cards to new members. Local partner agents also host meetings where beneficiaries share testimonials about the NHIF and answer questions from other community members, building trust in the organization (Wambugi, 2012). The NHIF is responsible for contracting and managing the health-care provider network, producing identification cards and bearing financial risk for the fund.

Distribution partners are supplied with enrolment documents for new NHIF beneficiaries and members benefit from reduced waiting times. In one arrangement with the *Afya Yetu Initiative* – an NGO-run HMI scheme

that targets farmers in rural Kenya – beneficiaries have benefited from a reduction in waiting time from 2 months to 28 days following enrolment, before being able to access the NHIF benefits.

The NHIF seeks to expand coverage. By using partners' field agents to sell the product, the NHIF benefits from their relationship with these communities. For partners, collaborating with the NHIF can contribute to their mission of providing social protection for their members. However, incentives for partners differ, and some seek commission for the services provided to the NHIF.

PhilHealth uses a similar approach by collaborating with distribution partners – termed “organized groups” – such as MFIs, cooperatives, professional organizations, NGOs and others (Appendix VI). Informal workers have been able to enrol in PhilHealth directly, through the Individual Paying Program, which requires a voluntary contribution. However, only one-third of members were paying premiums regularly. To combat this problem, PhilHealth developed a collective strategy that leverages groups to encourage enrolment and regular premium payments. The scheme began as a pilot in 2003, under the name PhilHealth Organized Group Interface (POGI).

The POGI programme evolved into KaSAPI (*Kalusanga Sigurado at Abot-Kaya sa PhilHealth Insurance* or Health Security at Affordable Cost in PhilHealth) in 2005. KaSAPI required a minimum group size of 1,000 and 70 per cent participation from any group to reduce adverse selection. Instead of the premium collection and marketing incentives offered to the organized group administrator under POGI, KaSAPI redesigned incentives for individuals by offering group premium discounts of 6–10 per cent to members who enrolled through KaSAPI. PhilHealth leveraged existing information campaigns to market a “Triple Win” strategy as a way of communicating the incentives for each group (Adelhardt, 2007). The organized groups value having the ability to protect their members against unexpected illness, which can also translate into fewer loan repayment delinquencies. PhilHealth benefits from increased enrolment and expanded risk pools, while individuals benefit from premium discounts.

By September 2007, KaSAPI partners had enrolled 5,000 families into one risk pool in PhilHealth's Individual Paying Program (IPP). KaSAPI continued throughout 2012 and by June of that year, the IPP covered 10.7 million individuals, representing 13 per cent of the total population (PhilHealth, 2012a).

In January 2013, KaSAPI evolved into the iGroup Program (Individually Paying Program for Groups), which introduced a new incentive structure for partners, enabling smaller-sized groups to join (PhilHealth, 2012b). As membership levels in each group grow, the benefits, such as premium discounts, available through PhilHealth also increase.

Table 1: Roles and responsibilities of government and distribution partners in the partnership model

	Government	Distribution partner
Marketing and promotion	Provides promotional materials and training to distribution partners Creates broader awareness through media campaigns	Actively promotes the product to its members Organizes awareness campaigns
Identification and enrolment	Can provide eligibility list for registration of the poorest, if identification systems are in place Provides incentives to distribution partner Produces membership cards	Confirms client identity and collects client information Delivers membership cards to the insured
Premium collection	Defines premium level, including incentive for group registration Receives premium	Collects premium in a flexible way, leveraging existing financial transaction methods with client if possible Transfers premium to government

Partnering with private companies in India

In India, various government schemes target the BPL population and these generally rely on intermediaries – commercial insurers and third party administrators – to manage key functions (Appendix VII).

India's RSBY scheme is the largest government driven scheme, covering 445 of the 625 Indian districts across 28 states and union territories as of 2012. It targets the BPL population and some other occupational groups, such as domestic servants and construction workers and is sponsored at both state and national levels, offering almost fully subsidized membership. RSBY has gone beyond outsourcing front-end functions to outsource back-end functions, such as risk carrying, claim processing and provider network management. Outsourcing risk carrying functions has enabled the government to have more predictable budgets, since insurers bid on annual premiums.

Box 7. Rashtriya Swasthya Bima Yojana (RSBY)

In 2007, the Indian Ministry of Labour and Employment (MoLE) launched the Rashtriya Swasthya Bima Yojana (RSBY) programme. RSBY targets the BPL population (occupational groups, such as domestic servants and construction workers were added in mid-2012). The scheme primarily covers inpatient benefits, offering up to INR 30,000 per family per year for inpatient treatment, in both public and private facilities. However, it is currently expanding coverage to outpatient benefits. Costs are shared between central (75 per cent) and state government (25 per cent). As of January 2013, the scheme served 445 out of 625 districts in India and reached 51 per cent of the target population.

RSBY operates through a network of state nodal agencies (SNA), which are housed in different state agencies (Department of Labour, Department of Health, Department of Rural Development). These SNAs are responsible for contracting insurance companies – both public and private – through a competitive bidding process. The insurance companies have responsibility for contracting the provider network, educating and enrolling beneficiaries and processing claims. The government retains oversight through district-level managers who monitor the scheme in their locality, although their capacity is limited. It continues to rely on insurance companies and their third party administrators to fill gaps in areas such as consumer information and protection, data management and analysis.

The functions of RSBY are shared between central and state governments, SNAs, insurance companies and third party administrators.

Source: RSBY (2012)

During RSBY's design phase, a task force with representatives from the insurance industry, relevant ministries, the technology industry and international organizations such as the World Bank and GIZ, reviewed HMI experiences in India and other countries, using a highly participatory approach to design the scheme's features and processes. Since no single insurer, nor the Ministry of Labour and Employment (MoLE), had the capacity to administer a scheme for 355¹ million eligible members, the task force made a strategic decision to involve the private sector, building partnerships between insurers, the central government and the states. A technology platform was developed to enable biometric identification of beneficiaries, paperless administration, portable coverage across the country and the efficient management of millions of beneficiaries.

The RSBY task force used a competitive bidding process to select insurers to manage these functions. The insurers – the majority of which are commercial, for-profit (14 out of 18) – were able to tap into a new market, with premiums

¹ Planning commission of India, number of persons below the poverty line 2009-2010

guaranteed by the government. The government maintains responsibility for regulation, information systems and ultimate oversight, while placing much responsibility in the hands of the insurers.

In common with Kenya and the Philippines, RSBY outsources portions of the enrolment process to insurers or third party administrators (TPAs). Enrolment is conducted at village level during enrolment camps, and registration is carried out on the spot by the insurer or TPA. The enrolment stations are equipped with hardware that can instantly register the fingerprints of beneficiaries. Once fingerprints and photographs have been collected, the 30 rupee fee per family is paid, the local government authority scans the new member's smartcard, which can be printed (RSBY, 2013). The process typically takes under 10 minutes.

Table 2: Roles and responsibilities for back-end functions in the RSBY scheme

	Government	Insurer / TPA
Risk carrying	Selects insurers through a bidding process	Defines premium rate and carries financial risk
Claims processing	Defines benefit package and standards	Processes claims and manages provider payments
Provider management	Provides guidelines and minimum quality standards to empanel hospitals	Selects and empanels hospitals Monitors claims and pays hospital bills

In order to align incentives and manage claims costs, claims processing has also been outsourced to insurers. However, the government monitors claims performance in order to ensure that legitimate claims are processed according to acceptable standards. RSBY insurers also oversee health-care provider selection and management, guided by government standards on quality. Inclusion of private facilities in the health-care provider network has led to high satisfaction levels among clients (Pande, 2011).

The partnership approach is supported in India by an active and competitive insurance sector, consisting of public and private insurers with management experience, technological acumen and professional manpower. Insurance companies can help promote incentives for service providers and beneficiaries, though proper checks and balances need to be in place to monitor quality of care and client satisfaction.

Scheme performance and current challenges

In India, the partnerships working in the RSBY system have helped to improve access to care for the BPL population, manage a high volume of policies and enable faster roll-out of the scheme. As of January 31, 2013, 51 per cent of eligible BPL families were enrolled (33,957,106 families). However, this data does not reflect re-enrolment rates and assumes that the entire family enrolls, which is not always the case. As a result, the number of families and lives actively enrolled may in fact be less (RSBY, 2013). Those results are encouraging, but they also highlight the fact that in spite of the availability of an almost fully subsidized programme, barriers still exist for informal workers to join the scheme. The variable penetration rate across districts and states (from 10 per cent in Delhi to 84 per cent in Kerala) also raises the issue of equity. The claim incidence rate, increasing from 2.3 per cent in year one to 5 per cent in year two, may threaten the long-term viability of the scheme and suggests a case for stronger controls to avoid fraud and manage utilization. The government is currently adding outpatient benefits to increase value for clients, and potentially improve overall financial viability of RSBY.

In Kenya and the Philippines, partnerships with organized groups are progressing, but penetration of informal workers by both of these schemes is still low, with just 3 per cent of informal workers covered in Kenya and 13 per cent in the Philippines, as of 2012. Both schemes are working to improve benefit design (the iGroup Program recently added outpatient cover to its benefit package) and quality of health-care delivery. In the Philippines, the decentralized model is a more complex mix between the central-level PhilHealth and local government units. The latter are responsible for enrolment and service delivery. PhilHealth has been able to leverage increased revenue from taxes on alcohol and tobacco, but efficiency gains will be needed in both countries. Kenya's use of PPPs is still relatively limited. To increase penetration, Kenya will probably need to increase the number of distribution partners that it contracts and standardize the arrangements across partners.

7 > LESSONS FROM THE FOUNDATION AND PARTNERSHIP MODEL

The ways in which HMI and other private actors have been leveraged in the foundation and partnership models differ. However, they share similar success factors and limitations, which are highlighted in this section.

Success factors

Successful cases of achieving UHC, such as in Mexico and Thailand, have been accompanied by long-term investments in health-care infrastructure, human resource capacity, primary care and referrals, prevention and promotion and improved quality of care. Success factors for the foundation and partnership models include on-going dialogue among stakeholders and adequate capacity, support provided to partners, engagement with private and local public partners and a clear business case for all partners.

- **Strong political commitment:** Strong political commitment is crucial to ensure that sufficient resources can be allocated to the scheme and clear government stewardship can guide all partners. In Ghana, national health insurance was a pledge made in the 2000 presidential election and became national policy with the 2003 National Health Insurance Act. Thailand passed the National Health Security Act in 2002, which paved the way for the UC scheme. India recently committed to increased spending on health as part of its 12th Five-Year Plan.
- **Local capacity and ongoing support:** Leveraging HMI schemes in foundation and partnership roles requires that partner organizations have existing capacities that can be engaged. Depending on the strengths and weaknesses of existing schemes, different roles and responsibilities have been shared among the stakeholders. Ghana identified CBHI schemes as trusted entities able to create support of the population for the upcoming national scheme. The CBHI schemes had members who were already sensitized to insurance, and the schemes had the capacity to manage insurance locally, since staff was already familiar with insurance tasks. But as district schemes were struggling to manage the additional demand, the central government offered higher salaries and extra field workers to help with marketing and enrolment. Kenya and the Philippines both partnered with organized groups to act as distribution agents. These groups have also required support to market and raise awareness of the schemes. RSBY benefited from the capacity of insurers in India that have much more experience in managing insurance functions and have needed less support; the government's role has focused on monitoring performance of the scheme.
- **Mutual benefits:** Partners must see mutual benefit and feel ownership in order to participate. In the Philippines, PhilHealth has marketed a Triple Win strategy to communicate the benefits to PhilHealth, organized groups and beneficiaries, and offers incentives to encourage enrolment. In Kenya, the business case for partners is weaker, and partners are beginning to ask for incentives, such as commission to conduct enrolment. In Ghana, buy-in from local CBHI schemes was critical. NHIS representatives visited the schemes to understand their strengths and weaknesses, explain the strategy and determine what incentives would be needed to encourage participation. In India, the insurers are motivated by viable business opportunities, with guaranteed premium payments from the government.
- **Clearly defined roles and responsibilities:** For a partnership to function effectively, each partner must agree to and be accountable for its precise scope of work. The task force that designed RSBY spent time developing a

detailed implementation plan which clarified roles and articulated the processes and systems to be put into place. Lack of clear roles and responsibilities in Ghana contributed to supervisory and regulatory problems.

- Ongoing dialogue: Dialogue among the relevant stakeholders at an early stage often helps increase buy-in and support for UHC expansion efforts. The participatory approach used for the design of RSBY enabled all actors to contribute to the design of the scheme and created high levels of commitment (interview with Sanjay Pande). In Ghana, early consultations with CBHI schemes helped engage them in the design of the NHIS, though not all were supportive of the transition. Dialogue needs to be ongoing, in order to make sure that partners' interests are aligned and that proper incentives are in place. When the UC scheme was designed in Thailand, the National Health Security Board was created to govern the scheme. The NHSB includes 30 members, representing different sectors and diverse interests. This promotes inclusive decision-making and a platform for ongoing discussion.
- Technology advances: In RSBY, new technologies have unlocked the potential to effectively service millions of beneficiaries. RSBY's success is largely due to a relevant technology platform that has been adopted by service providers, as well as biometric smart cards, which facilitates enrolment and claims. These advances enable closer monitoring of the scheme, as well as paperless claims administration and smoother back office processes. Ghana is also making strides in this direction.

Limitations of the foundation and partnership model

As illustrated in Figure 1, limited time and resources can restrict progress toward UHC.

- Step-wise development: Achieving universal health coverage requires years of experience to build management capacity, sensitize the population to insurance and improve the model. Thailand began with community health financing schemes in the 1970s and 1980s, and thirty years later, it was able to extend coverage to all citizens. It has been able to infuse a culture of quality and encourage improvement through a step-wise accreditation process, which has resulted in high quality care at low cost. Though other countries may be able to leapfrog steps by learning from more advanced countries, building infrastructure and improving care delivery requires time.
- Resources: UHC implies that the population benefits from cross-subsidies. In countries with high levels of informal labour it can be difficult to get contributions from those in the informal economy, even if they can afford them. For this reason, most countries must rely on general government taxes as the largest source of revenue. This can be politically difficult to execute and may require earmarked taxes in order to allocate sufficient resources to health. Examples include the value-added tax (VAT), which was introduced in Ghana, and tobacco and alcohol taxes imposed in the Philippines.
- Cost containment: As schemes expand and mature, claims can escalate, as Ghana and India are both experiencing. Governments, which bear ultimate responsibility for social protection within the country, are accountable for their health spending and tend to maintain responsibility for oversight, which requires strong monitoring and evaluation functions. Thailand demonstrated successful approaches to cost containment, but cannot escape rising costs. Governments should implement information systems and establish standards to enable better monitoring of programme performance over time.

8 > HEALTH MICROINSURANCE AS A SUPPLEMENT TO UHC

Even when countries have achieved some degree of UHC, there will be additional health care needs. HMI can continue to support UHC by filling gaps in coverage and supplementing existing benefits. This could include additional services, such as outpatient benefits, coverage for additional expenses such as transportation, lost wages, or child care or access to health facilities outside the government's health care provider network.

In some countries, existing HMI has scaled back in response to government reforms. Ghana and India are two interesting examples of this trend. In Ghana, after the government regulated the CBHI system, existing CBHI schemes were essentially given the option of participating in the government scheme and offering the benefit package that the government had prescribed, or scaling back their offers to services that were excluded from the government package. Most CBHI schemes chose to adopt the government programme completely, but those that remained redesigned their benefits to meet this requirement.

In other countries and regions where public facilities provide free or nearly free health care, some HMI schemes have begun to offer supplementary cash benefits. One example is the Caregiver product (*Ri'aya*) promoted by Jordan's Microfund for Women (Box 8). Caregiver pays a fixed cash amount of USD 14 for each night spent in the hospital. Cash benefits are intended to cover costs associated with hospitalization, such as lost wages, child care, and transportation.

Other HMI schemes blend partnership and supplement roles. In Kenya, some HMI schemes that distribute the NHIF product also sell a top-up product (*Afya Yetu Initiative*, 2012). The AYI field officers in Kenya sell two different packages. Package 1 offers NHIF coverage and reimbursement of any additional charges to be paid by patients at empaneled private/fait-based hospitals for surgical care. Package 2 offers the CBHI package, which provides inpatient coverage in public hospitals only and is cheaper than Package 1.

Box 8. Jordan's hospital cash product

In Jordan, women are the primary caregivers for a family and many also assume a dual role of household breadwinner. In April 2010, Jordanian microfinance institution Microfund for Women (MFW), with support from the International Labour Organization's Microinsurance Innovation Facility, launched a hospital cash product called Caregiver. The goal of Caregiver, also known as *Ri'aya*, was to "develop an affordable health insurance product that [would] offset some critical costs borne by MFW clients [when] accessing public health care." Thus, Caregiver was designed not to cover health care expenses, which are free in public facilities, but to provide additional financial protection for lost wages and associated expenses during a hospital stay, including child care, transportation fees or purchasing medicines that may not be available in the hospital. Caregiver is mandatory for all MFW clients, who are paid a fixed sum - currently US\$ 14 - per night spent in hospital. There is an annual limit equivalent to 4 nights per month, and maternity care, the most common cause for hospitalization amongst MFW clients, is covered. In April 2012, MFW began a pilot scheme to offer Caregiver benefits on a voluntary basis to clients' family members.

Source: ILO, 2011.

There are some cases where HMI products cover services that are provided by the public system, but which also provide access to private health care providers preferred by clients. In Guatemala, the *Viva Segura* product offers clients faster access to private practitioners for preventive gynaecology. Even though clients can access the public system for this, they perceive better quality from private providers and are therefore more willing to enrol and seek these preventive services. The inclusion of private facilities in provider networks can be a success factor for government initiatives, since private facilities are often perceived as offering higher quality.

In some countries, the role of HMI is quite limited, which could be a by-product of stronger government health care delivery systems. The first quantitative review of microinsurance in Latin America, released in October 2012, found 13 health insurance products across the whole of Latin America, with life insurance predominating. In Mexico, a country that recently declared universal health coverage, only 3 million of its 112 million people (2.6 per cent) receive some health coverage through microinsurance. HMI is almost non-existent in some other Latin American countries, such as Argentina, Belize, Bolivia, Colombia, Haiti, Paraguay and Venezuela (McCord et al., 2010). In Thailand, a country that has achieved UHC, there is a limited private health insurance market; emerging schemes target higher-income families.

Lessons learned about providing supplementary coverage

From start to finish, HMI plays an important role in supporting UHC by filling gaps in coverage. As governments strengthen financial protection and ensure adequate quality of care and service standards, the role of HMI can be expected to diminish. There is some debate about whether HMI fragments the market, or if it may actually spur healthy competition. The presence of HMI schemes offering duplicate services may indicate poor quality or restricted access in the public system. Over time, as quality and access within government schemes improve, overlap with HMI schemes should subside.

Success factors

Supplementary coverage should respond to demand from the community for additional (or better quality) protection. This demand could be for access to different providers, essential services excluded from the government package, elective services, or greater financial protection. Governments can support HMI by helping to identify needs and clarifying their own expansion plans, so as to avoid duplication.

- **Complementarity of products:** Governments can encourage HMI schemes to design products that are supplementary, rather than duplicative. Ghana's NHIA articulated options to existing CBHI schemes, when it announced the launch of the NHIS. This ensured that those CBHI schemes that did not merge with the government scheme offered products that would complement the NHIS.
- **Innovation:** HMI schemes are developing new, exciting products that meet consumer demand. However, these new products may be unfamiliar to regulators. In Jordan, for example, the Caregiver hospital cash product was the first of its kind. This led to delays in approval because the insurance regulator was unfamiliar with hospital cash products. By promoting an enabling regulatory environment for HMI, governments can support innovation and encourage scale.
- **Transition to government:** Governments should use their own market research to understand which supplementary benefits are in high demand, and consider which of these should be incorporated into the national scheme. In India, the government is incorporating outpatient coverage into the RSBY benefit package, based on results shown by a pilot scheme implemented by ICICI Lombard, with support from the government, ICICI Foundation and the ILO (see section X).
- **Concurrent marketing:** It may be advantageous to sell a supplemental product at the same time as a government package. The AYI model in Kenya is a case in point, with field agents offering the NHIF package along with an HMI top-up product. Combined sales can make it easier to explain the benefits of both products, and administrative efficiencies can also be gained.

Limitations

- Fragmentation of risk pools: If governments encourage HMI schemes to develop supplementary products, they may actually contribute to the fragmentation and proliferation of additional risk pools. This is a downside that needs to be balanced against the positive aspects of such additional products. The existence of supplementary products also entails more schemes to regulate and more information to track, but it may also mean that more individuals have access to relevant insurance protection.
- Limited demand: Many supplementary products have limited enrolment due to limited distribution, relatively high costs, lack of consumer awareness or other factors. At the end of 2012, after two years of voluntary sales, the *VimoSEWA* scheme in India had issued approximately 2,000 policies to supplement existing RSBY coverage. The AFYI package in Kenya covers only 3 of 46 total districts. Jordan's Microfund for Women's Caregiver product covers 100 per cent of its client base (currently it has more than 90,000 clients), but voluntary uptake among MFW client families is so far limited. Even if all family members of MFW clients were to be covered, the number of covered lives would remain limited (i.e. not more than 300,000 assuming 4.5 family members per client).
- Duplication: If the government and HMI do not establish transparent communication, HMI schemes may develop duplicative products that may compete directly with government initiatives.

As government capacity increases over time, the role of HMI appears to contract. Its role shifts from the earlier one of providing a substitute and instead becomes a supplement to the government scheme (Figure 1). In some cases, the role of supplementary products is to improve access (e.g. to private facilities perceived to be of higher quality). In others, it is to cover services that fall outside the government's package (e.g. outpatient benefits) or which fill a gap in government benefits (e.g. top-up payments). In each case, HMI meets client demand that is not met by the government. In the future, HMI may play a leading role by innovating to promote better health outcomes, or improving access to health-care services.

9 > THE DEMONSTRATION EFFECT OF HEALTH MICROINSURANCE

HMI schemes can be “learning incubators” and create a demonstration effect by providing valuable lessons to governments on how to reach excluded groups during the early stages of implementing a health financing strategy. Thereafter, they can pilot new products or operational models, in collaboration with the government.

HMI experience tends to offer information on the characteristics of informal workers (e.g. income patterns, health seeking behaviour) to inform benefit design (e.g. services and provider preferences), as well as data for more credible pricing (e.g. incidence and average cost of claims). HMI experience can also inform operational set up, by creating and testing new technologies (e.g. building management information systems or front-end technologies), building health-care provider payment mechanisms and developing skills needed to deliver insurance.

Organic demonstration

In every country, there have been iterative approaches to health financing that have built on lessons from past HMI experience. Countries such as Ghana, India, the Philippines and Thailand have used their existing HMI landscape as input for new reforms. Other countries, such as Cambodia and Tanzania, are learning from innovation and establishing ways of using this organic experience and systematizing knowledge transfer between HMI schemes and the government.

In Tanzania, informal workers can participate in the government’s Community Health Funds (CHF or TIKa schemes in urban areas) which are managed at district level and provide access to primary care public facilities in each district (Box 9). Coverage is currently running at about 9.8 per cent (adapted from Kuwawenaru, A. and Borghi, J., (2012)). The CHFs have been somewhat slow to scale up, and there have been complaints about quality and patient satisfaction afforded by the scheme (Appendix VIII).

Box 9. Tanzania’s organic innovation

Tanzania’s Community Health Funds (CHF) were launched in 2001, but rolled out through the country gradually. Meanwhile, the Centre International de Développement et de Recherche (CIDR), a French NGO, launched the Self-Managed Health Insurance Schemes (SMHIS) in villages in Mbozi district. The SMHIS is a member-based HMI scheme which provides services at a private, faith-based hospital. When the SMHIS was first launched, it existed on its own, but after the CHF was implemented in Mbozi district, it came into competition with the government scheme. The SMHIS gained in popularity, since consumers preferred access to private facilities. As a result, tensions between the SMHIS and the district CHF grew.

Over time, members of the SMHIS expressed interest in accessing public facilities, prompting dialogue between the SMHIS and CHF. What emerged was actually a mutually beneficial arrangement: joining forces allowed both the SMHIS and CHF to reap the benefits of a government-sponsored matching fund, whose amount was determined by the number of enrollees in the plan. A formal MOU was crafted in 2008 and the private hospital was formally incorporated into the CHF plan, the district public hospital was incorporated into SMHIS coverage and some access to the matching fund was provided for the SMHIS. These synergies between the SMHIS and the district CHF resulted in plans to incorporate even more of the SMHIS ideals into the CHFs. It resulted in the development of mutual organizations, known as Self-Managed Community Funds, which represent a hybrid approach that began in 2011. This model is now taking off in other neighbouring districts, such as Kyela district, and has the potential to be scaled out across the country. Mbozi district is now taking lessons from Kyela district and the demonstration effect is likely to continue.

Source: Galland et al., 2012.

Innovative models have emerged in two districts of Tanzania (Mbozi and Kyela districts), through a CBHI scheme called the Self-Managed Health Insurance Scheme (SMHIS), supported by French NGO, the *Centre International de Développement et Recherche* (CIDR) (Galland et al., 2012). Over time, the SMHIS and the government's CHF in Mbozi district decided to collaborate in order to reap the benefits of a government fund. By combining their membership, they were able to increase the funding to both schemes. As time went on, they saw value in the partnership and began to incorporate principles from each model to create a hybrid approach, which draws on both the member-based feature of the SMHIS and the CHF's network of facilities. This model spread to the neighbouring district of Kyela, which developed it even further, and now those lessons are now being passed back to Mbozi. This process did not originate from the government. However, the partnership that emerged has presented a compelling example for the government to consider, as it works to improve the strength of CHFs throughout the country.

Cambodia's CBHI schemes, which began in 1998, have been an important source of learning on how and what the government should propose as a health insurance programme to the low-income segment (reforms are still under way). They have provided information on an appropriate benefits package, enrolment procedures, healthcare facility contracting and price sensitivity, which have been used by the Ministry of Health to draw up CBHI guidelines. Previously, the transfer of knowledge had been fairly ad hoc and the CBHI community decided to find a new way to communicate. The CBHI operators formed the Social Health Protection Association in 2007, which has brought together and given shape to a group of schemes that previously lacked organization (Appendix IX).

This formal platform for dialogue is fairly new, but it has the potential to be instrumental in keeping the HMI community and the government linked as plans for UHC mature (Box 10).

Using HMI to pilot new models

Governments have also used HMI schemes to test new policies and operational designs before incorporating them into reforms, since HMI actors tend to be flexible and innovative.

Box 10. Improving knowledge transfer in Cambodia

Cambodia's first CBHI scheme was launched in 1998, and by 2011 a total of 18 CBHI schemes covered 170,490 members in 17 districts. The CBHI schemes are considered a key intermediate solution in the implementation of the government's UHC plans. In order to influence the reform discussions and collectively liaise with the government, the CBHI operators formed in 2007 what is now known as the Social Health Protection Association (SHPA). This aims to be the single platform for exchange with the MOH, and to ensure a coordinated dialogue between all CBHI operators. The network has grown to include other social health protection schemes in the country and was formally registered with the Ministry of the Interior as of May 2012. The following quote from the webpage of the SHPA website describes the vision and motivation for the development of the association:

A centralized association allows for joint knowledge development and learning, strengthening the skills and resources of CBHI/SHP operators and helping them to improve their penetration of the low-income market and expand their operations to a greater number of beneficiaries. The SHPA also directly addresses a fundamental need within the development sector of encouraging collaboration among key organizations and actors to serve beneficiaries in a more informed and efficient manner. - Social Health Protection Association website

Source: Social Health Protection website, 2013.

In India, the RSBY scheme is outsourcing research and development to non-governmental partners. ICICI Lombard - one of RSBY's private insurance company partners - is currently piloting two variants of outpatient benefits offered to beneficiaries in two districts in the states of Orissa and Gujarat. These pilots, which started in 2011 and are relatively small-scale by Indian standards, have reached 750,000 beneficiaries. Enrolment and eligibility follow the existing RSBY

process; patients have access to up to ten outpatient visits in empanelled outpatient clinics (public and private) per year, per family. Consultations (and follow up within 7 days), and drugs are covered.

During the pilot schemes, information on the impact of outpatient coverage on health seeking behaviour, enrolment and renewals in the programme are being evaluated, as well as the impact on utilization of hospitals. In the pilot phase, premiums are being subsidized by the ICICI Foundation. Based on early but encouraging lessons from the pilots, outpatient benefits will be extended to other districts in the future, with funding from the government. This transition will occur as new districts take up RSBY, or as partnerships with insurers offering RSBY in existing districts are renewed. Additional pilots are planned to test further variations of outpatient benefits, including coverage of diagnostic services. These will also test different provider payment mechanisms.

In Cambodia, the government is considering a broader strategy for UHC, that leverages the CBHI network, the Health Equity Funds (HEFs), donor supported funds that target the poor and the National Social Security Fund (NSSF), which targets the formal sector. The government is considering consolidating the three schemes into a single Social Health Insurance scheme. The NSSF health coverage was due to be launched in September 2012, but was delayed to September 2013. In order to gather data that could inform the design for national health insurance and best serve its members, GRET, a French NGO that has been active in Cambodia since 1998, joined forces with the employers' union for garment workers to develop a pilot model that targeted garment workers in Cambodia. This sector represents the major portion of Cambodia's formal employees. The pilot scheme revealed lessons about benefit coverage and pricing, tested new information system tools and established management procedures, such as provider contracting. The project has continued beyond its expected end date, as a result of the delays in rolling out the NSSF. This has added challenges to maintaining funding for extended operations. Despite a governance structure that enabled all stakeholders to participate, the pilot suffered from a lack of commitment from the NSSF to integrate the pilot as a key step of its reform process. This diminished the potential of learning from the experience.

An additional question posed by the government is whether or how the HEF and CBHI schemes could be combined. GRET undertook this experiment by consolidating its CBHI programme with one of the donor-funded HEF schemes. The result of the pilot has been highly debated, since it revealed that donors' contributions to cover the poor were subsidizing CBHI premiums for "near poor" informal workers. This raised the question of the effectiveness of a fragmented approach to health financing.

Key lessons learned about the demonstration effect of HMI

The demonstration effect is ongoing, with lessons that can be drawn from organic developments in different HMI schemes, as well as from HMI schemes that are used to pilot new models. The demonstration effect can have a particularly strong impact during a substitute phase, when the government is first designing UHC. However, the effect can also occur during later stages.

Success factors

- Review of past HMI experience: Thailand eventually moved away from the Voluntary Health Card Scheme to a mandatory, fully subsidized scheme known as the UC scheme, which rolled out in 2002 to cover 98 per cent of the population. New principles were enforced, including mandatory enrolment and a fully subsidized package. These features were based on lessons learned from earlier schemes, without which the policy design would

probably have been quite different. In India, the task force in charge of designing the RSBY scheme evaluated HMI initiatives, both internally and internationally, to harvest relevant lessons in the scheme design.

- **Transparency to achieve greater alignment:** Although HMI can provide a potentially invaluable source of information, the models pursued by different schemes may not always align with national priorities. Governments can facilitate greater partnership by being transparent and clearly communicating national strategies, recognizing that strategies are often evolving. Additionally, strong communication mechanisms can help HMI to align more closely with government objectives.
- **Formal platforms for exchange:** Learning from fragmented HMI schemes may be difficult. Establishing a platform to formalize HMI, as was the case with the Social Health Protection Association in Cambodia, can help to consolidate these lessons. The responsibility is shared. Governments need to seek out information about HMI. HMI schemes can aid this process by organizing and documenting their experience.
- **Clear research objectives:** For planned experimentation to be as effective as possible, there should be clear objectives, along with agreed methods and monitoring systems. It is important that the objectives and vision of planned experiments should be clearly articulated early in the process. This can be aided by ensuring strong buy-in from all stakeholders in the project, and by ensuring that the pilot is a fundamental part of government strategy. For RSBY in India, a key question was how to expand benefits to cover outpatient care. The government is leveraging PPPs to test a number of different variants to include outpatient benefits under RSBY.
- **Pilot scheme as an integrated part of the reform process:** In cases of planned experimentation, it is important to clearly articulate the exit strategy for the HMI scheme. If the pilot is successful, it is frequently transitioned to the government. In RSBY's outpatient experiments, a clear exit strategy that was articulated from the outset is allowing the pilot programme to transition from a private to a public premium subsidy. In Cambodia, lack of commitment from the government in adhering to the initial work plan for the Health Insurance Project has made it difficult for the HMI scheme to carry on the pilot beyond the anticipated end date.

Limitations

- **Potential for generalization:** HMI is generally smaller in scale and concentrated geographically. Results achieved through local or small-scale experience may not be applicable nationwide.
- **Funding:** Pilot schemes are, by definition, experiments, some of which will fail. Governments may be hesitant, and may lack the funding to support pilots. In the case of the RSBY, external donor funding enabled pilot testing of outpatient benefits.

The agility of HMI can be valuable to governments undertaking operational research or testing a new policy. HMI can be part of a broader health financing strategy, through partnerships and by serving as a resource.

10 > CONCLUSION

Government-led initiatives and HMI schemes both strive to provide quality and affordable health care to the poor and other vulnerable or excluded groups. Their common objectives and complementary capacities offer opportunities for fruitful collaboration. Such collaboration can enable progress in removing financial barriers to seeking health care, eventually leading to healthier populations.

There are many opportunities for leveraging HMI schemes and private actors in government initiatives, but there is no silver bullet to expand coverage. Achieving UHC takes time and resources. Countries that have significantly expanded coverage, particularly to individuals in the informal economy, have extended benefits, increased subsidies and enacted compulsory enrolment, while at the same time improving health-care infrastructure. Such policy decisions and the associated mobilization of resources are extremely challenging for most governments. The capacity of HMI schemes also varies. As a result, their ability to perform as government partners also differs. The demonstration effect from HMI initiatives can be valuable, but lessons may not be transferable to other settings. Furthermore, no matter how well designed or funded an HMI or government scheme may be, there can still be financial and behavioural constraints which may limit and distort demand.

A critical success factor of any type of collaboration between governments and HMI schemes consists of transparent, ongoing dialogue among all stakeholders, to align interests and raise awareness of each party's strengths and weaknesses. It is important for policymakers to understand and monitor the impact of HMI in their country, and to articulate the optimal role of HMI over time. It is equally important for HMI actors to advocate for the role they can play in supporting government efforts to achieve UHC.

Despite a lack of clear-cut solutions for achieving UHC, it is evident that HMI can contribute to government efforts to serve large numbers of informal workers, and that collaboration can reduce duplicative or competing models. Governments should look to HMI as a source of innovation and learning, and actively seek partners that have experience, fresh ideas and complementary capacities.

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APPENDIX I. METHODOLOGY

Our goal was to examine different models for partnership between governments and HMI providers that aim toward better coverage of those in the informal economy. To do this, we developed a conceptual framework that describes the relationship between HMI and UHC. Next, we identified and documented real world HMI and UHC examples that illustrate these relationships. Finally, we analyzed these cases to extract key lessons and insights.

In order to develop the conceptual framework, we carried out a literature study to identify existing frameworks. We found three main examples. A recent WHO framework takes a broad view of all voluntary health insurance programmes, including schemes targeting the formal sector and wealthy, and outlines its roles in relation to UHC (primary/substitute, complementary, supplementary and duplicative) (Mathauer, 2012). The ILO's recent update to its microinsurance compendium explores the relationship between microinsurance and social protection, and proposes different roles for HMI that closely mirror those proposed by the WHO: substitute, alternative, linked, complementary or supplementary (Churchill et al., 2012). Wang and Pielemeier (2012) explore the role of CBHI schemes in the movement toward UHC and propose a three-stage evolutionary model - basic, enhanced and nationwide - to develop the CBHI approach as a pathway for achieving UHC (Wang et al., March 2012). This initial review led us to refine our interpretation of the roles that HMI can play in relation to UHC. Using an iterative process that evolved as we explored the case studies, we developed a new framework for HMI and UHC, which is presented in section IV.

The second component of the paper was to select case studies that represent each piece of the conceptual framework. To select country case studies that could demonstrate this framework, we scanned the literature, talked with key advisors and narrowed the list of countries down to those that either have active HMI schemes in parallel with government reform, or which have used HMI as a building block for expansion of government health insurance. Because governments and microinsurers are grappling with the challenge of reaching informal workers, we considered government health insurance schemes that use a private institution to carry risk, register health-care providers or enrol clients and collect premiums. The final list of countries we selected includes Cambodia, Ghana, India, Kenya, the Philippines, Tanzania and Thailand. These country case studies were documented through desk research and key informant interviews with representatives from national initiatives, as well as with private HMI partners.

One limitation of the study has been the lack of any comprehensive list of countries that are actively working to achieve UHC. With this in mind, we attempted to triangulate information from multiple sources, including the ILO 2008 Social Health Protection strategy, UNICEF's National Health Insurance study, UHC forward case studies and information from the Save the Children Equitable Health Financing. (O'Connell, 2012; Social Security Department, 2008; UHC Forward, 2013) The ILO's Microinsurance Compendium, the Landscape of Health Microinsurance in Africa and the ILO Microinsurance Innovation Facility's partners were used to identify instances of active health microinsurance (Churchill et al., 2012; Dercon et al., 2008).

- The country case studies were selected based on the following criteria:
- Interesting linkages between microinsurance and public initiatives;
- Diversity of models and capacity to illustrate the four roles explored in the paper (substitute, foundation, partnership and supplement);
- Geographic diversity;
- Countries that are using a traditional insurance model to provide coverage for their population;
- Access to information. A preference has been given to the Microinsurance Innovation Facility's partners, since information was more accessible.

These countries include Cambodia, Ghana, India, Kenya, the Philippines, Tanzania, and Thailand. The case studies were documented through desk research and key informant interviews with representatives from national initiatives, as well as with private HMI partners.

The analysis was conducted by comparing country cases operating in the same role, as defined in the framework. We analyzed cases for similarities and differences in how the relationship between HMI and UHC was characterized, what the relative advantages were for each party, how dialogue between the two parties took place, what worked well and aspects that proved challenging. This analysis provided specificity regarding roles for HMI and generated insights and recommendations aimed at informing government policymakers, HMI providers, researchers and the global community on how to leverage HMI in the move toward UHC.

APPENDIX II. OVERVIEW OF COUNTRY CASES

Country	Cambodia (CBHI)	Ghana (NHIS)	India (RSBY)	Kenya (NHIF)	The Philippines (PhilHealth iGroup)	Tanzania (CHF/TIKA)	Thailand (UC scheme)
Population (in thousands)	14 305 (2011)	24 966 (2011)	1 241 492 (2011)	41 610 (2011)	94 852 (2011)	46 218 (2011)	69 519 (2011)
% of total population covered by any type of health insurance	10.6* (2010)	34 (2011)	25 (2008)	20	82	18.1 (2011)	98
% of total population covered by informal sector scheme	1 (2010)*	34 (2011)	5.6	16.9	13.1	9.8	75.0
Size of informal sector (% of population)	85-90 (2004)	67*** (2008)	83.5** (2004/5)	31.6 ¹	65	76.7	42.3** (2010)
Total health expenditure (% of GDP)	5.6 (2010)	5.2 (2010)	4.1 (2010)	4.8 (2010)	3.6 (2010)	6 (2010)	3.9 (2010)
Per capita expenditure on health (2005 PPP)	121.1 (2010)	84.9 (2010)	132.2 (2010)	77.7 (2010)	142.4 (2010)	83.4 (2010)	329.7 (2010)
Out-of-pocket expenditures (% of total health expenditure)	40.4 (2010)	26.9 (2010)	61.2 (2010)	42.7 (2010)	54.0 (2010)	13.6 (2010)	13.9 (2010)
Year scheme became available to informal workers	1999	2004	2007	1966	2005	2001	2002
Enrolment requirement	Voluntary products	Mandatory for all residents except police, military and persons who belong to private schemes, but no enforcement mechanism.	Voluntary	Mandatory for formal sector workers; voluntary for rest	Mandatory for formal sector; voluntary for rest	Mandatory for formal sector; voluntary for rest	Mandatory for all

Scheme eligibility	All citizens are eligible. Membership must be family-based. Poor households are covered through health Equity Funds	All residents in Ghana are eligible	Individuals below the poverty line.	Entire population is eligible	All citizens are eligible; informal workers enrol in the Individual Paying Program either through	Rural - household enrolment for a couple and their children under 18 years. Urban pop. eligible for TIKa scheme	All individuals who are ineligible for either the civil servant scheme or the Social Security Scheme
Individual contribution rate	Contribution varies according to size of the family, and between rural or urban schemes.	Informal, non-poor workers pay graduated contributions and registration fee based on ability to pay	Contribution of 30 INR per household per year. (US\$ 0.55)	30-320 Ksh/month depending on income (US\$ 0.34 - 3.60); 160Ksh (US\$1.80) for voluntary	P2400 (US\$ 58.93); contribution incentive depends on group size	Between TZS 5,000-20,000 per year/household (US\$ 3.05 - 12.20)	No contribution from members (30 Baht copayment - US\$ 1 - was abolished in 2006)
Benefit package	Comprehensive coverage, accessible only at public facilities (level of coverage at hospitalization level varies). CBHI coverage is regulated through MOH CBHI guidelines. Limited Life insurance cover.	Almost comprehensive outpatient, inpatient, surgery, maternity care and deliveries, immunizations and preventive care, consultations, diagnostics, essential medicines, eye care, dental, and emergency care, with services offered through government parallel programmes exempted	Tertiary: Secondary care only, accessible at both public and private facilities, up to INR 30 000	Inpatient services, no exclusions	Inpatient care and hospitalized outpatient services, such as malaria and TB-DOTS care	Primary level public facilities. Limited referral care in some districts	Outpatient, inpatient and accident and emergency services
Level of premium subsidy	Indirect subsidies via public health care subsidized fees and donor support to operations	Children under 18, persons above 70, pregnant women and the poor are exempted from payment. Only 4% of total income comes from informal workers' contributions	Almost 100% of the premium is subsidized by central and local government; the insured pay just US\$ 0.55, to cover the cost of the smart card	Voluntary enrolment subsidized up to 50% of full premium cost	Poor people are fully subsidized through sponsored programme. Informal workers receive partial subsidy and premium is subsidized based on group size.	Government provides 100% matching grant to the district council for each member who enrolls	Fully subsidized
Source: 2011, World Development Indicators, unless otherwise marked, *2010 Cambodia, DHS **ILO Statistical Update on employment in the informal economy (2011) ***Ghana Living Standards Survey (2008) and Seddoh and Akor, <i>BMC Public Health</i> (2012) †Kimani (2011).							



APPENDIX III. USING THE CBHI MODEL AS A FOUNDATION FOR UHC IN GHANA

Country context

Sixteen million (or 67 per cent) of Ghana's nearly 25 million residents, and 80 per cent of the working population, are considered to be part of the informal sector. Almost half of the population (49 per cent) lives in rural areas and over one-quarter (28.5 per cent) is living in poverty. Out-of-pocket health spending currently accounts for approximately 27 per cent of total health expenditure.

In 2000, new political commitments pushed forward a wave of experimentation, learning and reforms to achieve universal health coverage in Ghana. Three main health financing reform options were considered at the time: (1) focusing on the formal sector, (2) developing a public commercial insurance system and (3) scaling up community-based health insurance schemes with a focus on the informal sector. While there was strong pressure to focus on the formal sector, the government ultimately elected to develop a National Health Insurance Scheme (NHIS) as a universal system that would target the formal and informal sector and would leverage an existing platform of health microinsurance, or the community-based health insurance (CBHI) model.

Public sector options for informal workers

In 2003, Ghana embarked on a process of developing and implementing the NHIS to replace out-of-pocket fees at the point of service (referred to as "cash and carry"). The National Health Insurance Authority (NHIA) was implemented to regulate and supervise the NHIS and to manage the National Health Insurance Fund from which subsidies are paid to District Mutual Health Insurance Schemes, the local operational schemes of the NHIS. The NHIS was designed to cover both formal and informal workers, fusing elements of state-sponsored social health insurance (SHI) and health microinsurance, or the CBHI model. While the NHIS is considered mandatory for all residents except members of the police and military forces, as well as people enrolled in private schemes, the NHIS operates as a voluntary health insurance programme due to the difficulty of enforcing enrolment. The NHIS reports that approximately 65 per cent of the population has enrolled in the NHIS since it was established, and as of 2011, 34 per cent of the population was actively covered.

Table 1: Key statistics on Ghana

Population (in thousands) total	24 966 (2011)
Population covered by insurance (%)*	34% (2011)
Size of informal sector (% of population)**	67%** (2008)
Gross national income per capita (PPP international \$)	1620 (2010)
Total health expenditure (% of GDP)	5.2 (2010)
Per capita total expenditure on health (PPP constant \$2005)	84.9 (2010)
Private expenditure on health as percentage of total expenditure on health	40.5 (2010)
Out-of-pocket expenditure (% of total health expenditure)***	26.9 (2010)
Life expectancy at birth (years) average	60 (2009)
Infant mortality rate (per 1 000 live births) both sexes	50
Maternal mortality ratio (per 100 000 live births)	350 (210-630)
Hospital beds per 1 000 people***	0.9 (2011)

Source: *NHIA 2011, Ghana Living Standards Survey (2008) and Seddoh and Akor, *BMC Public Health* (2012), ***World Health Statistics, World Development Indicators

Private sector options for informal workers

A small segment of the population in Ghana has access to private health insurance options outside the NHIS. The National Health Insurance Act of 2003 stated that any resident of Ghana must be covered by the NHIS, private commercial health insurance or private mutual health insurance. Today, the private commercial and mutual health insurance markets are small relative to the NHIS, covering less than 1 per cent of the population.

Some informal workers have access to private mutual health insurance through organized groups, such as employer associations, social groups or churches. Rates of enrolment through these groups is limited; however, there is some evidence to suggest that some informal workers are enrolling in commercial insurance schemes for a NHIS "top-up" to cover certain medicines or to receive cash assistance aimed at covering hospital-related room and board and transportation costs.

Table 2 : Characteristics of major insurance schemes in Ghana

Insurance scheme	Eligibility	Contribution rate	Benefit package	Coverage
National Health Insurance (NHIS)	All residents in Ghana, including formal and informal sectors, aged (70+), children under age 18, and low-income people	Informal, non-poor workers pay graduated contributions and registration fee based on ability to pay; formal sector employees pay registration fee and contribute 2.5% of social security contributions; all other populations exempt	Almost comprehensive outpatient, inpatient, surgery, maternity care and deliveries, immunizations and preventive care, consultations, diagnostics, essential medicines, eye care, dental, and emergency care, with services offered through government parallel programmes exempted	34
Private commercial health insurance	Formal sector employees	Variable, depends on private insurance product. No NHIS subsidy available.		<1%
Private mutual health insurance	Members of some organized groups (e.g., employer associations, social groups, churches, etc.)	Variable, depends on mutual health insurance product. No NHIS subsidy available.	Variable, may be a comprehensive package or a NHIS "top-up"	Information not available

The CBHI model as a foundation for UHC

In Ghana, the CBHI model has played an important role in the transition from fragmented coverage pre-2004 to a UHC plan through the NHIS. The NHIS has utilized existing CBHI schemes to facilitate the gradual scale-up of coverage through publicly sponsored District Mutual Schemes over the past 8 years.

Since the launch of CBHI schemes in Ghana in 1999, the country has scaled up coverage in two phases: first, through a rapid and organic proliferation of CBHI schemes, which has fostered a culture of health insurance and laid a foundation for rapid scale-up, and second, through a melding of the CBHI model with publicly sponsored District Schemes and a top-down, national framework. During the second phase, coverage rates increased 30-fold over a relatively short period of time.

Phase I

In the late 1980s and early 1990s, several CBHI initiatives developed in response to concerns about the negative effects of user fees on service utilization. These early experiments faced numerous challenges in their design, but they provided important lessons that influenced later larger-scale efforts to develop CBHI schemes in Ghana. For example, an early experiment developed by the Catholic Diocese of Sunyani set up a facility-based health insurance product at St. Theresa's Hospital, Nkoronza. While enrolment levels were high, the system excluded the poorest, lacked community ownership and was financially unsustainable.

In 1997, the *mutuelles* model of CBHI, organized as district schemes, was introduced. The model was based on principles of social solidarity and community ownership (as opposed to an earlier focus on provider management). These schemes initially covered inpatient benefits (e.g. hospitalization, surgery and deliveries). Over time, they started adapting to population requirements and covering outpatient services that were most needed by the population (e.g. snake bites, farm injuries, dog bites and some selected expensive essential medicines). The first district scheme was established as a pilot in Dangme West District.

The CBHI model began to take hold and expand rapidly, increasing from three schemes in 1999 to 258 by 2003. Development partner support, especially that delivered through DANIDA, PHR-plus (USAID) and faith-based organizations, had helped to establish 34 community schemes. These schemes were concentrated in Brong Afofo and Eastern regions, in part due to technically-savvy 'champions' from the Ghana Health Service, Christian Health Association of Ghana (CHAG) support – in an area where there were many missions – and an active interest on the part of district and regional leadership. Between 2001 and 2003, the government piloted the district mutual health insurance approach in two sites. The first was in the Ashanti Region and the second was in the Greater Accra Region. The approach was then rapidly scaled out to district mutual schemes in 125 districts.

Phase II

When the NHIS was established in 2004, the government gave existing CBHI schemes the choice of affiliating with the NHIS and benefiting from the government subsidy and other district support, including Board membership and, depending on the skills and experience of the CBHI scheme, the opportunity for CBHI staff to transition into salaried positions with the district schemes. Or, if they preferred, they could remain as CBHI schemes and modify benefits packages to supplement the NHIS benefit package.

There were concerns among some CBHI schemes, particularly union and donor-funded ones, that the NHIS district schemes would receive automatic sponsorship from the government, irrespective of efficiency, effectiveness or responsiveness. There were also fears that mutual health organizations operating at the time would be classified as private, with no support or subsidies from the government. Organized unions and some facilities wanted their own schemes. Donor-funded CBHI schemes were opposed to the law, because they had already invested in the informal sector and felt their investments were being disregarded.

Ultimately, despite these concerns, the majority opted to join the NHIS district-based schemes. Those CBHI schemes that remained opted to transition to providing top-up coverage to supplement the NHIS. For example, the scheme affiliated with the Methodist Church began offering coverage for medicines not offered through the NHIS, and provided cash support to cover room and board and transportation costs for hospitalization. The civil servants' scheme provided similar types of top-ups.

Prior to NHIS implementation, CBHI schemes only covered a small portion of the population – an estimated two per cent in 2003. There was no legal framework for regulating the CBHI schemes and obtaining data and information about them was difficult. Furthermore, the small portion of the population enrolled in CBHI schemes generally only had coverage for limited inpatient care, so individuals still paid large out-of-pocket costs for outpatient care, or for more extensive inpatient care.

Some of the key successes of Ghana's approach to leveraging the CBHI system in the transition to publicly sponsored District Mutual Schemes included:

- Reducing coverage fragmentation through the integration of multiple CBHI funding pools
- Strong population willingness to participate in the NHIS due to previous exposure to risk pooling principles through CBHI
- Decrease in out-of-pocket expenditures from 50 per cent in 2002 to 27 per cent in 2010
- Growth in patients' awareness of the NHIS and a shift in patient perceptions and attitudes about health care over time, according to district scheme managers
- Incremental improvements to operations, e.g. gradual streamlining of enrolment and claims payment processes, the roll-out of a biometric smart card, improved approach to poverty targeting, and regular meetings and an information platform to facilitate communication across the schemes.

Despite some major successes in scaling up coverage, Ghana has faced a number of strategic and operational challenges:

- With increases in coverage and demand for services, the NHIS faces concerns about inefficiencies, fraud and abuse, which has led to broader concerns about cost control and the financial viability of the NHIA. Each district scheme operates as a risk pool and the NHIA has to effectively equalize risk across the schemes and serve as a reinsurer.
- Administration of the NHIS, with complex systems for enrolment, collection of enrollee contributions, provider empanelment, accreditation and claims payment, has required a significant investment of resources and capacity

development. Currently, however, the NHIS spends only 5 per cent of total expenditure on administrative costs (excluding one-off start-up costs), a relatively minimal investment compared with many health insurance schemes. With a surge in the volume of claims and the need to enrol more individuals and collect enrollee contributions, the NHIS district schemes faced capacity constraints in their new role as regulator at central level and implementer at district level. The NHIS had to hire extra staff and strengthen its skills base. This need was partly addressed by incorporating staff from previous CBHI schemes.

- Enrolment of informal sector workers, especially the poor, has been an ongoing challenge for the NHIS. Although the district schemes conduct outreach and seek to identify the poor, there is no systematic process for identifying individuals within this sector. Major barriers to access remain (e.g. distance to travel for enrolment, length of time - up to several months - for membership cards to be delivered), and there are ongoing concerns about equity in coverage across socio-economic groups.
- Assigning calculation of enrollee contributions to district schemes has resulted in considerable variation in enrollee contributions across the country, as well as challenges in understanding the basis for these calculations.
- Some functions in the insurance value chain (e.g., claims payments) that are currently managed by district schemes may be more effective and efficient if managed centrally.

Key lessons

CBHI schemes had grown organically in response to a need during the 15-year period prior to the implementation of the NHIS. Health reformers saw an opportunity to fuse the CBHI model with the characteristics of tax-based financing and social insurance schemes. Other countries, such as China, Rwanda and Thailand, have similarly evolved nationwide models of CBHI. This synergy between bottom-up CBHI and a top-down government framework has facilitated the rapid scaling up of coverage for rural and informal sector populations. In addition, Ghana has leveraged the administrative structure of districts to rapidly expand coverage across the country. These design decisions were very country context specific, building on the historical evolution of the CBHI model in Ghana and responding to a high level of political will and public support for UHC.

- Evolutionary approach: Governments with a HMI base may want to consider an evolutionary approach to developing UHC, starting with a bottom-up model and centralizing over time. The NHIS was able to build on the CBHI structure that already existed across Ghana. The NHIS reinforced the CBHI model with a centralized authority (the NHIA) and a source of funds (the National Health Insurance Fund) to ensure nationwide coverage and guarantee the financial sustainability of the schemes. Most CBHI schemes, and their enrolled populations, were incorporated into district-level schemes when the NHIS was launched. Some CBHI schemes also evolved to provide top-up, or supplementary benefits to complement the NHIS benefit package. By merging with the NHIS district schemes, the existing CBHI schemes could transition their enrollees into a comprehensive benefit package that offered subsidies for the poor and portability across districts. CBHI enrollees were able to understand insurance principles and more easily transition into the NHIS district-based schemes.
- Resource mobilization: Governments need to mobilize resources to subsidize coverage of the poor and vulnerable who are unable to contribute to the cost of insurance. The NHIS is funded by a 2.5 per cent consumption tax (VAT), covering approximately 70 per cent of costs, as well as 2.5 per cent pension fund contributions, enrollee contributions, and accruals from NHIS fund investments.

- Win-win scenario: A mutually beneficial partnership between the government and the CBHI model evolved. This facilitated greater coverage through government subsidies and new regulatory oversight, while leveraging community interests through established CBHI schemes. CBHI enrollees benefited in transitioning to the NHIS because they had access to a comprehensive benefit package (whereas previously, most CBHI schemes had emphasized inpatient care), and the poor and vulnerable were exempted from contribution requirements due to government subsidies. NHIS district schemes offered attractive opportunities to transition CBHI staff into salaried positions and to give CBHI schemes a voice in the reform process.

The government benefited because existing CBHI schemes provided a ready enrolment base on which to build when the NHIS was launched. It also had the advantage of capable CBHI staff, with skills and expertise in the insurance value chain (e.g. trained in identification of eligible enrollees, enrolment and claims processing), as well as sensitized communities that were already familiar with the concept of insurance. While many of the schemes were very small and had limited penetration (covering just 5-10 per cent), a few schemes, particularly in the cocoa region and in the north, achieved significant coverage levels.

Conclusion

Many countries look to Ghana as a positive example of progress on UHC. The evolution from small-scale, fragmented CBHI schemes in the early 2000s to the current NHIS offers a compelling example of how CBHI schemes can be effectively leveraged, in a foundation role, by a national initiative to expand coverage to the poor and informal sectors.

Now that the NHIS is well established, Ghana is focusing efforts to ensure that working poor enrol in NHIS and use the health-care services that they need. The NHIA is currently seeking to improve the way it identifies the poor and is considering revisions to enrollee contribution requirements. In 2012, Ghana legislated on equity measurement, so as to ensure the poor and vulnerable are included in the scheme. The NHIA is also exploring various options for raising revenue through an increase in VAT tax and controlling costs through initiatives such as pharmacy cost containment, centralizing claims payments, alternative provider payment mechanisms and biometric identification.

As policymakers around the world seek ways to achieve UHC, the path that Ghana has travelled offers many valuable lessons and practical experiences. While Ghana still grapples with complex policy and operational challenges, it offers a case study that can be particularly instructive to other countries with a CBHI landscape and the political will to expand coverage to the whole population, including the poor and most vulnerable.

This case study was prepared with input and review from Dr. Sam Adjei (CHeSS Ghana), Mr. Philip Akanzing (Ghana Health Service), Mr. Kingsford Gyamfi (Nkoranza District Scheme of the NHIS) and Mr. Nathaniel Otoo (NHIA).

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APPENDIX IV. A STEP-WISE APPROACH TO UHC IN THAILAND

Country context

Thailand has promoted UHC since the 1970s, investing in infrastructure, primary health care and prepaid insurance schemes, which culminated in the expansion of coverage to the total population in 2002. This achievement can be tied largely to reforms aimed at covering informal sector populations. What began as community health financing evolved into the Voluntary Health Card scheme, and then eventually into the Universal Coverage (UC) Scheme, a major policy reform which was unveiled in 2000. The UC Scheme was rolled out rapidly to cover 75 per cent of the population, with the remaining 25 per cent covered by the Civil Servants Medical Benefit Scheme and Compulsory Social Security Scheme (Evans et al., 2012). Thailand's success stems from significant investment in strengthening its health-care infrastructure at all levels - health centres, rural district hospitals and public provincial hospitals, and in improving access to health services. A strong political movement against the military government in 1973 resulted in temporary democracy in Thailand. This, combined with a global focus on

"Health for All," resulted in many policy changes, particularly a major push for primary health care, universal health coverage, recruitment of village health volunteers and the establishment of many community-based health financing schemes (e.g. village drug funds, sanitary funds, nutrition funds).

Private sector employees were the first to be covered through a prepaid scheme, which was rolled out in 1974 (Workmen's Compensation Fund). This was followed by the Medical Welfare Scheme in 1975, which targeted the poor, and the Civil Servants Medical Benefit Scheme in 1980, which covered government workers and dependents.

Table 1: Key statistics on Thailand

Population (in thousands) total*	69 519 (2011)
Population covered by insurance*	98%
Size of informal sector (% of population)***	42.3 (2011)
Gross national income per capita (PPP international \$)*	8 190 (2010)
Total health expenditure (% of GDP)*	3.9 (2010)
Per capita total expenditure on health (PPP constant 2005\$)*	330 (2010)
Private expenditure on health as percentage of total expenditure on health*	25 (2019)
Out-of-pocket expenditure (% of total health expenditure)**	14 (2010)
Life expectancy at birth (years) average*	70
Infant mortality rate (per 1 000 live births) both sexes*	11 (2010)
Maternal mortality ratio (per 100 000 live births) *	48
Hospital beds per 1 000 people*	21 (2010)

Sources: * World Development Indicators Database, Worldbank.org, ** National Health Accounts Database, ***ILO Statistical Update on Employment in the Informal Economy (2011)

Table 2: Insurance schemes in Thailand

Insurance scheme	Operational dates	Eligibility	Contribution rate	Benefits package	Population coverage
Workmen's Compensation Fund [†]	1974 - 1990	Compulsory coverage for workers.	Employer pays full contribution, which ranges from 0.2-1.0% of payroll.	Benefit for injury and sickness from workplace.	All workers.
Compulsory Social Security Scheme (SSS)	1990 - present	Private sector employees, excluding dependents.	1.5% of salary financed equally by employees, employers, central government contributions.	Sickness, maternity, invalidity, death, child allowance, old age pension, unemployment.	16%
Medical Welfare Scheme	1975 - 2002	Indigent, including the poor, elderly, children up to secondary school and disabled.	No member premium; general tax-funded.	Comprehensive coverage.	32% (in 1999)
Civil Servant Medical Benefit Scheme	1980 - present	Government employees, dependents, and retirees.	No member premium; general tax-funded.	Comprehensive coverage.	9%
Voluntary Health Card Scheme	1983 - 2002	Non-poor households not eligible for the MWS, community leader and health volunteer family.	Household Baht 500 + tax 1,000 Baht.	Comprehensive coverage.	19% (in 1999)
Universal Coverage Scheme	2002 - present	All individuals who are ineligible for either the civil servant scheme or the SSS.	30 Baht (30 Baht copayment was abolished from 2006-2012, reintroduced in 2012).	Outpatient, inpatient, and accident and emergency services.	75%

Source: Tangcharoensathien et al, (2002); [†]Policy and Planning Division, Social Security Office Thailand.

An incremental approach to UHC

Thailand's story is one of incremental evolution. Unlike countries such as Ghana and Rwanda, which have regulated that CBHI schemes be the primary mechanism for reaching UHC, Thailand demonstrates how ultimate success may require a number of different iterations. Thailand has its roots in early community-based health financing schemes, known as village-based funds, but eventually redesigned its system to target informal workers through a voluntary, contributory scheme – the Voluntary Health Card Scheme. It finally discarded that scheme and moved to the mandatory, subsidized Universal Coverage (UC) Scheme.

Step 1: Emergence of village-based funds to finance health care

Thailand's National Socio-economic Development Plan in the 1960s focused largely on village development and the replication of primary health care concepts nationwide (Wibulprasert, 1991). This was achieved by recruiting different local health personnel, including village health volunteers and village health communicators. In the late 1970s, when these individuals were being recruited and trained, the Ministry of Public Health (MOPH) also initiated an essential drug programme. This initiative involved supplying drugs to the community, with the expectation that the profits from sales would be reinvested to purchase new inventory.

Although the funds only covered a very limited share of total health-care costs, this model led to the development of community-based funds and improved community managerial skills (Wibulprasert, 1991). Starting in 1980, the village drug funds were followed by a nutrition fund, a sanitation fund, a health card fund and a village development fund. The health card fund provided access to basic medical care and privileged access to hospitals after referral. The drug fund was the most successful of all the initiatives. It appealed to the immediate demands of villagers and by 1987, 27,135 drug funds covered 45.5 per cent of rural villages (Wibulprasert, 1991). Individual families contributed to these funds and over time, what began as single purpose funds became multipurpose funds.

By 1987, the health card funds covered 30 per cent of rural villages and less in urban communities, due to different contextual characteristics. There was no direct subsidy of the funds from the government.

Step 2: Transformation of village funds into nationwide voluntary scheme

In 1983, the MOPH, which has been a key promoter of policy reforms over the course of Thailand's development, launched the Health Care Project, later named the Voluntary Health Card Scheme. This grew out of the village health care funds and covered the near-poor population - those who were ineligible for the Medical Welfare Scheme (Pannarunothai et al., 2000; Supakankunti, 2000).

- Phase 1: (1983) A pilot programme focused on the replication of the health card funds in selected provinces, highlighting maternal and child health, family planning, immunization, communicable disease and health education (Sakunphanit, unpublished). It was tested in seven provinces for a period of 8 months. The programme aimed to promote community development through emphasis on primary care and proper referrals, as well as increased health resources through community financing. The pilot was designed to test different outpatient benefit packages and to determine which of these would reduce the number of hospital admissions.
- Phase 2: (1984-1986) Following the success of the pilot scheme, the MOPH decided to gradually expand the programme. It aimed to have the programme operational in all sub-districts by 1987 (Pannarunothai et al., 2000). The programme became known formally as the Health Care Project and by 1985, just over half of all households in Thailand were participating (Sakunphanit, unpublished). The government indirectly subsidized the schemes by requiring only 75 per cent of the MOPH health facility premium to be paid by the beneficiary. The exact benefits package and premium varied across communities, with some limiting maximum numbers of visits and others specifying a limit on costs of benefits. By the end of the second phase, the financial sustainability of some of the funds was in question and the premium was raised while additional solutions were sought.
- Phase 3: (1987 - 1992) From 1987 onwards, the government tried to address some of the weaknesses in the programme. Individuals needed greater incentive to enrol, including better quality care and access to facilities beyond those supplied by the MOPH. The funds were initially governed locally, through a village committee that

was supervised by community health workers, but success varied, based on each village's management capacity. Between 1986 and 1987, the funding of the card changed from community financing to voluntary health insurance and management shifted from village level to more highly involved sub-districts (Pannarunothai et al., 2000). It became clear that the government needed to invest more by providing higher subsidies for the funds. It also needed to improve efficiency by centralizing administrative functions (Sakunphanit, unpublished). In the redesigned programme, the MOPH took responsibility for managing the funds, and created a larger, more consolidated risk pool. The premium was raised, but the government began to subsidize half of the cost (500 Baht from individuals and 500 Baht from the government). The name of the programme also changed in 1993, from the Health Care Project" to the Voluntary Health Card Scheme.

- Phase 4: (1993 - 2001) From 1994 onwards, the total annual premium was 1 000 Baht per household, for up to five members. Benefits covered curative outpatient care, inpatient services and maternal and child health care. Half of this premium was subsidized by the government, and was calculated to provide a break-even amount of revenue to health-care providers (Pannarunothai et al., 2000; Patcharanarumol et al., 2011). There was no cap on the benefits in terms of utilization, but members were required to use MOPH facilities. One open enrolment period was offered each year, which was aligned with seasonality of income. The management of the funds shifted again in 1995 to the provincial level, supplemented by a central reinsurance fund (Supakankunti, 2000). Another important shift was from an annual budget to a revolving one, which allowed the resources to carry over to the following year (Pannarunothai et al., 2000).

The programme suffered a number of challenges, including adverse selection resulting from the voluntary nature of enrolment, threatening financial viability. This was one of the factors behind the development of the UC Scheme. Enrolment of the card scheme peaked in 1997, at which point it covered 13.5 per cent of the total population. However, 30 per cent of informal workers still remained uninsured (Pannarunothai et al., 2000).

Step 3: Evolution from voluntary scheme to subsidized mandatory scheme

By 2001, four different schemes were operating, each with different rules and benefits packages, making the concept of an equitable universal coverage scheme hard to achieve (Somkotra et al., 2008). Approximately 30 per cent of the population (18 million people) was still uninsured and most of these individuals were informal workers (Evans et al., 2012). Out-of-pocket payments remained high in 2001, accounting for 33 per cent of total health expenditure. The experience of the Voluntary Health Card Scheme revealed a number of important lessons (Sakunphanit, unpublished):

- A community management structure was not viable for UHC, since not all communities had the required management capacity;
- The voluntary nature of the scheme led to adverse selection. In order to achieve UHC, compulsory membership was necessary;
- A one-size-fits-all model would not work. The needs of rural communities differ greatly from those of urban communities and the same benefit design may not be relevant in each case;
- Fragmented risk pools across communities limited capacity to apply cross subsidies. In order to expand the risk pool, the government needed to centralize fund management.

The UC Scheme began as a pilot in April 2001 in six different provinces. It combined the beneficiaries of the Medical Welfare Scheme and the Voluntary Health Card Scheme, as well as any additional uninsured eligible persons, and grouped them under the umbrella of the new UC Scheme (Somkotra et al., 2008). Originally, the scheme was known as the "30 Baht Scheme," because it collected a small copayment of 30 Baht from beneficiaries at each visit, excluding

previous enrollees of the Medical Welfare Scheme. There was a high level of opposition to this idea, and there was lively debate on the cost-efficiency of such a system, with high administrative costs to collect small copayments.

Abolishing the practice of copayment became a way for the new government to distinguish itself. The UC scheme was free of charge from 2006 to 2012. The 30 Bath copayment charge was reintroduced when the previous government party returned to power, citing the need to reduce unnecessary use of health-care services. The copayment charge is payable at time of use and many citizens (children, poor and elderly) are exempt.

The UC Scheme offers comprehensive benefits to all beneficiaries, including preventive and promotional services, and currently covers 75 per cent of the population. The scheme promotes a gatekeeping function of primary care centres by requiring that a beneficiary visit there first in order to receive subsidized care.

An independent agency, the National Health Security Office (NHSO), manages the UC Scheme, and is responsible for defining the benefit packages, registering beneficiaries and health-care providers and paying claims. Private clinics are eligible to contract with the NHSO. The split between the purchasing function, led by the NHSO, and the provider function, which comes under the responsibility of the MOPH, was a major change, creating greater accountability for quality services. In order to control costs, the UC Scheme implemented a capitation payment system for outpatient care, and a case-based payment system for inpatient care, with a global budget ceiling (Hanvoravongchai, 2013). The number and mix of health-care providers was not geographically aligned with that of beneficiaries. With new payment mechanisms, the money followed the patient, encouraging a redistribution of health-care providers to meet demand (Evans et al., 2012).

Uninsured individuals were automatically eligible for the UC Scheme and had to register at a public health centre, hospital or provincial health office (Hanvoravongchai, 2013). When the UC Scheme was first launched, the NHSO used door-to-door campaigns, leveraging existing identification systems (civil registry, house registration system and national identification numbers) and worked with community leaders to identify eligible individuals.

Although the scheme still faces challenges, such as the unification of three remaining schemes and cost containment, the transition to the UC Scheme marked a substantial increase in the percentage of the Thai population covered. Coverage of the target population rose from 92.48 per cent in 2002 to 97 per cent in 2007 (Sakunphanit, unpublished).

Key lessons

Thailand's pathway toward UHC presents a compelling model for other countries to consider. The CBHI model was leveraged in early days to promote UHC. The UC Scheme was rolled out extremely quickly nationwide, relying on the foundational infrastructure and management capacity that had been developed through earlier HMI.

- Political commitment: Governments need to mobilize strong political will to enact reforms. The UC Scheme built on a record of strong political commitment to extend coverage to the entire nation.
- Step-wise development: The UC Scheme built on earlier iterations of financing schemes, consolidating and learning from previous experience. It leveraged an existing membership and risk pool through the Voluntary Health Card scheme, as well as key managerial capacities and acceptance from the public.

- Compulsory membership: The UC Scheme needed a compulsory membership model in order to address adverse selection. In the case of informal workers, achieving compulsory membership meant that Thailand had to offer a premium subsidy. A fully subsidized model may not be possible for some countries with limited fiscal space, but there may be ways to learn from Thailand's gradual increases.
- Fiscal space: Thailand was unable to offer fully subsidized coverage to informal workers until it had the fiscal space to do so. Establishing a tax-funded fully subsidized system meant that strong controls had to be put into place to contain costs. This issue was addressed by setting a fixed annual budget and "closed-end" provider payment mechanisms, which essentially meant that a cap was placed on the amount that health-care providers could recover (Evans et al. May 2012).
- Local capacity: Thailand benefited from the schemes that had preceded the UC Scheme. These were successful in building capacity at community level so that when the UC Scheme was implemented, it could be rolled out quickly.
- Centralized management: The UC Scheme required central fund management, but it also established a governance board that included representatives from all levels of the system. The centralization of management has been progressive, with caution exercised to ensure that all stakeholders still have a voice in the system.
- Investments in infrastructure: The scheme benefited from long-term investments in infrastructure by the Thai government, including health facilities, health personnel training, and management capacity for information technology and claims processing. Governments need to focus on developing infrastructure, including health facilities and technology, in order for health insurance to scale-up successfully.
- Inclusion of private facilities: If providing accessible coverage for all citizens was the goal, it became clear that using just the MOPH facilities would not be enough. Private facilities needed to be included in the scheme in order to extend *effective* access to all. Other countries may also need to consider this as they scale up.
- Primary care: The Thai system emphasized primary care early on in its development of health insurance. A focus on primary care, outpatient benefits and use of local health centres as gatekeepers has helped to contain costs and make the scheme financially solvent. If other countries follow this incremental approach, they may also need significant investment in primary health-care services.

Conclusion

Thailand's achievement of UHC in 2002 – just 30 years after its first insurance system was set up – has positioned it as a global leader in the field. As in many countries, the informal sector was the last sector of the population to be covered, due to challenges of identification, enrolment and funding.

The evolution from community level financing, via a Voluntary Health Card scheme to the current UC Scheme provides an interesting example of how a country can pursue an iterative, incremental approach to UHC. Early investments in the village health funds during the 1980s improved the managerial skills of fund committees and sensitized communities to insurance, while also increasing access to primary health-care services. Although these community financing schemes could not be scaled up, they offered advantages that later insurance schemes were able to leverage.

The dissolution of the Voluntary Health Card Scheme to make way for the UC Scheme highlights the importance of creating a mandatory, subsidized scheme in order to achieve UHC. Without these two factors, the Voluntary Health Card Scheme would never have achieved success. Thailand had the financial capacity to offer these subsidies, which may not be the case for every country. However, the intermediate steps and the ultimate path taken by Thailand undoubtedly offer valuable lessons for other countries designing their own pathways to UHC.

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APPENDIX V. PARTNERING WITH ORGANIZED GROUPS IN KENYA

Country context

Since Kenya's independence in 1963, its health care system has been largely tax-funded and run by the Ministry of Health. However, the government has introduced different cost-sharing mechanisms over time (Carrin, G. et al., 2008). The National Hospital Insurance Fund (NHIF) was established by the Ministry of Health in 1966 under the principle that "the rich should support the poor, the healthy should support the sick, and the young should support the old." The NHIF scheme was originally available only to salaried employees, but was extended to all citizens for voluntary enrolment beginning in 1972. Although the NHIF is almost 50 years-old, it only covers approximately 16 per cent of the total population.

Those employed in the formal sector pay a graduated premium based on income, ranging from Ksh 150 to Ksh 2 000 per month (US\$ 2 to 24) (Kimani et al., 2012). Those who join voluntarily pay a flat rate of Ksh 160 per month, capped at Ksh 320 per month (NHIF, 2012). It is estimated that approximately 31.6 per cent of the workforce is found in the informal sector, but research estimates that only 3 per cent of this population is covered by the NHIF (Kimani et al., 2012).

In addition to the NHIF, there is a significant private and NGO sector, including employer self-funded schemes, private health insurance and community-based financing schemes, putting total population coverage at 7.77 million people, or 20 per cent of the population, as of 2010 (Deloitte, 2011). Of this number, the NHIF covers 6.6 million people (85 per cent of total coverage), most of whom are in the formal sector. According to the 2005/2006 National Health Accounts, NHIF funded 40.6 per cent of health expenditure, with 59.4 per cent coming from private sources.

Individuals in rural areas can access community-based health insurance (CBHI), but the concept is newer, having originated in 1999. The Kenya Community-Based Health Financing Association estimates that there are 38 different community health financing schemes, covering 270 550 beneficiaries (1 per cent) (Kenya Community Based Health Financing Association, 2012).

Public sector options for informal workers

Non-poor informal workers and the self-employed are eligible to participate in the NHIF through a

Table 1. Key statistics on Kenya

Population (in thousands) total	41 610
Population covered by insurance	20%
Size of informal sector (% of population)**	31.6%
Gross national income per capita (PPP international \$)	1 640
Total health expenditure (% of GDP)	4.8
Per capita total expenditure on health (PPP constant 2005\$)	78
Private expenditure on health as percentage of total expenditure on health	55.7
Out-of-pocket expenditure (% of total health expenditure)*	42.7
Life expectancy at birth (years) average	60 (2009)
Infant mortality rate (per 1 000 live births) both sexes	55
Maternal mortality ratio (per 100 000 live births)	360 [230-590]
Hospital beds per 1 000 people*	1.4

Source: World Health Statistics, *World Development Indicators, ** Kimani (2012)

contributory mechanism, available for Ksh 160 per month (NHIF, 2012). As of 2010, voluntary membership levels topped the 500 000 mark (Deloitte, 2011). In 2010, the NHIF also initiated the Sponsored Programme, with the aim of mobilizing donor resources to finance health insurance for indigents, including orphans and vulnerable children, poor older persons, persons with disabilities and destitute families. As of September 2012, those sponsorships included 3 500 indigent beneficiaries, entitled to utilize inpatient services at NHIF facilities. Currently only 25 per cent of those considered poor have coverage through NHIF (Joint Learning Network et al., 2012).

Private sector options for informal workers

The reintroduction of user fees into Kenya's public system sparked the launch of a number of community-based financing schemes. The first private scheme was started by the Chogoria Mission Hospital in 1991, in partnership with the Apollo Insurance Company, though it eventually dissolved due to higher premiums and decreased levels of enrolment (Kenya Community Based Health Financing Association, 2012). Three organizations promulgated community-based insurance schemes in Western Kenya: Support for Tropical Initiatives in Poverty Alleviation, Western Region Christian Community Services, and Anglican Development Services. Community-based health financing is recognized and acknowledged in national plans. Currently, 38 schemes provide coverage to approximately 100,510 principle members and 470,550 beneficiaries, representing 1.2 per cent of the population. (Deloitte, 2011; Kenya Community Based Health Financing Association, 2012).

Private insurance companies are also developing health insurance products that target the low-income segment, but these are still struggling to reach financial viability.

Table 2: Insurance schemes in Kenya

Insurance scheme	Operational dates	Eligibility	Contribution rate	Benefits package	Coverage
National Hospital Insurance Fund	1996; Restructured in 1998 - present.	Mandatory for formal sector workers; voluntary membership for the rest of the population.	Ksh 30-320/month depending on income; Ksh 160 for voluntary.	Inpatient services, no exclusions.	6.6 million lives covered. 16.9% of population.
NHIF Sponsored Programme	2010 - present.	Indigents, including orphans, vulnerable children, poor older persons and disabled.	No contribution.	Inpatient coverage in NHIF accredited providers.	3 500
Community-based insurance	1991 - present.	Rural populations.	Varies.	Varies.	470 550 1.2%
Private health insurance		All are eligible.	Varies.	Varies.	700 000 1.8%

Partnering with organized groups to extend coverage

Although NHIF coverage is technically available to everyone in the country, the NHIF has very limited penetration of informal workers (3 per cent). From the demand side, there is a lack of awareness about NHIF or understanding of insurance as a concept. Some mistrust of the fund has developed due to recent allegations of corruption in the administration. NHIF contracts can also change frequently, meaning that a beneficiary may be faced with changing networks of health facilities that they can access. The NHIF product is largely inpatient coverage, and outpatient services must still be financed out-of-pocket.

From the supply side, the NHIF has a limited number of “branches” or field officers, so although it has the central authority to extend coverage, it faces constraints in actually reaching informal workers. With low voluntary enrolment rates, it risks increasing adverse selection, so the potential for expanded enrolment is offset by hesitation about the fund’s sustainability.

One strategy that the NHIF is using to boost enrolment rates among informal workers involves partnerships with organized groups. The NHIF has partnered with microinsurance schemes, NGOs, worker unions and cooperatives, among others. Examples include the *Afya Yetu* Initiative, Universal Traders Savings and Credit Cooperative Organizations (SACCOs), *NICA Gatumbi*, *Rukuriri Tea Growers SACCO*, *ARECA-DAPS*, *Muungano Mwema Enterprises*, *Meru Farmers SACCO* and the Cooperative Insurance Company. Partnerships with existing group structures typically rely on the group to collect premiums and remit the amount to the NHIF on a quarterly basis. The groups benefit from some incentives, that are distributed based on group size.

One example of this partnership is a community-based scheme called the *Afya Yetu Initiative* (AYI). AYI was launched in Nyeri in 2001 by the International Centre de Development et de Recherche (CIDR), which is now its primary technical partner. The programme was one of the first member-based voluntary insurance schemes in the country; until that point, most had been provider-managed and functioned as health maintenance organizations. AYI, which has been autonomous since 2006, now operates in three countries in the Mount Kenya region: Nyeri, Kirinyaga and Murang’a. Currently, AYI manages 30 community-based health insurance schemes and covers 25 386 beneficiaries, with inpatient benefits and partial drug coverage. The partnership was formed at a time when the NHIF was struggling to reach the informal workers and members of the AYI’s CBHI scheme were dissatisfied with their limited access to facilities. The AYI agreed to allow its CBHI agents to sell the NHIF product. CBHI agents are now selling two different packages: Package 1 offers NHIF coverage and reimbursement of any additional charges to be paid by patients at empaneled private/faith-based hospitals for surgical care. Package 2 offers the CBHI package, which provides inpatient coverage in public hospitals only and is cheaper compared to Package 1. At the end of 2012, the AFY was managing 29 CBHI schemes, with a total of 25,000 beneficiaries. A majority of the members opted for Package 2, as the NHIF offer is expensive for the low-income segment.

Division of responsibilities

Partners such as the AYI handle enrolment by collecting family details, taking photographs for identification cards and sending premium payments to the NHIF. They also take responsibility for promoting and marketing the scheme. Local agents host meetings that offer opportunities for beneficiaries to share testimonials about the NHIF and answer questions from other community members, building up trust in the organization (Wambugi, 2012).

Essential functions in the insurance value chain	NHIF	Partner
Marketing		x
Identification and enrolment		x
Premium collection		x
Distribution		x
Risk carrying	x	
Fund management	x	
Claims payment	x	
Provider management	x	

The NHIF retains responsibility for managing the provider network, handling claims, carrying risk and managing the fund. It supplies necessary eligibility documents and identification cards to the organized groups for new NHIF beneficiaries.

The NHIF stands to expand enrolment of informal workers and can outsource key functions in marketing, recruitment, enrolment and premium collection. By using the CBHI field agents, the NHIF also benefits from their immersion in these communities. For those organized groups whose mission is to provide social protection to their members, linking up with the NHIF cover can help them fulfill this goal. Members benefit from a reduced waiting period, from 2 months to 28 days. The incentive structure for partners differs though, and some are negotiating commission for the services provided to the NHIF. In the case of the AFY, they were not getting commission from the NHIF, which has created tension in the partnership.

Advantages for the NHIF	Advantages for organized groups
Access to new market segment	Access to wider provider network , which increases enrolment
Ability to leverage time/resources from organized group field agents for promotion and awareness building, recruitment, enrolment, premium collection and distribution	Transfer of risk to the NHIF for CBHI schemes
Information about informal sector	Greater fulfilment of social mission in extending coverage to those in the informal sector
CBHI field agents are trusted by the community	Promotion of complementary benefits is more enticing when products can be bundled together

Key lessons

The coverage of the informal sector in Kenya is still quite low (3 per cent), but the NHIF is focusing on strategies to extend coverage. In early 2012, it announced an expansion to civil servants and teachers union, providing unlimited inpatient and outpatient coverage, paid through a capitation model. This expansion has been fraught with controversy, with suspicion of potential fraud within the provider network, and this has stalled progress (Kigali Konnect, 2012; World News. 2012).

- Value proposition: Any viable partnership rests on the notion that there is a mutually beneficial value proposition for each stakeholder. In the case of the partnership between the AYI and NHIF, the value proposition was unclear. In early iterations of the model, the AYI assumed greater responsibility for promoting the NHIF product, facilitating the collection of premiums and distribution of NHIF identification cards, but did not receive commission as requested for the additional time and energy expended. This has caused tension in the arrangement.

- **Partner profile:** The profile of the partner may be a relevant factor when considering strategies for greater distribution. For instance, microfinance institutions have an implicit benefit in helping their members access health insurance, since it helps prevent loan default. However, CBHI schemes may have a conflict of interest as a distribution agent, since they are concurrently promoting their own product.
- **Scale:** In order for a partnership model such as this to work efficiently, it must achieve scale either by partnering with organizations that have many members, or by partnering with a greater number of organizations. For instance, the AYI's reach is limited to approximately 13 000 people, the equivalent of 0.03 per cent of the total population. For a partnership model to be effective, the NHIF may need to seek out a wider range of partners. There may be a need to standardize the partnership model and management structure, in order to achieve greater efficiency.
- **Support and capacity building:** Partners may need additional support for key functions at the local level, including raising awareness, product marketing and support for additional field agents travelling back and forth to the NHIF offices.
- **Communication:** Partners can provide useful information to governments about which types of benefits are appealing, and this can help government to attract informal sector workers. Information may include preferences about products or facilities. It is important to establish mechanisms to communicate between partners and the NHIF, both regarding consumer preferences and partner experiences.

Conclusion

Kenya's progress towards UHC hinges on its ability to reach the informal sector. Although voluntary enrolment was extended to informal sector workers in 1972, only 3 per cent of the population has enrolled. One strategy that the NHIF is using is to partner with existing organized groups, such as microcredit institutions and microinsurance schemes, but this is having limited success. There may be potential to improve the effectiveness of the model by tailoring benefits specifically to the population, standardizing the management and model of the partnership and increasing the number of partners with which the NHIF engages in the informal sector. There may be large pockets of the informal sector that are unorganized, so alternative strategies will be needed to capture these groups.

This case was prepared with input and review by Catherine Wambugi (Afya Yetu Initiative) and Daniel Mulinge (NHIF).

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APPENDIX VI. PARTNERING WITH ORGANIZED GROUPS TO EXTEND PHILHEALTH'S REACH TO INFORMAL WORKERS

Country context

Social health insurance in the Philippines was originally introduced in 1969 through the establishment of the Medicare programme, which offered coverage for formal sector workers, informal sector workers and the poor. The Philippines Medical Care Commission ran the programme, but it struggled to gain a high level of enrolment, largely because it only covered inpatient benefits. In 1995, the National Health Insurance Act was passed, guaranteeing universal coverage to the population. The act created the Philippine Health Insurance Corporation (PhilHealth), which remains the primary provider of health coverage in the country. PhilHealth provides coverage through six different programmes that serve various sub-populations. As of June 2012, combined coverage was equal to approximately 85 per cent of the population (PhilHealth, 2012b). Although PhilHealth is making considerable strides, the remaining 18 per cent of the population who lack coverage is concentrated in the informal sector. In order to boost enrolment and reduce adverse selection, PhilHealth has leveraged organized group structures - including microinsurance and microcredit schemes or cooperatives - to reach informal sector workers.

Public sector option for the informal sector

Those in the bottom income quintile are automatically enrolled under PhilHealth's Sponsored Program. Individuals are identified through household targeting and receive a fully subsidized comprehensive benefits package. Local government units also identify the poor in the community and offer varying levels of subsidy. Those who are ineligible for the Sponsored Program are eligible for the voluntary Individual Paying Program (IPP). Of the 37.2 million working individuals, approximately 18.2 million fall into the non-poor informal sector. Approximately 4.7 million are registered with the IPP and 13.5 million have the potential to join (PhilHealth, 2012a). As of 2003, informal sector workers became eligible for a separate pilot programme called POGI, which leveraged existing, private group structures to act as distribution channels for the PhilHealth insurance product. POGI evolved into KaSAPI in 2005 and again into the iGroup Program in January 2013. The iGroup Program now offers additional outpatient benefits (lack of these was a major barrier that

Table 1: Key statistics on the Philippines

Population (in thousands) total	94 852
Population covered by insurance (%)	82%
Size of informal sector (% of population)	65%
Gross national income per capita (PPP international \$)	3 980
Total health expenditure (% of GDP)	3.6
Per capita total expenditure on health (PPP constant 2005\$)	142
Private expenditure on health as percentage of total expenditure on health	64%
Out-of-pocket expenditures (% of total health expenditure)*	54 (2010)
Life expectancy at birth (years) average	70 (2009)
Infant mortality rate (per 1 000 live births) both sexes	23
Maternal mortality ratio (per 100 000 live births)	99 (66-140)
Hospital beds per 1 000 people*	0.5 (2011)
Source: World Health Statistics, *World Development Indicators	

limited enrolment in KaSAPI), lowers the minimum group size to facilitate enrolment of smaller groups and eases documentation requirements. The premium discount offered now has a direct correlation with group size.

Table 2: Public insurance schemes in the Philippines

Scheme	Eligibility	Contribution	Benefits	Number of primary beneficiaries	% of total population
PhilHealth Sponsored Program	Indigents in the lowest 25% of the population.	2 400 Php premium paid by national government and sponsor (e.g. local government unit).	Inpatient care and hospitalized outpatient services, such as malaria and TB-DOTS care. Additional outpatient primary care benefits at clinics.	9 467 184	27%
PhilHealth Employed Sector Program	Government employees and formal sector workers (including overseas Filipino workers).	2.5% of salary, shared by employer and employee.	Inpatient care and hospitalized outpatient services, such as malaria and TB-DOTS care.	11 354 059	33%
PhilHealth Individual Paying Program	Self-employed.	Premium amount of 1200 Php per year for those whose income is <25 000 Php; 3 600 Php if considered a professional (e.g. doctor, lawyer).	Inpatient care and hospitalized outpatient services, such as malaria and TB-DOTS care; IGroup segment eligible for outpatient primary care benefits.	4 714 265	13%
PhilHealth Oversea Workers Program	Land-based overseas Filipino workers.	Premium amount of 1200 Php.	Inpatient care and hospitalized outpatient services, such as malaria and TB-DOTS care. Additional outpatient primary care benefits at clinics.	2 631 434	7%
PhilHealth Lifetime Membership Program	Old-age retirees who have paid 120 months of membership.	Free if >60 years and have paid 10 years of contributions through Employed Program.	Inpatient care and hospitalized outpatient services, such as malaria and TB-DOTS care.	612 718	2%

Source: (PhilHealth, 2012a; PhilHealth, 2012b) (Philippine health insurance corporation)

Private sector options for the informal sector

During the 1990s, a number of community level financing schemes also emerged as options for the informal sector. The more sophisticated ones were actual insurance schemes while the less elaborate ones were essentially solidarity-based health financing groups (Dror et al., 2002). Funeral insurance was the most widespread form of cover at the time -- approximately 50 per cent of the cooperatives included some form of cover. This represented a formalization of the tradition of collecting through a fund after death. Community level insurance for health-care services was less common. For many cooperatives, health insurance fell outside the scope of their main business objectives and as a result, schemes suffered from administrative inefficiencies. Those cooperatives that did provide insurance benefited from knowing their clients, which enabled them to tailor benefits and demonstrate the value of insurance.

Evolution of the organized group partnership model

In 2003, an innovative idea emerged to leverage organized group structures in order to enrol informal sector workers. At the time, only 8.4 per cent of informal workers were covered under PhilHealth, and of those individuals, only 36 per cent had been active (*Mandating PhilHealth membership for organized groups: A good business? the case of Bontoc Multipurpose Cooperative Inc. (BCCI) and Libagon Area Multipurpose Cooperative (LAMP)*. 2004).

- 2003: This idea was piloted in 2003 under the name, PhilHealth Organized Group Interface (POGI), which partnered with 11 cooperatives in Southern Leyte and Cavite provinces (ILO Subregional Office for Southeast Asia). The microcredit cooperatives took responsibility for advertising PhilHealth, enrolling individuals and collecting premiums. From PhilHealth's standpoint, the group structures enabled them to identify and enrol additional individuals, combat adverse selection with mandatory enrolment, increase overall administrative efficiency and provide a trusted intermediary between consumers and government. The cooperatives saw value in protecting their members from unexpected illness, which could also translate into fewer loan repayment delinquencies or defaults. But only one-third of the group members were contributing regularly and the scheme suffered from adverse selection. The benefits package included hospitalization and some outpatient care at hospital (for malaria and TB).
- 2005: In 2005, POGI transformed into KaSAPI (*Kalusugan Sigurado at Abot-Kaya sa PhilHealth Insurance or Health Security at Affordable Cost in PhilHealth*) (ILO Subregional Office for Southeast Asia). The new name, KaSAPI, conferred notions of solidarity and resonated better with community members than the former acronym (POGI), which actually meant "handsome." KaSAPI was positioned as a winning model for each party – PhilHealth (the insurer), the partner organization (MFI, cooperative, group) and the informal sector workers. PhilHealth benefited by increasing membership in the individual paying programme and therefore stabilizing it with a larger risk pool. Partner organizations benefited by fulfilling their social mission and helping to avoid delinquent payments among members, thereby reducing the organization's credit risk. Individual workers benefited by receiving health insurance for a more affordable premium payment, as well as from flexible payment mechanisms. A minimum group size (1,000 members) and percentage of total membership (70 per cent) were established, to push for more enrolments and less adverse selection. Discounted premiums were defined, based on the percentage of the group enrolled, group size and frequency of payment.
- 2013: The new iGroup Program uses the KaSAPI model, but includes a number of important changes. The iGroup Program will cover existing KaSAPI partners, any organization that pro-actively promotes social health protection to its clients, organized groups within the group enrolment scheme and other groups, such as microfinance

institutions, cooperatives, professional organizations, non-profit organizations and other similar entities. The minimum group size has been reduced to 30 in order to facilitate enrolment. However, these benefits now depend on a graduated scheme – bronze, silver and gold. The administrative requirements for all groups have been reduced. Premium incentives still exist, but the smallest groups (30-699 individual paying members) are not eligible.¹ The premium rates assigned to each new group will be based on group classification, size, validity period, mode of payment and other characteristics. Waiting periods for eligibility of benefits have been eliminated and outpatient benefits have been added across the board. The largest groups are also offered a no balance billing policy, meaning that beneficiaries will not pay any extra charges when admitted to government hospitals.

Division of responsibilities

Organized groups take responsibility for promoting the scheme, identifying enrollees, collecting premiums and distributing PhilHealth cards. An administrative fee, set by the organized group, is bundled with the premium paid by the enrollees, and retained by the organized group to offset its administrative costs in providing the services on behalf of PhilHealth (no commission is paid).

Individuals pay their premium on an annual, semi-annual or quarterly basis to the cooperative, which then submits regular payments to PhilHealth. PhilHealth retains responsibility for carrying the financial risk, contracting and managing providers and making claims payments. Upon enrolment, members receive a PhilHealth membership card and can start using benefits after a 3-month waiting period.

The KaSAPI Program was built on a triple-win concept, based on the premise that PhilHealth, the organized groups and the beneficiaries each have something to gain. Their premise persists under the iGroup Program. PhilHealth gains enrollees and advances toward UHC, the organized groups offer health protection to their members and strengthen performance of their loan portfolio and the beneficiaries have greater capacity to finance health-care needs and mitigate financial risk. Though the business proposition is fairly clear, the evolution of the organized group programme from POGI to KaSAPI to iGroup has conferred a number of advantages, both to PhilHealth and to the organized groups.

Advantages for PhilHealth	Advantages for the organized groups
Increased enrolment of informal sector workers.	Health benefits and protection so that clients can maintain their loan payments.
Improved retention of enrollees.	Health benefits and protection so that clients can maintain their loan payments.
Insurance management functions shared with organized groups.	Capacity building from central government for insurance management.
Improved knowledge regarding needs of informal workers.	Input and feedback into national level policy decisions on health insurance.
Decentralization of information and data collection.	Utilization of centralized web-based software.

At the end of 2008, KaSAPI had registered nine organized groups, covering 23,000 members (PhilHealth, Analysis report of KaSAPI Program, 2009). As of the end of 2011, 82 per cent of the total population was covered by PhilHealth, with 13 per cent from the informal sector, but only a minority coming from the KaSapi Program.

Key lessons learned

- **Business case:** In any partnership, each party should benefit from the arrangement. PhilHealth promoted the incentives of the programme to encourage more groups to participate.
- **Capacity building:** The capacity of the organized groups to manage the promotion, enrolment and premium collection processes is variable and requires additional support from central level. Additional support was specifically needed in these areas to help the organized groups to boost enrolment. Governments should consider what types of support might be needed to enable partnerships to succeed.
- **Adaptability:** PhilHealth has now implemented three iterations of its organized group partnership strategy and it continues to monitor and evaluate the scheme's performance. The ability to be flexible and adapt to the changing needs of informal workers has benefited the PhilHealth Program.
- **Political support:** The focus on informal workers has long been supported by the German Development Corporation (GIZ), which until recently, had an office within PhilHealth. That office has recently closed, though there is still significant support from GIZ. However, the priority given to expanding coverage of informal workers may ebb and flow, depending on those who currently hold leadership positions.
- **Cater to informal groups:** For some organized groups, the large group size and documentation requirements in KaSAPI became a major barrier. These issues are now being addressed through the iGroup Program. Governments can benefit by listening to feedback from organized groups and continually modifying their arrangements to address any challenges.

Conclusion

The Filipino experience of striving to reach the informal sector is a work in progress. The evolution from relatively modest community-based financing schemes to POGI, to KaSAPI, and most recently to the iGroup Program demonstrates that PhilHealth is actively learning and improving its strategies. The story highlights the scope of partnering with organized groups - which exist in most countries grappling with the challenges of extending coverage to informal workers; this may be one strategy that policymakers should consider. There must be a business case for each partner involved, including the central government, the local organized group and the individual beneficiaries. However, due to the relatively low outreach of this strategy, other options should also be considered.

This case study was prepared with input and review from Elmer Soriano (ACCESS Health Philippines), Lourdes Irena Minoza (PhilHealth) and Beverly Ho (PhilHealth).

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APPENDIX VII. PARTNERING WITH PRIVATE INSURERS TO EXTEND HEALTH INSURANCE COVERAGE IN INDIA

Country context

India is a federated country, with 29 states and 6 union territories. As of 2010, approximately 19 per cent of the population – 240 million people – was covered by a government-sponsored health insurance scheme. Just over 25 per cent was covered by some form of health insurance, either public or private. (Public Health Foundation of India,

2011). Although a number of health insurance schemes have emerged, particularly since 2007, private out-of-pocket spending remains high at 86.4 per cent of total health expenditure (WHO, 2010). Public spending on health has traditionally been low, though the 12th Five Year Development Plan commits to increased spending. The massive size of the informal economy (93 per cent) also makes tax revenue generation and insurance provision challenging.

Since the 1950s, the Government of India (GOI) has used a mix of tax-financed supply-side delivery and demand-side insurance mechanisms to provide health care to its population. The Employees State Insurance Scheme (ESI) was launched in 1952 to cover formal employees. Two years later, the Central Government Health Scheme (CGHS) was launched to cover civil servants. These schemes cover around 5 per cent of the total population, and both rely on supply-side financing (Public Health Foundation of India, 2011).

In 1999, the government opened the insurance sector up to private companies. Health insurance products were developed for the more affluent, but others still lacked access to affordable, quality care. The private insurance industry has grown rapidly in India since then, with annual growth rates from 2001 onwards of about 30 per cent (Laforgia, 2012).

The Ministry of Finance partnered with public insurers in 2003 to launch the Universal Health Insurance Schemes (UHS), one of the first insurance schemes to be sponsored by

Table 1: Key statistics on India

Population (in thousands) total	1 241 492
	(2011)
Population covered by health insurance (%)	25%
	(2008)
Size of informal sector (% of population)	93%
Gross national income per capita (PPP international \$)	3 560
	(2010)
Total health expenditure (% of GDP)	42
	(2010)
Per capita total expenditure on health (PPP constant \$)	542
	(2010)
Private expenditure on health as percentage of total expenditure on health	70.8
	(2010)
Out-of-pocket expenditure (% of total health expenditure)	86.4
	(2010)
Life expectancy at birth (years) average	65.1
	(2010)
Infant mortality rate (per 1 000 live births) both sexes	48.2
	(2010)
Maternal mortality ratio (per 100 000 live births)	200
	(2010)
Hospital beds per 1 000 people	0.9
	(2005)

Source: The World Bank Database; WHO database; ILO Reports; IRDA 2010-2011 Annual Report

the government. It offered a heavily subsidized hospital indemnity product that was available for voluntary purchase. The goal was for the UHS to cover 10 million beneficiaries, but weak processes and a lack of accountability among partners contributed to the failure of the scheme (key informant interview).

Public sector options for informal workers

From 2005 onwards, a number of innovative government-sponsored schemes emerged, both at central and state levels. These schemes have largely targeted the poor. They have included customized benefits packages and introduced new innovative technologies to enable efficient enrolment and back office processes. The schemes have also introduced the largest examples of demand-side financing in India.

In 2005, the Ministry of Textiles launched a scheme for weavers, before extending it to other groups of artisans in 2006. This scheme contracted public and private insurance companies and by the end of 2012, had reached almost 5.2 million people.

In 2007, the state of Andhra Pradesh launched the Rajiv Aarogyasri scheme, which covers around 84 per cent of the state population (2010 estimate).

Inspired by this successful experience, the Ministry of Labour and Employment (MoLE) launched the Rashtriya Swasthya Bima Yojana (RSBY) programme the following year. RSBY is sponsored by the national and state governments. It mainly targets the below poverty line (BPL) population (occupational groups such as domestic servants and construction workers were added in mid-2012). As of 2012, the scheme is in place in 450 or the 625 districts in India across 28 states and union territories and reaches 50 per cent of the target population (RSBY, 2012).

Other states, including Tamil Nadu, Karnataka, Himachal Pradesh and Delhi have developed their own state schemes, which mainly target the BPL population and are heavily subsidized by the state. Table 2 describes these and other insurance schemes available.

Private sector options for informal workers

Since the early 2000s, India has seen the development of a large number of health microinsurance (HMI) schemes, which aim to use health insurance as a mechanism to improve access to health care for low-income households. A wide variety of channels is used to deliver HMI, from NGOs to self-help groups or cooperatives; some of these schemes partner with an insurance company (known as a partner-agent model), while others assume financial risk themselves. A national review of HMI in India, conducted by the ILO in 2009, registered more than 100 such schemes. In 2007, an estimated 5 million persons were covered (Devadasan et al., 2004).

HMI schemes cover households below and above the poverty line and provide mainly inpatient benefits. *Yeshasvini* is one of the biggest HMI schemes, with 3 million individuals covered (2010 estimate). It is also the first scheme to implement a public-private partnership in India.

Private commercial insurers have also started to target informal workers, partially in response to new regulations - the Rural and Social Sector Obligations. Life insurers are required to obtain at least 7 per cent of their gross premium from the rural sector. General insurers must generate a minimum of 2 per cent of gross premiums in their first year, and 7 per cent after 10 years from the rural sector (IRDA, 2002).

Table 2: Characteristics of major health insurance schemes in India

Insurance scheme	Eligibility	Contribution rate	Benefits package	% of total population covered
ESIS (1952)	Mandatory for employers with more than 10 employees and employees earning less than 15 000 INR/ month + dependents. Accessible only in specific areas.	12.5% subsidy from state. Premium ranging from 2 340 to 11 700 INR, as a percentage of wages.	Comprehensive coverage, accessible at both public and private facilities.	0.24%
CGHS (1954)	Mandatory for civil servants.	Premiums range from 600 to 6 000 INR. 95% subsidy from central government.	Comprehensive coverage, accessible at private facilities only.	4.46%
Yeshasvini (2003)	Voluntary for members of cooperatives in Karnataka state.	Premium of 150 INR. 40% subsidy from state.	Inpatient: Secondary and some tertiary care, accessible mainly at private facilities.	0.24%
UHS (2003)	Voluntary, targeting BPL population nationwide.		Inpatient: Secondary care, ceiling of 30,000 INR. Accessible only in public facilities.	Negligible
Weavers and artisans insurance (2005)	Targets weavers and artisans nationwide. Covers spouse + 2 dependent children.		Comprehensive coverage, outpatient care up to 7 500 INR, inpatient care up to 15 000 INR.	0.23%
Rajiv Aarogya (2007) Andra Pradesh	Voluntary, initially for below the poverty line households with eligibility; now extended to entire population.	Premium of 267 INR. 100% subsidy from state.	Inpatient: Tertiary care only, accessible at both public and private facilities, up to INR 100 000.	5.64%
Rashtriya Swasthya Bima Yojana (RSBY) (2008)	Voluntary, targeting BPL population in 28 states	Premium from 440 to 750 INR. 75% subsidy from central government, 25% subsidy from state. Contribution of 30 INR per household per year.	Tertiary: Secondary care only, accessible at both public and private facilities, up to INR 30 000	9.2% (October 2012)
Chief minister's comprehensive health insurance scheme (2009) Tamil Nadu	Voluntary, targeting BPL population in Tamil Nadu state	100% subsidy from state	Inpatient: Tertiary care only	2.82%

Source: Public Health Foundation of India, 2011. *A critical assessment of the existing health insurance models in India.*

Drawing on previous experience in the design of RSBY

In 2007, the Indian Prime Minister unveiled the RSBY scheme as a major initiative to provide access to health care and financial protection for the BPL population. The design and implementation of the scheme was a significant undertaking, and required input from a broad set of stakeholders. The MoE was charged with overseeing the scheme's development and formed a task force in 2007, including representatives from the insurance industry, relevant ministries and the technology industry, as well as international organizations such as the World Bank and GIZ. This task force evaluated past experience with different HMI schemes in India and internationally. A number of RSBY's features drew on past experience from public and private insurance schemes:

- **Benefit package:** Offers benefits up to a maximum level and focused first on inpatient coverage. It covers up to INR 30 000 for a family of five on a floater basis, with no age limit.
- **Contributions:** The full premium is jointly financed by the central and state governments (75 per cent and 25 per cent respectively). Premiums were set by reviewing previous microinsurance experiences.
- **Enrolment:** The task force recognized that success would rely on effective enrolment processes, including incentives for implementers to enrol people. They decided to 1) outsource enrolment to private insurers, who receive premium revenue based on enrolment and 2) reduce manual, paper-based procedures and use "smartcards" to store client information, thus enabling more efficient management of a high number of policies.
- **Identification of enrollees:** All eligible families enrolled under RSBY are issued a RSBY membership card every year. This "smartcard" enables biometric identification of beneficiaries at health-care facilities using photographs and fingerprints. It also records other member data, such as date of birth and gender.
- **Cashless transactions:** The RSBY smartcard enables cashless transactions (until benefits are exhausted) at empanelled hospitals, as well as paperless billing and payment between the insurer and health-care providers. It also supports portability of benefits across the country. This technology is one of the major success factors of the RSBY programme, since it has enabled the management of a scheme with now well over one hundred million members.
- **Hospital network:** Recognizing the many challenges faced by public health care-facilities, RSBY empanels private and public health-care facilities. Hospitals are empanelled by insurance companies under contract according to guidelines designed to ensure a required level of quality. Other HMI experience has encouraged RSBY to adopt a payment system based on a negotiated package of services, rather than one based on fee for service.

Partnering with private insurers to deliver RSBY

One major question for the RSBY task force was whether the government had the capacity to implement and administer RSBY in its entirety, or whether it should consider outsourcing certain functions. In the 10 years prior to the design of RSBY, the private insurance market in India had grown substantially.

Since neither private nor public insurers, nor the MoE had the capacity to administer a scheme with 355 million eligible members, the task force decided to design a public-private partnership between insurers, the government (central and state levels) and hospitals (public and private). A special agency was created at state level. Called the state nodal agency (SNA), it is responsible for working with the government to supervise and implement RSBY. The SNA selects insurers through a competitive bidding process according to a set of eligibility criteria. Insurers are contracted for one year, a feature designed to spur healthy competition.

The state and central government jointly finance the premiums for enrollees, but many of the functions of administering RSBY fall to the insurers. These are responsible for selecting and monitoring hospitals, enrolling beneficiaries and

processing claims. Some insurers hire third-party administrators to support these functions. The government maintains responsibility for regulation, information systems and ultimate oversight. In addition to the SNAs, there are district officials - district key managers - who are appointed to monitor the scheme.

Table 3: Role and responsibilities in RSBY programme

	Role of central government	Role of state government / state nodal agency	Role of insurers / TPA
Oversight of the scheme	X		
Financial management and planning	X		
Definition of benefits package	X	X ²	
Selection of insurers		X	
Empanelment of hospitals, based on RSBY guidelines			X
Sensitization		X	X
Enrolment and premium collection		X	X
Processing claims			X
Monitoring the scheme (real time data)	X	X	X

Each party benefits from the arrangement. The insurers - the majority of which are commercial, for-profit companies (14 out of 18) - benefit from access to new market segments, with premiums guaranteed by the government. The government is able to leverage the capacity of the insurers and expand enrolment into RSBY faster than it would otherwise. Enrollees benefit from access to subsidized benefits, made easier through new technologies.

Table 4: The mutual benefits of linking HMI to UHC initiatives

Advantage to the government	Advantage to private insurers
HMI informed the design of RSBY and enabled client centred design.	Linking with the public initiative has enabled private insurers to develop a new market segment and secure their revenue thanks to access public subsidies.
HMI provided data enabling initial pricing of the scheme.	Engagement of state government has enabled better acceptance of the scheme by the population, and supported implementation and scaling up.
Outsourcing key insurance functions to capable insurers enabled fast development of the scheme, proactive adjustment and promotion of innovation.	Including local authorities at the enrolment stage has improved efficiency and reduced fraud, as insurers have access to the list of eligible members and a local government representative validates the identity of enrollees.
Outsourcing enrolment to insurers has accelerated enrolment.	Partnering with the government on the RSBY initiative has enabled private sector actors to develop IT solutions to target the low-income segment. This can also benefit other business segments.
Transferring the financial risk for claims to insurers secured the government's financial obligation to cover BPL population.	
Competitive bidding to provide insurance services can enable contain cost and improve quality.	

In India, the partnerships under RSBY have helped to improve access to care for the BPL population, manage a high volume of policies and enable a faster roll-out of the scheme. As of January 31, 2013, 51 per cent (33 957 106) of eligible families are enrolled, although this data does not reflect re-enrolment rates, so the number of families that are

actively enrolled may in fact be lower. (RSBY, 2013) These results are encouraging, but they also highlight the fact that despite an almost fully subsidized programme, barriers remain to enrolling the informally employed population in the scheme. The variation of penetration rates across districts (from 10 per cent in Delhi to 84 per cent in Kerala) also raises the issue of equity in access to the scheme.

Enrolment rates are increasing, with a 50 per cent penetration rate in November 2012. Clients are satisfied (as they have been given the possibility to access private health facilities where they may perceive higher quality of care), and have started to trust and use the scheme (Amicus, 2011).

States have ownership of the scheme and have created a community to share learning. A total of 18 insurers (4 public, 14 private) are partnering in RSBY. Average enrolment has increased along with the average expense ratio, which increased from 77 per cent in the first year of the scheme, to 143 per cent for the 47 districts with 2 full years of experience in mid-2011 (CIRM, 2011). Access to health-care facilities has also increased, with 12 500 hospitals empanelled, of which 68 per cent are private (RSBY, 2013).

Leveraging partnerships to pilot new models

RSBY continues to improve and it is using HMI to test new operational models and mechanisms for expansion. Research shows that 67 per cent of out-of-pocket expenditure by clients is for outpatient services (especially drugs), meaning that the RSBY benefits package still has a limited impact on overall household health spending (Sakthivel Selvaraj et al., 2012). To address this challenge, RSBY is experimenting with more comprehensive benefits, including outpatient services. In partnership with the MoLE, ICICI Foundation, ICICI Lombard and the ILO's Microinsurance Innovation Facility, pilots were started in two districts located in two states. Enrolment and eligibility follow the existing RSBY process, but clients have access to up to ten outpatient visits in empanelled outpatient clinics (public and private) per year, per family. Premiums for the outpatient benefits in these two districts during the pilot are being subsidized by the ICICI Foundation. Consultations (and follow up within 7 days), as well as most drugs are covered. Additional pilots are beginning to test other outpatient benefit packages, such as including diagnostics, as well as other provider payment mechanisms (ICICI Lombard, 2013).

Close monitoring of the outpatient pilots should provide information on the impact of outpatient coverage on health seeking behaviour, enrolment and renewals in the programme, as well as the impact on hospital use. This should support the government to determine whether, and under which conditions, adding outpatient coverage to the current RSBY offering is beneficial and viable.

Based on early but encouraging lessons from the pilots, outpatient benefits will be extended to other districts in the future, with funding from the government. This transition will occur as new districts begin to implement RSBY, or as partnerships with insurers to offer RSBY in existing districts are renewed. Additional pilots are planned to test further variations of outpatient benefits, including coverage of diagnostic services. These will also test different provider payment mechanisms.

Key lessons

The RSBY partnership model offers some key lessons about both the benefits and drawbacks to outsourcing parts of the insurance value chain.

- On building efficient PPPs: Governments should consider whether outsourcing key insurance functions can be a viable way of implementing UHC. This requires first finding out if there are reliable organizations in the country with the capacity to provide expertise that government lacks.
- To build an effective PPP, governments should make sure all parties have an interest in the scheme and are engaged in a participatory manner from project inception. Key stakeholders were consulted during early design discussions and invited to contribute and innovate, resulting in strong support from all parties, and increased interest from the private sector.
- In order for a partnership model to be successful, it is important that all processes are clearly defined at the beginning and that roles and responsibilities are carefully mapped. The task force that designed RSBY spent time developing a very detailed implementation plan. There was enough flexibility in the scheme to enable innovation and rapid improvements: for example, maternity coverage was added after one year to improve client value; the smart cards have become even “smarter”, with greater capacity to capture more information on clients, and processes to empanel hospitals have been improved.
- On the importance of technology: Technology has unlocked the potential to effectively service millions of insured members. RSBY’s success strongly relies on the development of a relevant technology platform that has been adopted by service providers and promotes efficient enrolment and back office processes with paperless claim management.
- On financial sustainability and the need for strong control mechanisms: The increase in claims ratio and incidence rate (2.28 per cent in year one to 5 per cent in year two), is due to increased utilization of health care, but also possibly to increased fraud (Amicus, 2012). This threatens the financial sustainability of the scheme and makes a case for strong monitoring and controls, as well as for more systematic audits of potential malpractice (CIRM, 2011). With limited claims experience and interest to enter a huge under-served market segment, insurers may have bid low, but as more data becomes available, premiums could increase.
- On scheme governance: So far, RSBY has not been mandated by law, and only involves contracts between state governments and insurers on the one hand, and insurers and hospitals on the other.

Conclusion

The RSBY scheme provides an example of how HMI can inform the design of a national scheme and support testing of new approaches and products. It also makes a case for building intelligent public-private partnerships, where all actors deliver to the best of their capacity. RSBY has improved access to health-care facilities, especially once private hospitals were empanelled in the scheme. It has also created technology enabled enrolment, eligibility verification and claims processes. The time may come when the scheme should be endorsed by an act of Parliament, to ensure citizens' rights are recognized and that citizens play a stronger role in the scheme (Dror, 2012).

To be sure, the case of India is unique for a number of reasons: it is a fast growing economy, with increasing fiscal capacity to enable investment in a massive health insurance scheme, both in terms of premium subsidies and infrastructure development; the Indian IT industry is well developed, a factor that enabled the scheme to deploy smart cards and effective policy administration and claims management systems; the insurance sector is well developed and sufficiently strong to manage large volumes of policies and claims. Even if the Indian example cannot and should not be duplicated everywhere, India's experience is an example of strong government involvement, careful partnership and engaged partners – one that other countries may be able to replicate.

This case study was prepared with input and review by Mr. Nishant Jain (GIZ), Mr. Birendra Mohanty (ICICI Lombard) and Mr. Sanjay Pande (Amicus).

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APPENDIX VIII. THE DEMONSTRATION EFFECT OF MICROINSURANCE IN TANZANIA

Country context

The introduction of health insurance in Tanzania came in response to health sector reform efforts, which began in 1993. For the previous 30 years, Tanzania had offered free health care to its citizens, but the tax-financed system was unable to keep up with rising health-care costs and the emergence of widespread communicable diseases such as HIV/AIDS (Mtei et al., 2007; The Director General, 2012). In response, the government undertook reforms to introduce cost-sharing mechanisms, including insurance. Tanzania has continued efforts to expand health insurance; the current Health Sector Strategy Plan 2009-2015 aims to cover 30 per cent of Tanzanians with health insurance by 2015. Recent 2011 estimates from the Ministry of Health and Social Welfare claim 18.1 per cent national coverage, including 17.1 per cent through public schemes and the remaining 1 per cent through private health microinsurance schemes (Table 1) (Kuwawenaru et al., 2012). Those who lack coverage must pay for health-care services out-of-pocket (OOP). Data for 2010 shows that OOP expenses represent 14 per cent of total health expenditure (National Health Accounts, 2012; ILO Department of Statistics, 2012).

The major public schemes in Tanzania include the National Health Insurance Fund (NHIF), the National Social Security Fund (NSSF), the Community Health Funds (CHF) and *Tiba Kwa Kadi* (TIKA) schemes (Table 2). The NHIF is the largest scheme, operating since 2001. It provides comprehensive coverage for formal sector and government employees and up to five family members. The NHIF is funded through wage-based contributions (3 per cent of individual's salary, matched by employer). The National Social Security Fund (NSSF) is also developing an insurance package for formal workers funded by mandatory 20 per cent contributions (Save the Children, 2011). Though the NHIF and NSSF provide viable options for civil servant and formal sector employees, 76.7 per cent of the population works in the informal economy and lack viable options for public-based insurance (ILO Department of Statistics, 2012).

Public sector option for the informal sector

In order to target the informal sector, the Ministry of Health and Social Welfare implemented the district level Community Health Funds - a voluntary, community financing scheme - in 2001 (Mtei et al., 2007). As of June 2012, the CHFs existed in 72 of 92 rural districts in the country and represented the largest scheme in rural areas

Table 1: Key statistics on Tanzania

Population (in thousands) total	46 218 (2011)
Population covered by insurance (%)*	18.1 (2011)
Size of informal sector (% of population)*	76.7% (2011)
Gross national income per capita (PPP international \$)	540 (2011)
Total health expenditure (% of GDP)	6.01 (2010)
Per capita total expenditure on health (PPP constant 2005\$)	83.4 (2010)
Private expenditure on health as percentage of total expenditure on health	32.68 (2010)
Out-of-pocket expenditure (% of total health expenditure)	14% (2010)
Life expectancy at birth (years) average	57 (2010)
Infant mortality rate (per 1 000 live births) both sexes	60.2 (2010)
Maternal mortality ratio (per 100 000 live births)	460 (2010)
Hospital beds per 1 000 people	0.7 (2010)
Sources: World Health Indicators, *MOSHW Estimates	

(Kuwawenaru et al., 2012). In 2009, a similar scheme called Tika was designed for urban areas and as of 2010, had been implemented in 18 urban councils. Initially, CHF and TIKA were both administered by the Ministry of Health and Social Welfare, but the NHIF assumed responsibility for a three-year period, beginning in 2009. Approximately 9.8 per cent of the population is covered by the CHF and TIKA combined.

Private sector options for the informal sector

In addition to the CHFs that target informal sector rural populations, and TIKA funds that target urban populations, additional HMI schemes have developed throughout the country to address gaps in coverage for low-income, vulnerable populations. A 2006 inventory completed by Health Systems 20/20 estimated that there were 11 Community Based Health Financing Schemes. More have emerged since 2006, including schemes such as *Umasida*, *Vibindo* and *MicroEnsure*.

Table 2: Insurance schemes in Tanzania

Insurance scheme	Eligibility	Contribution rate	Benefits package	Coverage
National Health Insurance Fund (NHIF)	Mandatory for public servants and covers up to 5 dependents. Currently opening up to other members of the formal sector.	6% of gross salary, split between employer and employee.	Inpatient & outpatient care from public and accredited faith-based & private facilities & pharmacies.	7.3%
National Social Security Fund (Social Health Insurance Benefit-SHIB)	Mandatory for private and parastatal employees and covers up to 5 dependents.	No earmarked contribution; reimbursement funds taken from NSSF contributions.	Outpatient and inpatient care up to 80 000 TZS at selected facilities. Members have to sign up in order to receive benefits.	1.1%
Community Health Fund (CHF)	Rural - voluntary, household enrolment for a couple and their children under 18 years.	20 000 TZS per year/household.	Primary level public facilities. Limited referral care in some districts.	9.8% (including TIKA)
Tiba Kwa Kadi (TIKA)	Urban households.	30 000 TZS per year/household.	Primary level public facilities. Limited referral care in some districts.	9.8% (including CHF)
Microinsurance	Market vendors, individual's enrolment.	~50 TZS / person/day.	Private outpatient care, plus transport to a referral facility and up to 10 000 TZS referral costs.	1%

Leveraging private partners to strengthen CHFs

The CHFs are set up within each district, according to policies set at the national level. However, each District Council has autonomy over member contributions and by-laws (Stoermer, M. 2011). Households (up to six members) pay an annual contribution that ranges from 5,000-20,000 Tanzanian shillings (TZS) per year, which grants access to services at primary level public facilities, including some drugs, as well as referrals to secondary or tertiary facilities where district managers have elected to do so (Stoermer, M. 2011). The government offers a subsidy through a matching fund, which provides a lump sum amount that is equal to member contributions. The CHFs are governed by a Council Health Service Board (CHSB), which is composed of community representatives, private and public health-care providers and district authorities. The CHSB is responsible for both purchasing and providing services, and for making key decisions about the allocation of resources, with input from the District Executive Director.

The CHF aimed to reach 60 per cent of households by 2003, but recent 2011 estimates reveal only 15 per cent coverage between the NHIF and CHF combined (Humba, 2011; Marriott, 2011). The CHF has faced numerous challenges with implementation and management, due to a “lack of commitment by some regional and district officials, inadequate follow up by the MOH [Ministry of Health and Social Welfare], lack of capital for initiation of the scheme, lack of uniformity of premiums, inadequate mechanisms renewal of membership and unclear referral mechanisms” (Mtei et al., 2007). The CHF is governed by the CHSB, but board members are not typically enrollees in the scheme and therefore have less of a vested interest. There is also room for increased transparency in the management of funds. Key informants have suggested that the CHFs face major challenges in providing high quality care due to frequent drug shortages and limited management capacity. Cross-subsidization at the district level is also challenging, due to adverse selection and varying ability to raise district level resources (Mtei et al., 2007).

There are several examples where specific district-based CHF has been strengthened through the involvement of private partners – involving both separate HMI schemes and private companies. Two experiments in the Mbozi and Kyela districts of the Mbeya region provide key insights into the potential advantage of linkages with private partners.

Self-Managed Health Insurance Scheme in Mbozi district

In 2002, the *Centre International de Développement et de Recherche* (CIDR) launched Self-Managed Health Insurance Schemes (SMHIS) in villages in Mbozi district. The SMHIS are CBHI schemes, which provide access to services at a private, faith-based hospital, as well as at public clinics and hospitals, excluding public health-care centers in the first stage (Galland et al., 2012). By contrast with the CHF, the SMHIS' contributions are based on actuarial pricing. The schemes are managed by their members and the benefits package includes access to private hospitals and ambulance services.

The SMHIS were already active when the CHF was launched in Mbozi district, creating competition. Individuals were attracted to the existing scheme because it offered access to private hospitals. This caused growing tension between the SMHIS management and district officials, as performance was higher than that of CHF (13 per cent penetration rate in 2006, compared with 4 per cent for CHF overall). Over time, members of the scheme expressed interest in being able to access additional public facilities that were closer to home than those included in the network. The District Council was keen to increase the appeal of the CHF, and in 2008 this led to a first Memorandum of Understanding (MoU) between the two: private hospitals were included in the CHF plan and district public hospitals were included in the Mbozi scheme.

Later in 2009, the scheme obtained access to the matching fund offered by the government. The partnership between the CHF and the scheme enabled the district to pool funds from both. This increased the amount of the matching fund (twice the level of individual contributions) which was then transferred from central to district level. The matching fund was distributed between the scheme (25 per cent), the CHF (50 per cent) and the private hospitals (25 per cent). These funds can be used to procure additional drugs, invest in facilities or pursue other avenues to improve the quality of facilities. Ultimately, the goal is to improve quality, so that demand will increase and the need for subsidies will gradually decline.

Finally, in 2011, the Council and the SMHIS network decided to merge the SMHIS network and the CHF in order to create a unique district-wide scheme, known as the Self-Managed Community Health Fund (SMCHF), which combines the advantages of both schemes. SMCHF schemes had been established in five villages as of 2011, with 288 members and 1,051 beneficiaries.

Refining the model in Kyela district

A representative from a private hospital in Kyela district, located in the same region as Mbozi, visited Mbozi's hospital. This visit sparked ideas of replication in Kyela and CIDR agreed to conduct a feasibility study. Initially, the Kyela District Council was concerned that a parallel offering would be created, and that this would threaten the viability of Kyela's CHF. Through ongoing discussions with the District Council, a MoU was signed in 2010 to establish Community Health Insurance Funds (CHIF), a hybrid model combining elements of both the SMHIS and the CHF. This was to be the district's sole scheme. The end goal was to strengthen the CHF, rather than create a separate structure. A CHIF Association was established to co-manage the CHF with the Council (CHSB). The association is member-based and professionally managed, providing an attractive product, including faith-based health care and a private CHIF ambulance.

The partnership also attracted Biolands, a private cocoa company in the district, which was interested in subsidizing health care for its employees to offer them better access. Biolands agreed to subsidize the premiums of its 20,182 registered cocoa producers for 5 years, with the expectation that as membership increases over time, the premium would diminish and the contributions borne by Biolands would decline. The company agreed to subsidize 3,000 of the 5,000 TZH payable for all cocoa producers, whether they worked for Biolands or not, and the district agreed to provide the same level of subsidy for non-cocoa producers. Patients can access services in the Matema Lutheran private hospital, the local district hospital and public health centers and clinics, as well as an additional clinic owned by a mining company.

By June 2011, just over 6 months after the programme was launched, 40 CHIF village sections existed, with a total of 10,569 beneficiaries.

Key lessons

The two experiences in Tanzania's Mbozi and Kyela districts demonstrate how partnerships between public and private insurance schemes can result in a stronger overall design. The following lessons can be drawn from the experiences:

- Build on existing schemes: Governments should encourage private companies to strengthen existing government schemes, rather than set up their own. In both Mbozi and Kyela districts, the organizations merged efforts and built on the existing CHFs. This resulted in hybrid schemes that are arguably stronger than any that might have been developed separately. Governments need to invest the time to identify and understand the scope of community-based financing schemes. Any private partners considering developing a separate scheme should also consider whether they can build on existing public initiatives.
- Financial sustainability: The hybrid model has enabled CBHI schemes to benefit from the matching fund while the new hybrid model is benefiting from actuarial skills developed by the CBHI schemes. This enables schemes to better manage risk and calculate level of contribution, enhancing potential for financial sustainability from both sides. The financial sustainability of the partnership in Kyela districts relies on the ongoing subsidy from Biolands. Replication in other districts may not be possible unless the district is able to fund a higher premium. This may rely on subsidies from central government.
- Scale: These partnerships are still limited in scope. They only feature in two districts, with more than 25,000 beneficiaries in Mbozi and more than 30,000 beneficiaries in Kyela as of December 2012, and the benefits are not portable across districts. A future goal may be to replicate the model across other districts.

- Alignment: The development of the CHF's relied on clear policy guidance from the central level, though districts do have a high level of autonomy in the specific implementation of the CHF's. The innovation that is emerging at the local level will need to ultimately be aligned with central goals if there is to be a possibility of replication.
- Communication: One step towards achieving this alignment is through clear and open communication among all partners, and across levels of government. Without open communication channels at local level, the CHF and private schemes would have been positioned at odds with each other. A future challenge will be to share lessons across districts and regions.

Conclusions

Tanzania's Community Health Funds and TIKa programme for urban populations have struggled to reach scale and success, but the demonstrations in Mbozi and Kyela districts offer lessons to inform the strengthening of the CHF's and plans for UHC. Though these experiments are limited in their geographic scope, they represent ways of blending community-level schemes with central level policies.

One of the main successes of the experiments in Kyela and Mbozi districts was the buy-in from central and regional level officials. At local level, it was important to present the business case to district level officials to persuade them that partnership could be beneficial and reassure them that the innovation did not solely mean competition. Biolands was another key stakeholder, given its purchasing power in the district. Clear and open communication among all parties was critical to develop the partnerships. Without this, the schemes may have been positioned at odds with each other and would not have been as successful as the combined effort proved to be.

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APPENDIX IX. USING CBHI SCHEMES TO PILOT MODELS FOR NATIONAL HEALTH INSURANCE IN CAMBODIA

Country context

Despite rapid economic growth over the past decade, Cambodia remains one of the poorest countries in South East Asia. More than two-thirds of total health expenditure is accounted for by out-of-pocket expenses and insurance penetration remains very low. The Royal Government of Cambodia has made significant investments in public health infrastructure since the 1990s, with 5.6 per cent of GDP spent on health (World Bank, 2010). In later years, more restricted funding of facilities has led to use of unofficial fees, resulting in high and unpredictable levels of out-of-pocket spending.

In 1996, the government enacted a National Health Financing Charter to address this problem. The Charter allowed facilities to charge user fees under certain conditions, and waived fees for the poor, who are identified by the Ministry of Planning. However, since the government did not provide subsidies to offset the lost revenue from waived fees, these were applied in an inequitable manner. In 2000, Cambodia's Health Equity Funds (HEFs) were introduced to address this challenge by pooling and allocating donor funds to subsidize the user fees waived for the poor. By the end of 2011, these HEFs covered 78 per cent of the poor in Cambodia (Annear et al., 2012).

In addition to the HEFs, there were 16 community-based health insurance (CBHI) schemes by the end of 2012 (Social Health Protection Association, 2012). The government has also been piloting the National Social Security Fund (NSSF) for formal workers in Phnom Penh, with the goal of extending the scheme to all formal workers. The NSSF was formally approved in 2007, and started a work injury scheme for formal workers in November 2008. But as of January 2013, comprehensive health insurance has yet to be launched. These demand-side programmes are considered intermediate steps as the government continues to develop its long-term vision for achieving universal health coverage (UHC).

Table 1: Key statistics on Cambodia

Population (in thousands) total	14 305 183
Population covered by health insurance (%)**	11%
Size of informal sector (% of population)***	85 - 90 ILO Reports (2004)
Gross national income per capita (PPP international \$)	2 040 (2010)
Total health expenditure (% of GDP)	5.6 (2010)
Per capita total expenditure on health (2010 \$)	45.2 (2010)
Private expenditure on health as percentage of total health expenditure *	62.8 (2010)
Out-of-pocket expenditure (% of private expenditure on health)*	64.3
Life expectancy at birth, total (years)	62.5 (2010)
Infant mortality rate (per 1 000 live births)	42.9 (2010)
Maternal mortality ratio (per 100 000 live births)	250 (2010)
Hospital beds per 1000 people	0.8 (2010)

Sources: World Bank, (2010), * WHO (2010), ** ILO, (2004), *** Cambodia Demographic Health Survey, (2010)

Cambodia is building its UHC strategy on 3 pillars: HEFs for the poorest, CBHI schemes for the near poor, who are mostly informal workers, and the NSSF for the formal sector. The concept is described by the Ministry of Health in the 2010 Draft Master Plan for Social Protection, which proposes that these three pillars eventually be merged to form one compulsory national health insurance programme. The Plan advocates an initial focus on merging the HEFs and CBHI schemes. This could help to improve the administrative efficiency of running multiple schemes across donors, the government and various NGOs.

Private insurance options for informal workers

CBHI schemes represent the primary private sector option available to informal workers. The first CBHI scheme was launched in the late 1990s and by 2012, a total of 16 CBHI schemes covered 180 032 members in eight provinces of Cambodia (Social Health Protection Association, 2012). CBHI schemes are regulated by the Ministry of Health (MOH). All CBHI schemes in Cambodia are operated either by international or local NGOs. The benefits of the schemes vary from case to case, but typically each scheme provides cover for the low-income population for primary and secondary health care at public health-care facilities (ranging from health centres to provincial hospitals, and sometimes including national hospitals).

In 2007, the CBHI operators in Cambodia grouped themselves into an informal network. This led to the launch of a formal institution for the sector, known as the Social Health Protection Association (SHPA), in 2012. The SHPA aims to be the platform for exchange with the MOH, and to ensure coordinated dialogue between all CBHI operators, as well as a resource centre for social health protection and microinsurance. The SHPA has grown to include other social health protection schemes in the country. It was formally registered with the Ministry of the Interior in May 2012. After more than 10 years of activities, CBHI schemes are reaching a maximum of 40 per cent (SHPA briefing note, 2012) of their target population. However, most schemes still have coverage of below 20 per cent. Reasons for this low level of penetration include the voluntary nature of enrolment and a low perception of quality of care, despite a relatively affordable fee (US\$ 0.20-0.50) for accessing primary health care in a health centre. Limited exposure to insurance and constraints in ability to pay are also influencing factors.

In the case of HEFs, where enrolment is not an issue, the challenge is for poor people to effectively access the health facilities.

Public sector insurance options for informal workers

At present, non-poor informal workers have no public health insurance options. MOH facilities do receive funds, but those people who are not eligible for waived fees still face user fees that may exceed their capacity to pay.

The poor can receive fee waivers through the HEFs, which were launched in the early 2000s. HEFs are demand-side financing mechanisms that essentially act as a third-party payer. They are financed by a group of donors (World Bank, AusAid, GIZ, UNICEF), together with MOH counterpart funds. Though HEFs are autonomous and often district-based, they are regulated by the MOH and have to follow the HEF guidelines drawn up in 2003.

Individuals are identified nationwide through a community-based identification process or at the point of service, according to a set of objective criteria. They are provided with free access to primary, secondary and tertiary health care in public health facilities. The benefits package also includes a daily allowance for food and transportation in the case of hospitalization.

HEFs currently cover 78 per cent of Cambodia's identified poor population, in 44 districts of Cambodia (Annear et al., 2012). The MOH Strategic Framework for Health Financing (2008-2015) recommended the extension of HEF to all

districts of Cambodia, and as a result, an extension plan is adopted every year. The entire country is expected to be covered by the end of 2015 (Health Strategic Plan, 2008-2015).

Table 2: Characteristics of major insurance schemes in Cambodia

Insurance scheme	Eligibility	Contribution rate	Benefits package	% of total population covered by scheme
CBHI (example of SKY)	Voluntary product, targeting informal workers. Family enrolment is mandatory. Premium varies according to size of family, and between rural and urban schemes.	Premium varies according to size of family, and between rural and urban schemes.	Comprehensive coverage, accessible only at public facilities (level of coverage for hospitalization varies). CBHI coverage is regulated through MOH guidelines. Limited funeral benefits.	Between 3% to 40% penetration rate of the target population, depending on the districts and scheme processes.
Health Equity Funds	Families recognized as poor by local authorities.	No contribution - premium is 100% subsidized.	Comprehensive coverage, accessible only at public facilities. HEF coverage is regulated through MOH guidelines. Food and transportation is covered.	78% of the target population.
National Social Security Fund (NSSF)	Formal workers.	Still to be defined.	Still to be defined.	Early pilot in Phnom Penh.

CBHI schemes as demonstration for UHC

In the formation of its National Health Financing strategy, Cambodia's active CBHI schemes have been a valuable source of information and learning. They have also offered opportunities for testing new approaches to delivering health insurance. The SKY CBHI scheme and the Health Insurance Project provide two examples.

Pilot 1: Merging CBHI and HEF

The SKY CBHI scheme was launched in 1998 by the French NGO, GRET. It is a voluntary scheme that provides coverage in public health facilities. In line with the government's long-term vision of harmonizing the different demand-side financing mechanisms (CBHIs, HEFs and NSSF), and with support from the German Government through GIZ, GRET led a pilot project to link the SKY programme with the local HEF in one district (Kampot district). The pilot was based on the premise that merging the two programmes would limit operational costs, reduce discrimination for HEF members and promote cross-subsidization from the near poor to the poorest. After the merger, the SKY programme received the HEF member premiums via donor contributions. HEF members were given the same benefits package as SKY CBHI scheme members, with additional food and transport allowances for HEF members, as defined in the HEF guidelines (Annear, 2011).

The HEF recipients involved in the pilot had higher utilization rates – 1.47 visits per person per year at health centres, compared with the national average among HEF users of 0.5 visits. By May 2010, HEF members represented more than twice the number of voluntarily enrolled SKY members, whose utilization rate was significantly higher, at 3 visits per person per year. Voluntary members represented just 6 per cent of the eligible population, a figure that highlights the difficulty of reaching a large proportion of the population with a voluntary product (Goursat, 2011). Since the

premium calculation was made based on the overall voluntary member and HEF member utilization rate, and since provider payment was made based on a capitated payment, donors willing to support only the poor's contribution claimed that their contributions were also subsidizing voluntary members. This experience illustrates some of the limitations of a fragmented implementation strategy for achieving UHC. In this example, restricting subsidies to just the poorest sector would not only limit the total amount of subsidies. It would also mean leaving the "near poor" without options to obtain health insurance at an affordable cost. The SKY CBHI scheme ended in rural areas in 2012. Its membership was transferred to local counterparts and subsidized by donors and the Ministry of Health to deliver both HEF and CBHI services.

Policymakers have viewed the pilot as a demonstration of what the effect of consolidating HEFs and CBHI schemes could be. While there is no agreement between donors and ministries on the best way to increase health coverage among non-poor informal workers, the lessons from the pilot have informed plans.

Pilot 2: Informing early designs of the NSSF

GRET designed a second pilot in 2007, called the Health Insurance Project (HIP). This was at the request of the Garment Manufacturers Association of Cambodia (GMAC), and aimed to test the ultimate design of the NSSF scheme. The HIP, financed by the French government, was launched in 2009 with a number of objectives. These included the design and development of an information system, together with marketing tools, contracting and risk management techniques and statistical and financial analysis, all with the ultimate goal of transferring these to the NSSF.

The HIP product costs US\$ 1.60 per month. The cost is shared equally between employees and employers, and offers comprehensive coverage at public health facilities, including outpatient and hospitalization coverage. A number of stakeholders were involved in the design process, including GRET, employers, labour unions, employees, and representatives from NSSF and Ministries of Labour and Vocational Training, Health and Finance.

By July 2012, 11 factories had joined the HIP, covering 6 200 members. The pilot faced its own challenges: the uncertainty around the launch of the NSSF affected the willingness of garment employers to join the scheme, factories showed limited willingness to make the product compulsory and donor funding was only guaranteed through the end of June 2012. However, with the delayed implementation of the NSSF, there was financial pressure to keep the scheme running.

Key lessons

Since their launch in 1998, CBHI schemes in Cambodia have proved an important source of learning for the government in its design of the national health insurance scheme. They have helped to define benefits packages, determine how to best facilitate enrolment, develop contracting arrangements and determine appropriate prices for the target population. Key lessons from these experiences follow :

- Political will: Success of the pilot requires strong political will. Although Cambodia is concurrently developing health insurance for three target populations (poor, informal workers, formal workers), it has been difficult to obtain the same level of stewardship and political support for all three areas from the central government. This may have stifled the development of the CBHI pillar of Cambodia's approach to UHC.
- A participatory approach: All stakeholders should be part of early discussions to establish objectives for the pilot. Varying donor interests may have limited the parallel extension of CBHI schemes and HEFs. It is important for the government to have a clear vision and strategy regarding health financing when

negotiating with donors. If not, it may be difficult to define a common position for all stakeholders, which may have different agendas.

- Strengthening pilot design: Cambodia's experience highlights the importance of including CBHI and other microinsurance initiatives as part of a broader health financing strategy. As such, insurance pilots should be conceived as an integrated activity with clear objectives, methodology and monitoring systems.
- Knowledge transfer: The CBHI experience revealed useful lessons for the government, but knowledge transfer from CBHI schemes and pilot initiatives should be planned carefully. There is a need to ensure a better transfer of knowledge from CBHI operators to policy level, as well as to any future social protection agency. In the HIP programme, although the pilot's governance bodies included all relevant stakeholders, clear government stewardship was lacking and this had repercussions on the pilot's role as a fundamental part of the national strategy.
- Coordination and timing: All stakeholders need to establish a clear exit plan and transfer of administrative and financial support. The HIP in Cambodia has been strained by different timelines on the part of donors and government. As a result, the implementation of the NSSF has been severely delayed, to a date when donor support had ended.
- Use of the CBHI model as a foundation for UHC: The pilot that merged the CBHI and HEF models highlighted benefits but also some potential drawbacks of fragmenting the health financing approach between poor and "near poor" populations. If donors are willing to subsidize only the poorest segment of the population, it will not be cost effective to apply the same cost structure to calculate the contribution level of both sub-populations.
- Role of HMI: In a country where the informal sector accounts for a large proportion of the population, the government should not consider HMI as the solution for achieving UHC if HMI schemes are not mandatory and /or highly subsidized. HMI should be seen as a way of building the infrastructure, processes and skills for faster implementation of UHC once appropriate sources of financing are in place.

Conclusion

Cambodia has been a pioneer in implementing health financing mechanisms that have increased access for the poorest. It welcomed innovative financing schemes in early years when experience with CBHI and other financing schemes was limited. This contributed to a strengthened knowledge base regarding the needs and preferences of informal workers. This in turn has helped to inform the government's strategy.

Cambodia is at an early stage in its journey toward UHC. Much of its financing is provided by external donors and international NGOs and very separate strategies are being used for different sub-populations. It is encouraging to see that strategies are being developed with the aim of eventually merging these different systems. It is unlikely that CBHI schemes will be able to reach a majority of informal workers without significant investment from the government. However, the interim solution clearly shows that CBHI schemes can provide partial coverage for informal workers, and that the CBHI model can play a role in building HMI management skills. The next step for Cambodia is to launch the NSSF scheme for the formal sector and clarify the road map aimed at ensuring increasing coverage for the informal sector.

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MICROINSURANCE INNOVATION FACILITY

Housed at the International Labour Organization's Social Finance Programme, the Microinsurance Innovation Facility seeks to increase the availability of quality insurance for the developing world's low income families to help them guard against risk and overcome poverty. The Facility was launched in 2008 with generous support from the [Bill & Melinda Gates Foundation](#) to learn and promote how to extend better insurance to the working poor. Additional funding has gratefully been received from [several donors](#), including the [Zurich Foundation](#) and [AusAID](#). See more at: www.ilo.org/microinsurance

