BRIEFING NOTE 20

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# LEVERAGING HEALTH MICROINSURANCE TO PROMOTE UNIVERSAL HEALTH COVERAGE

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Every member of society has the right to social security, including access to health care. However, approximately 75 per cent of the world's population is not adequately protected and approximately 40 per cent lacks even basic protection. Meanwhile, momentum for universal health coverage (UHC), "a system in which everyone in a society can get the health care services they need without financial hardship," (see Box 1 for definition) is building in countries as diverse as China, Ghana, Indonesia, Mexico and South Africa.

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.

A major barrier to provide social health protection in many low and middle-income countries is the difficulty in reaching informal workers and their families. Governments struggle to identify individuals, enrol them and collect premiums, 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 briefing note 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.

**BOX 1. Definition: Universal health coverage**

Universal health coverage (UHC) is "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.

Sources: Savedoff, W., de Ferranti, D., Smith, A. & Fan, V. 2012. «Political and economic features of the transition to universal health coverage» *in The Lancet*. *And* World Health Organization. 2010. *World health report 2010. Health systems financing: The path to universal coverage.* (Geneva. WHO).

## 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 ongoing 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. Figure 1 illustrates these roles within 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 presents a simplified illustration of this progression.

[1] This brief is excerpted from Microinsurance Paper No. 23 available at http://www.ilo.org/microinsurance. Meredith Kimball, Amanda Folsom and Gina Lagomarsino are part of the Results for Development Institute. Caroline Phily and Jeanna Holtz are part of the ILO's Microinsurance Innovation Facility.

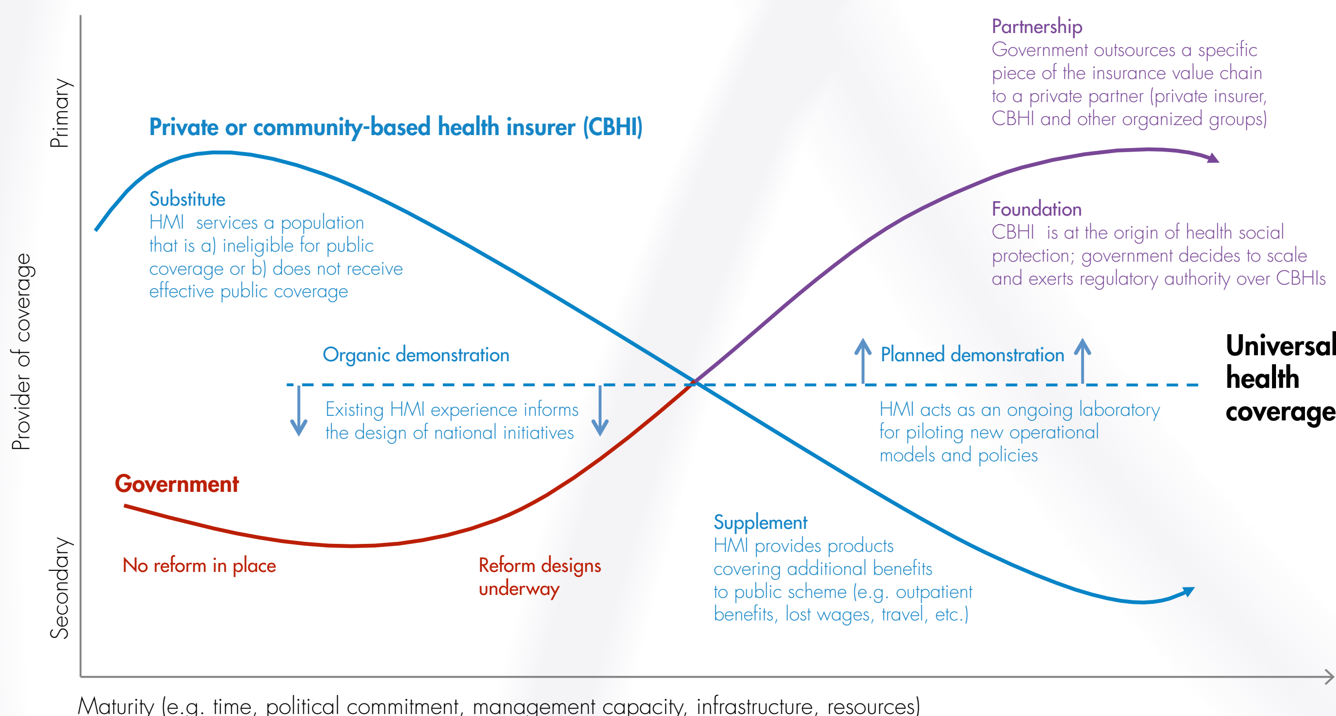
**1.** Early on, HMI schemes, often in the form of community-based health insurance (CBHI), **substitute** government initiatives that have not yet been designed or effectively implemented. In cases where government engagement remains limited, this substitution may predominate for an indefinite period. 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 that is managed at a district level (see Box 2). 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 – the Universal Coverage Scheme – that covers informal workers and the poor.

**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, enrolment, 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 additionally does the same for back-end insurance functions, such as claims administration (see Box 3).

**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.

**FIGURE 1.** Leveraging HMI to promote UHC



## **BOX 2.** 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.

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1. 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.
2. 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, C. 2010. *Background paper on NHIS for Oxfam GB (unpublished).* Unpublished manuscript *And* Joint Learning Network. July 6, 2012. *Interview with Sam Adjei,Executive Director of CHESS, and PhilpAakanzinge,Gghana Health Service.*

## **BOX 3.** Rashtriya Swasthya Bima Yojana (RSBY)

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In 2007, the Indian Ministry of Labour and Employment (MoLE) launched the *Rashtriya Swasthya Bima Yojana* (RSBY) programme. RSBY targets the Below the Poverty Line (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. Benefits are currently being expanded to cover outpatient services. Costs are shared between the 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, roughly 34 million persons.

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, 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. 2013. *RSBY: Rashtriya swasthya bima yojna. Available at:* http://www.rsby.gov.in/Overview.aspx [8/2/2013].

## THE DEMONSTRATION EFFECT

HMI schemes can be "learning incubators" and create a **demonstration effect** for policymakers. During the early stages of implementation of a health financing strategy HMI schemes 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.

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.

## CONCLUSION

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.

The capacity of HMI schemes also varies; their ability to perform as government partners varies as a result. The demonstration effect from HMI initiatives can be valuable, but lessons may be context specific. Furthermore, 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 consumer 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.

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 Z Zurich Foundation and AusAID.
See more at www.ilo.org/microinsurance

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