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Health insurance in low-income countries

Where is the evidence that it works?

Some donors and governments propose that health insurance mechanisms can close health financing gaps and benefit poor people. Although beneficial for the people able to join, this method of financing health care has so far been unable to sufficiently fill financing gaps in health systems and improve access to quality health care for the poor. Donors and governments need to consider the evidence and scale up public resources for the health sector. Without adequate public funding and government stewardship, health insurance mechanisms pose a threat rather than an opportunity to the objectives of equity and universal access to health care.

Summary

All people have a right to health. In poor countries, the challenge is to finance systems that will deliver that right. After 20 years of one failed health financing mechanism – user fees – some actors in the international community are proposing that health insurance mechanisms will close health financing gaps and benefit poor people. This paper describes those mechanisms and their success or failure to deliver health rights particularly for people living in poverty. The paper shows that although health insurance can have a positive effect on access to health services and on reducing (catastrophic) health expenditure for some parts of the population, it can also pose a threat to equity and efficiency of health systems.

If we are to avoid another 20 wasted years, advocates of insurance mechanisms need to produce evidence that those will work before promoting their implementation in poor countries. Universal access to health care took 100 years to develop in Europe. In a world rich in resources and knowledge, 100 years is too long for poor people to wait.

The mechanisms discussed in this paper are: Private Health Insurance (PHI); Private for-profit Micro health insurance; Community Based Health Insurance (CBHI); and Social Health Insurance (SHI).

More than 25 years after the introduction of private health insurance (PHI) in developing countries, there is still no evidence that it can benefit more than a limited group of people. In low-income countries coverage rates are generally less than 10 per cent of the population. In countries where PHI has shown a strong growth, its contribution to universal access to health care has been insignificant or has even had an adverse impact by increasing inequalities. In Chile, premiums were set 2.5 times higher for women than for men. The costs of regulating PHI and the fragmentation of risk pools make this an inefficient and expensive way of improving health access.

Private for-profit micro health insurance schemes offered to poor people have low premiums but offer limited benefits packages. By excluding important services the effect in reducing out-of-pocket payments has been limited, particularly for those who are most disadvantaged. In India, 12 out of 14 schemes were found to exclude childbirth and pregnancy-related illnesses, and most excluded people living with HIV.

So far community-based health insurance (CBHI) schemes have managed to cover two million people in Africa, out of an estimated population of 900 million (0.2 per cent). There is some evidence that CBHI schemes have, on a small scale, played a role in reducing out-of-pocket payments and CBHI can potentially contribute to the empowerment of poor people in relation to health providers and policy-makers. However, members of CBHI often continue to depend on out-of-pocket expenditure to cover more than 40 per cent of their health needs. Only through linkages with national health systems and heavy subsidisation can CBHI offer even a minimum level of care to poor people.

Social health insurance (SHI) has achieved universal coverage in developed nations, but the context in most low-income countries is not conducive to expanding SHI coverage. Informal sector workers (in some countries 80 per cent of the economically active population) and unemployed people almost always remain excluded as our evidence from Ghana illustrates. The countries that have been able to substantially extend the coverage of SHI

towards the poor are those that are heavily subsidised by treasury revenue from taxes and with pre-existing institutional capacity.

Insurance schemes are often evaluated for their performance with regards to their members. But this evidence ignores the impact of such schemes on entire populations, and particularly on people living in poverty who cannot afford prepayments. This paper therefore recommends:

- Countries and donors should evaluate insurance mechanisms not just in terms of the advantages to the sub-populations they serve but also with regards to the contribution they make towards universal coverage, horizontal and vertical equity and efficiency within a country.
- Health financing should specifically focus on the needs of vulnerable groups, such as women, poor and elderly people, and people living with HIV, who are most likely to be excluded by insurance mechanisms.
- Governments should increase national budgets for health, by improving the generation of tax income, and donors through greater budget/sector support. This is the only proven method for achieving universal coverage and access in the short term. Governments particularly need to ensure sufficient funding for vitally important preventive services (which suffer particularly under PHI models) and to increase public health awareness.
- National health plans developed within (and outside of) the International Health Partnership (which was launched in 2007) should respond to the needs of the population at large, should include a national coverage plan, and should be fully financed. In this context donors must acknowledge the existing evidence, or lack thereof, relating to health insurance mechanisms as a way of financing health care.
- Countries wishing to abolish user fees and expand free health care through funding from general revenues should be supported to do so, as this could be a more promising and more equitable route to universal access.
- While donors are supporting risk-sharing mechanisms in developing countries, they are failing to show adequate levels of solidarity on the global scale by consistently falling short on their international aid commitments. Urgent action is needed to enable people in developing countries to exercise their right to health.

1 Introduction

'*Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.*'

Universal Declaration of Human Rights (1948), Article 25 (1).

Thirty years after the Declaration of Alma-Ata, an estimated 1.3 billion people worldwide still lack access to the most basic levels of health care.[1] Although the right to social security and health is well established in international law, governments and international donors are still failing in their responsibility to guarantee these rights to millions of people.[2] Huge disparities between rich and poor people remain evident between and within countries.[3]

The reality for the vast majority of poor people in low-income countries is that public services are unavailable, skewed towards the needs of the rich, or unaffordable.[4] Each year, 100 million people are pushed into poverty by the need to pay for health care.[5] The 2007 Social Watch Report concluded that, at the present rate of progress, sub-Saharan Africa will achieve universal coverage of minimum essential needs only by 2108 – 93 years after 2015, the target date for achieving the Millennium Development Goals (MDGs).[6]

Renewed interest in health insurance

Throughout decades of underfunding of health systems by governments as well as donors, an important mechanism for financing health care in poor countries has been user fees.[7] There is now a growing international consensus that user fees are an inequitable form of financing, an impediment to health access, and a cause of impoverishment, and that concrete measures need to be taken to abolish them.[8]

Developing countries, multilateral agencies (particularly the World Bank, the International Finance Corporation, the International Labour Organization, and the World Health Organization), and donor countries (for example, France, Germany, the Netherlands) have shown an increased interest in health insurance as a mechanism to collect and distribute resources for the health sector in a more equitable way, with pre-payment and risk pooling being considered preferable to payment at the point of service.[9] Germany is one of the leading countries in the 'Providing for Health' Initiative, which will promote social protection mechanisms, including SHI, in developing countries. However, there are differences of opinion on the extent to

which health systems should be financed through general revenues from taxation and the extent to which different insurance mechanisms could be put in place.[10] There are also disagreements on the role that government should play and even to what extent equity in health-care access should be pursued.[11]

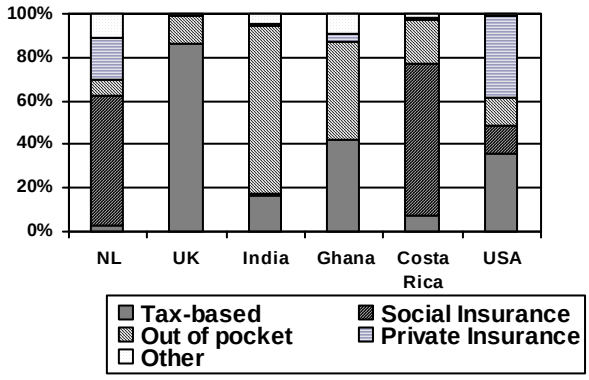
A commitment to the concept of equity is particularly important, considering that ill health is a particular concern for people living in poverty: they are more likely to get sick, to remain sick for longer, to live shorter lives, and to lose out on productive activities through illness. Equity does not simply mean equal access for all (i.e. horizontal equity), but also differential access according to people's different needs (i.e. vertical equity). Pursuing equity in health care means working to reduce structural unequal opportunities between different social groups.[12] Efforts must therefore strengthen universal coverage and reach in particular poor people and other disadvantaged groups.

While these issues are being debated and donors and governments roll out their own, often fragmented, projects in developing countries, the majority of poor people and many vulnerable groups continue to be excluded from coverage and access to health care.

2 Health financing for the poorest people

The purposes of health financing are to mobilise resources for the health system, to set the right financial incentives for providers, and to ensure that all individuals have access to effective health care.[13] Individuals should not be unable to pay for such care or be impoverished as a result of doing so. Most high-income countries rely heavily on general taxation (for example, the United Kingdom) or mandated social health insurance (France, Germany) for health financing. Low-income countries depend mostly on service users making out-of-pocket payments at the point of service, and some also rely heavily on international donor support. Most countries have built health systems based on a combination of two or more financing arrangements (see Figure 1).

Figure 1: Health financing in selected countries[14]



The choice of different institutional models depends to a large extend on the history, economic situation, institutional capacity and culture of each country.

In the current debate, a number of arguments are put forward to stress the advantages of health insurance in improving financing of and access to health care in poor countries:

- Insurance can increase the availability of resources for health care freeing up limited public funds to be directed towards poor people.
- Insurance offers a more predictable source of funding compared with the unpredictability of tax finances. This also facilitates private investment in health.

- The pooling of resources allows for cross-subsidies between those who are healthy and those who are sick, and between rich and poor.
- Insurance reduces uncertainty for citizens and gives them financial protection against impoverishment as a consequence of illness.
- Health insurance schemes contribute to better-quality health care by separating the purchasing and provision of services, especially if payment is based on performance.
- People are more willing to pay for health insurance than to pay taxes, as their contribution is linked to entitlement.

However, the various forms of health insurance advanced – private health insurance (PHI), micro-insurance, community-based health insurance (CBHI), and social health insurance (SHI) – all have serious limitations in poor countries. These include difficulties in raising significant revenues, the unpredictability of funding, inequalities in risk-sharing and the level of protection offered, and difficulties in improving the quality of the service. There are also specific concerns regarding their contribution to the equity and efficiency of health systems as a whole.

Private health insurance

Private health insurance (PHI) is becoming more prevalent in both developed and developing countries, and is considered by some to have great potential in Africa.[15] The World Bank in particular has been influential in driving the growth of PHI markets in Latin America, Eastern Europe, and Central Asia. However, PHI coverage is still limited: in 2005 it exceeded 20 per cent of total health expenditure in only six countries worldwide, and in low-income countries coverage rates are below ten per cent of the population.[16]

The inequity of PHI

Although PHI can increase financial protection and access to (quality) health services to those able to pay, it is known to be particularly inequitable unless poor people are subsidised. As can be seen in the United States, PHI without strong government intervention can lead to rising costs and inequitable access.[17] The Institute of Medicine estimates that 18,000 Americans die prematurely each year because they lack health insurance. [18] Even though the US has the highest per capita expenditure on health in the world, the current US system does not ensure universal coverage, in contrast with systems in other industrialised nations, and in the near future is likely to undergo reform.[19]

PHI schemes can be highly beneficial to the (often) relatively small number of people who enjoy membership of them, but in countries

where PHI has shown strong growth, its contribution to universal access to health care has been insignificant or has even had an adverse impact by increasing inequalities.[20] In the case of Latin America, where PHI was introduced in the 1980s, private schemes typically cover the percentile of the population with the highest income; low-income groups are left with existing social insurance schemes, which offer fewer benefits, or have no health insurance at all. Inequalities of this nature have been reported in Argentina, Chile, Colombia, Brazil, and Peru.[21] This lack of equity and efficiency is one reason for questioning why donors and governments continue to advance PHI systems as a solution in developing countries.[22] It also explains why civil society groups in some countries are increasingly and fiercely opposed to such privatisation reforms as it is the case in Egypt.[23]

In PHI, membership is generally voluntary and the premium is related to the risk profile of the member. This does not support solidarity (risk sharing) between people with high and low risk profiles. It also encourages insurance companies to design policies with the aim of attracting people with lower-than-average health risks and excluding those with higher health risks – for example, through practices such as screening, exclusions, waiting periods, and co-payments. Insurance companies justify this practice (commonly known as cream skimming) by claiming that voluntary insurance schemes might otherwise attract people with existing high health risks (a phenomenon known as adverse selection). Practices of this nature lead to discrimination and the exclusion of specific groups including women, elderly people, and people living with HIV (see Box 1).

In some countries special arrangements have been made to include poorer people in the system, for instance through government subsidy of membership for people living below a certain poverty threshold. The issue that arises then, however, is what happens to people who are not quite poor enough to qualify for subsidy but who are not wealthy enough to purchase PHI coverage for themselves, or to those who cannot 'prove' they are poor. Where subsidisation of the premium of the poor only covers a fraction of the poor population, the question is what access to services remains for the poor non-subsidised.

Box 1: Private health insurance and equity in Chile

In Chile, reforms in 1980 allowed private insurance companies (ISAPREs) to compete with the public National Health Fund (FONASA). The two schemes have opposing rationales: FONASA is financed by a seven per cent payroll tax and has no exclusions, while ISAPREs can adjust premiums and benefit packages to reflect the individual risk of the client.

Consequently, the richest and healthiest 27 per cent of Chile's population have taken out policies with the ISAPREs, which offer extended benefit packages at a higher premium, while almost all low-income workers and their families, as well as the majority of over-60s, remain covered by FONASA.

The separation of the population into different risk pools has limited possibilities for cross-subsidisation and has resulted in a severe segmentation of the market. In addition, it has seen discrimination against women in ISAPRE health plans, which typically set premiums for women 2.5 times higher than for men.[24] The interests of the private sector were clearly demonstrated when one private insurer closed its plans to women aged 18-45, following withdrawal of the government maternity subsidy.[25]

The inefficiency of PHI

In order to prevent growing inequality in access to health services, regulation of the private insurance market is essential. Without regulation, PHI leads to an escalation of costs, a deterioration of public services, a reduction in the availability of preventive health care services, and widening inequalities between poor people and those who are better-off.[26] In most low-income countries, there is a lack of capacity for effective regulation. Regulating PHI is complicated, and costs related to regulation can represent up to 30 per cent of revenue from premiums.[27] This is one reason why the costs of administrating PHI have been estimated to be up to ten times higher than the administration costs of social insurance.[28]

It must be asked whether the donor and government subsidisation of PHI would not have been spent much more justly on a system that was more efficient and had potential to bring about access equitably. Arguably if equal resources were invested in the public sector – which to date has been severely underfunded – universal access could be achieved much more quickly and much more equitably.

Private micro health insurance

Worldwide, approximately 35 million people are covered by micro health insurance schemes offered by private institutions such as insurance companies or microfinance institutions (MFIs); of these, 90 per cent live in Asia, nine per cent in Africa, and one per cent in the Americas. The main difference between PHI and micro health insurance is that the latter specifically targets poor people. Nevertheless, both are typically for-profit. Premiums are low, but

likewise benefits packages are limited. Moreover, the poorest people still find themselves excluded.

Coverage through micro-insurers often includes primary health care (PHC) or (limited) hospitalisation, which can protect households against catastrophic health expenditure.[29] However, the coverage provided by such schemes is often restricted. The case of India shows that by excluding important services, micro health insurance has had a limited effect in reducing out-of-pocket payments. As with all insurance models, it is important to make a clear distinction between coverage in terms of membership of a scheme and coverage in terms of access to services. Coverage in terms of membership is meaningless if essential services and drugs are unaffordable or are not included in the benefits package.

The spread of micro-insurance schemes contributes to fragmentation of risk pools, with lack of cross-subsidisation between risk pools of richer and poorer members.[30] Micro-insurance threatens the principle of equity and the objective of universal access, especially when schemes exclude people with higher risk profiles (for example, people living with HIV, elderly people), or set higher premiums for high-risk groups. Although micro-insurance has its merits, it also has serious limitations.

Box 2: Fragmentation of risk pools in India

India has experienced growth in micro-insurance schemes since 2000.[31] Private insurance companies are permitted to operate in the Indian market on condition that they also offer insurance to low-income households. Of 14 micro health schemes listed in 2005, nine covered hospitalisation expenses. However, 12 schemes excluded childbirth and pregnancy-related illnesses, and most excluded people living with HIV.

A field study of six health insurance schemes in India indicated that they played a positive role in reducing catastrophic health expenditure in the case of hospitalisation, but had only a limited impact on out-of-pocket expenditure, as hospitalisations represented only 11 per cent of total household expenditure on health.[32]

Community-based health insurance

Community-based health insurance (CBHI) is a not-for-profit mechanism based upon solidarity among a relatively small group of people. CBHI schemes vary a great deal in terms of who they cover, how, for what, and at what cost. The majority of CBHI schemes operate in rural areas, and their members are relatively poor. The best-known examples are the schemes in Africa known as *mutuelles de santé*.[33]

CBHI in West and Central Africa has grown exponentially, from 76 active schemes in 1997 to 199 in 2000 and 366 in 2003. In addition, another 220 schemes in the early stages of development were counted.[34] CBHI schemes in Africa cover almost two million people,

out of an estimated 900 million people[35]; 70 per cent of such schemes have fewer than 30,000 members and 26 per cent have fewer than 3,000 members. Around 64 per cent of health *mutuelles* charge premiums of less than $1 a month.[36]

Because of their small scale, their voluntary nature, and their low premiums, CBHI schemes face severe limitations in terms of financial sustainability and managerial capacity. Managers are often volunteers: this allows administrative costs to be kept relatively low (varying between five per cent and 17 per cent of total fund revenues[37]), but managers often lack the skills and time needed to improve the performance of the scheme.[38]

An important difference between private micro-insurance and CBHI schemes is that the latter are governed by their members. CBHI can thus increase the participation of communities in decision-making and health care policy development, which can enhance the responsiveness of health services. However, there is limited evidence on the extent of empowerment through CBHI.

CBHI premiums are based on the risk profile of the community and not of individual members. This means that there is a greater level of solidarity between people with higher and lower health risks; however, the level of cross-subsidisation between income groups is very limited, as most scheme members tend to be equally poor.

As CBHI can count on only very small contributions from its members, the health services it offers are normally complementary to services provided by governments, which means that the success of such schemes depends largely on the quality of government financing and public care. Several studies have indicated the positive effects of CBHI in terms of access to health care, measured in terms of utilisation rates.[39] However, members of CBHI schemes often continue to depend on out-of-pocket expenditure to cover more than 40 per cent of their health needs.[40]

Due to their small scale and limited coverage, the performance of CBHI schemes in creating effective and equitable health systems is negligible. The threat of financial collapse is real, especially in times of need. Enrolment rates can vary between 0.3 per cent and 90.3 per cent of the target group, but are often low.[41] Very few schemes reach the poorest or most vulnerable groups, unless governments or other actors facilitate membership.[42] An evaluation of Oxfam CBHI schemes in Armenia with (relatively high) average participation rates of 40 per cent reported exclusion of the poorest who could not afford to join the schemes (financial constraints being cited by 79 per cent of non-participants as major reason for not joining). The poorest therefore could not benefit from the subsidy invested in supporting the scheme.[43]

CBHI schemes are often seen as an interim solution to help meet the financial needs of poor people and as a step towards the introduction

of social health insurance (SHI).[44] However, the expectation that CBHI schemes can be upgraded to help create an SHI system is highly optimistic. European countries which have managed to do this have enjoyed strong economic growth that enabled members to pay increasing premium rates, as well as helping to increase tax revenues that enabled high levels of subsidy (50–100 per cent).[45] Moreover, these schemes were only able to develop because of strong political stewardship and the development of appropriate legislative frameworks, another condition not yet satisfied in many poor countries. Even under these circumstances it took countries such as Germany close on 100 years to achieve universal coverage.[46]

Several developing countries, however, have opted to introduce specific regulations with the aim of scaling up CBHI as part of their national health systems. Although coverage in terms of numbers may seem impressive – in Rwanda, for example – it has so far not translated sufficiently into improved access to health care (see Box 3).

Box 3: Scaling up CBHI in Rwanda

CBHI schemes, or *mutuelles de santé*, emerged in Rwanda's health sector as community responses to the reintroduction of user fees in public and mission health facilities, and were supported by health authorities and NGOs.[47]

The number of *mutuelles* increased from six in 1998 to 76 in 2001 and 226 in November 2004. Coverage of low-income groups was possible only after the Ministry of Health began subsidising membership fees for the poorest ten per cent of the population. This measure helped to boost the coverage of *mutuelles* to 70 per cent in 2007, however too many poor people are still excluded.[48] In January 2007, the membership fee for *mutuelles* was set at $1.70 per person, and every household was obliged to register all of its members. When seeking health care, a member must pay ten per cent of the total cost as a co-payment. This amount is still problematic for the poorest families. Twenty per cent of the population remains excluded from health insurance schemes.[49]

Utilisation of services also remains low. In 2005, the utilisation rate was estimated by the Ministry of Health to be 0.45 consultations per person per year which is very low compared with estimated episodes of illness (two to three per person per year). The high level of maternal deaths in Rwanda can partly be attributed to the low utilisation of health facilities for deliveries. Of women surveyed during the Demographic and Health Survey 2005, 71 per cent mentioned lack of money as the main barrier. Other barriers include the low quality of services and distances to facilities, especially in under funded rural areas.[50]

Schemes requiring a contribution of little more than a few US dollars per year remain beyond the reach of the poorest, while at the same time they seem unable to finance attractive health services.[51] Without sufficient funding for the health sector, the burden of financing health care is therefore likely to continue to largely rest with the users.[52]

Social health insurance

Although in theory social health insurance (SHI) has the most potential to achieve universal coverage, in practice this has been difficult to achieve in low-income countries.[53] Among the main distinguishing features of SHI are the facts that membership is mandatory, and that premiums set are in proportion to income. Payment into the system is generally shared by employers, workers, and the government.[54] SHI has the potential to create large risk pools, and to subsidise premiums for poorer members. Schemes of this nature are widespread in OECD countries, Latin America, and Eastern Europe, and also exist in some countries in Africa (Egypt, Senegal) and Asia (Indonesia, the Philippines).[55] Other countries have recently started implementing forms of SHI, or are considering its introduction, among them Cambodia, Ghana, India, Indonesia, Kenya, the Philippines, Tanzania, Viet Nam, and Yemen.[56]

Social insurance schemes require strong institutional capacities, especially for revenue collection.[57] In low- and middle-income countries, where the majority of the population are employed in the informal sector (which in some countries absorbs 80 per cent of the economically active population) and where there are large rural populations, weak administrative capacity, and a lack of government stewardship, SHI is generally not considered a viable option. [58] Even in Latin America, which has higher levels of development than many other regions and where SHI has the longest history in the developing world, coverage is generally limited to public and formal sector workers. Informal sector workers and unemployed people remain disadvantaged. Women in particular risk exclusion as they are employed disproportionately in the informal sector. This exclusion leads to delays in seeking care until it is (nearly) too late, causing death and suffering especially among the poorest and most vulnerable groups – precisely those groups most in need of access to health services.

Having failed to extend SHI to the informal economy, several countries have opted to create a parallel system financed by taxation, with separate facilities operated by health ministries.[59] Such facilities commonly deliver health care that is more limited and of poorer quality than the care offered by facilities accessible to insurance scheme members. Parallel systems of this kind may also result in higher contributions to health care being required from those who can least afford it – either because non-members have to make a co-payment or because they end up paying out-of-pocket.[60] Non-members – who are mostly the poorer members of society – may thus end up subsidising a system that has been developed primarily for scheme members, who are mostly formally employed and better-off. Again it is important to distinguish between membership of SHI schemes and access to health care. A striking example is provided by some social insurance schemes in Latin America (for example,

Honduras), where benefits packages for wives of members are limited to pregnancy and childbirth.

Some schemes, however, have managed to extend coverage to workers in the informal economy. Examples of such schemes are the Seguro Popular de Salud (SPS) in Mexico and the universal coverage (UC) scheme in Thailand (both middle-income countries) (see Box 4), and the National Health Insurance Scheme (NHIS) in Ghana (see Box 5). The National Health Insurance Scheme (NHIS) in Ghana shows how difficult it is to extend coverage to poor households. Reasons for low enrolment rates among the poorest include administrative problems in identifying and registering eligible people, poor people failing to apply for membership, and insufficient transfer of financial resources from the central government to subsidise premiums.[61]

Box 4: Universal access in Thailand

Thailand is a good example of a middle-income country that has managed to provide near-universal coverage to its population. The universal coverage (UC) scheme offers any Thai citizen not affilliated to schemes for formal or public workers full access to health services operated by designated networks of providers. Eligible individuals receive a free insurance card and pay a nominal co-payment of 30 baht ($0.94) for each visit.[62] The scheme combines insurance elements (legal benefit entitlements) and public service elements (general revenue financing). Since 2001 the scheme has covered 46.5 million beneficiaries, or 72 per cent of the population. Of these, 24.3 million are exempted from the co-payment of 30 baht. Together with the country's two other schemes (Social Security Health Insurance Scheme and Civil Servants' Medical Benefits Scheme) health care coverage in Thailand has reached 96 per cent of the population.[63]

Thailand did not achieve near universal coverage overnight. Several decades of investment in rural areas (where the large majority of the population lives) and in primary health care centres preceeded this, as well as experience with insurance schemes and an effective administrative system that was able to register 45 million people for the UC scheme within a very short time.[64]

There are concerns about the financial sustainability of the UC system and about equity with regards to the quality it offers.[65] The financial sustainability of the scheme depends on sufficient allocation of government resources, as well as on the affordability of medicines, which in turn depends on local production or the import of generic drugs.

Efficiency and the cost of reaching poor people

The administrative costs of SHI in Western European countries amount to about five per cent of total fund revenues. Large formal sectors, significant and growing urban populations, and large risk pools have enabled SHI schemes in Europe to be efficient and to guarantee quality of care. In low-income countries, however, the administrative cost of covering large populations of informal workers can be significant. Collection costs for SHI systems are substantial compared with general tax collection (which needs to be collected for

other puposes anyway). For this reason, schemes aiming to extend coverage to the informal sector depend largely on general tax revenues or on specific taxes created to finance the scheme.[66]

Box 5: Extension of SHI in Ghana

Ghana, faced with the problem of underfunding of its health facilities, introduced the National Health Insurance system (NHIS) in 2003. The objective of this scheme was to provide sustainable health financing to ensure accessible, affordable, and good-quality health care, especially for vulnerable and poor people.

By September 2005 the new system was fully operational in 83 of the country's 138 districts. Total membership of the scheme was 2.9 million, equivalent of 14 per cent of the population.[67] By the end of 2006 the scheme's overall coverage was 38 per cent of the population. However, only 19 per cent of informal sector workers had received ID cards and were able to access services through the scheme. The proportion of the poorest people in the NHIS dropped from 30 per cent of those registered in 2005 to 1.8 per cent in 2006.[68] The reason for this fall in numbers is still under investigation, but it is at least partly due to difficulties in identifying and including poor people in the scheme (almost a third of Ghana's population live below the poverty line and the informal sector accounts for about 75 per cent of the total labour force). There have also been difficulties in integrating several existing but fragmented insurance schemes, whose risk pools vary in terms of benefits, membership, and premiums.

The NHIS, which is primarily funded using tax financing, is raising additional funds for the Ghanaian health sector in a reasonably equitable way. However, with only 38 per cent of the population holding valid membership cards the benefits of improved access to health services are being allocated inequitably. If Ghana is to make progress in attaining the health MDGs it will be important to ensure that vulnerable groups are covered by the NHIS at the earliest opportunity.

Especially poorer countries and countries with little institutional capacity in the field of SHI need to carefully consider if, and under which conditions SHI proves a way forward in terms of efficiency, effectiveness and equity, or if other types of funding are more promising in rapidly scaling up access to the poor population. There are countries/regions that have reached a rapid scale up of services through a burst of government intervention, including Botswana, Sri Lanka, and Kerala state in India[69]. Governments and donors alike should consider these examples before betting on models that will take a century to develop.

3 Global solidarity

One observation frequently made of universal coverage is that it cannot be achieved overnight. As this paper has shown, improving access to health care in Low Income Countries through insurance mechanisms is likely to be a lengthy process. The question is, how long can people be expected to wait for the realisation of their rights to health and social security? Countries as well as international donors need to take their responsibilities and ensure that proper investments in health are made in the most equitable, efficient and effective way possible.

Many governments however, still lack polices for achieving universal access or do not have explicit policies on health justice or for reaching the poorest people.[70] Public spending on health is also far below what is needed. By 2006 only about a third of sub-Saharan African countries were allocating ten per cent or more of their national budgets to the health sector, 38 per cent of countries were allocating five to ten per cent, while 29 per cent allocated less than five per cent, despite the Abuja target of 15 per cent spending on health [71].

Rich countries are also far off track with supporting developing countries to improve access to health. At the Gleneagles summit in 2005, G8 leaders promised to support African partners willing to ensure free access to basic health care in order to reduce mortality among those most at risk from dying from preventable causes, particularly women and children. Several countries also set targets to achieve the longstanding objective of spending 0.7 per cent of their gross national income (GNI) on aid to poorer countries by 2015. To date only five countries have reached this goal.[72] The fragmented, uncoordinated, and unpredictable aid currently given to health sectors adds to existing problems.

The whole idea of health insurance is to share health risks and the burden of health care. Predictable and reliable health resources do not need to come from within a single country. Countries and international donors should demonstrate their commitment to international and national risk-sharing that would make health access truly universal and equitable. Urgent increases in predictable national and international resources dedicated to health are needed. This funding can be raised through different mechanisms, particularly tax resources and through sectoral and direct budget support[73]. These resources need to first and foremost address the needs of poor people.

Governments and donors should demonstrate how insurance schemes contribute to equity in health and universal access before investing in those. Without such a focus, the Millennium

Development Goals will not be achieved and the realisation of the right to health will remain a dream for many.

Co-operation around the International Health Partnership (IHP), agreed in 2007, offers a way forward. A number of donors and agencies have signed up to the IHP, which aims to co-ordinate their involvement around national health plans. Such plans, in IHP and other countries, need to include a national coverage plan, and ensure at least a basic level of care to the whole population, equitably and universally, and such plans need to be fully financed.

4 Conclusion and recommendations

Although Insurance schemes can have an important role to play, so far they have been unable to contribute substantially to universal coverage in low-income countries, and millions of people remain excluded from access to health services. There is no evidence so far that any of these mechanisms – PHI, micro health insurance, CBHI, or SHI – have been able to substantially fill financing gaps in the health sectors of low-income countries; provide coverage to poor people; increase risk-sharing and the level of protection offered; and improve quality. We recommend that:

- Insurance schemes have to be considered in relation to the contribution they make towards universal access (including for vulnerable groups), horizontal and vertical equity and efficiency within a country. Governments and donors should ensure that before health financing reforms are undertaken, an impact assessment is carried out of these indicators, in full and transparent consultation with civil society, including representatives of the most vulnerable groups.
- Donors and governments should pay particular attention to the concept of equity, which requires that funding is targeted so that the poorest people and other vulnerable groups see their access to services increased. This will require a significant shift in resources towards rural areas and investment in primary health care.
- Donors and governments should be particularly cautious with regards to private health insurance, which is an inefficient, inequitable, and expensive way of increasing health access, and as such poses a threat to achieving the objectives of universal access and equity.
- In national health plans, whether developed in co-operation with the International Health Partnership or not, governments should set out a timeline towards universal access, and countries and donors should ensure that these plans are fully financed. Donors must acknowledge the existing evidence, or lack thereof, on health insurance mechanisms as a means of financing health care and improving access to services.
- Increasing public resources is necessary to increase coverage of services for poor people and the only proven method of achieving universal access. Governments should increase national budgets for health and work towards improved generation of tax income. Donors should support national budgets by providing budget/sector support to governments.

- Countries wishing to abolish user fees and expand free health care through funding from general revenues should be supported by donors to do so, as this is potentially a more promising and more equitable route to universal access.
- Urgent action is needed to enable people in developing countries to exercise their right to health. People in low-income countries cannot be expected to wait up to 100 years to achieve universal access to health care as their counterparts in the richer world have had to.

Annex 1: Summary of insurance mechanisms

Mechanism	Advantages	Disadvantages
Private health insurance (PHI)	• Increases financial protection and access to quality health services for those able to pay	• Premium based on risk profile of the member • Efficiency is generally related to maximising profits • Big risk of adverse selection and cream skimming • Particularly unequitable unless poor people are subsidised • Coverage usually limited to a small percentage of the population due to premium levels, selection methods, and voluntary nature • High administrative and regulatory costs • Can lead to significant cost increases of health care and can negatively influence services available to poor people
Micro health Insurance	• Targets those with low incomes • Can reach the informal sector	• Big risk of adverse selection and cream skimming due to for-profit nature and voluntary membership • Poorest people may be excluded unless subsidised • Financially vulnerable unless supported by government funding • Often has limited administrative capacity
Community-based health insurance (CBHI)	• Targets the low-income market, not for profit • Can reach the informal sector • Risk premiums are based on the risk profile of the community and not of individual members, which	• The poorest people are excluded unless subsidised • Prone to adverse selection due to voluntary membership • Financially vulnerable unless supported by government funding • Often has limited administrative capacity

	means a higher level of risk-sharing • Has shown some ability to improve access to services for poor people, but not the poorest • Potentially facilitates empowerment of communities	
Social health insurance (SHI)	• Mandatory membership • High level of risk-sharing due to large and varied risk pool • Premiums proportional to income and not profit-oriented • Generates relatively stable revenues	• Poor people are excluded unless subsidised. SHI struggles to identify groups to subsidise and to enroll them, including informal sector workers • Poses a threat to equity when subsidised (poorer) groups receive less comprehensive benefits packages • Complex to manage and low-income countries lack the capacity to do so

Bibliography

Action for Global Health (2007). "Health Warning; Why Europe must act now to rescue the health Millennium Development Goals.

Appiah-Denkyira and Preker (2005) 'Reaching the poor in Ghana with national health insurance – an experience from the districts of the Eastern Region of Ghana', in ILO, GTZ, WHO (2007) *Extending Social Protection in Health, Developing Countries' Experiences, Lessons Learnt and Recommendations*.

Bennet (1997) 'Private Health Care and Public Policy Objectives in Marketizing Education and Health in Developing Countries: Miracle or Mirage?'

Barrientos and Lloyd-Sherlock (2002) 'Older and poorer? Ageing and poverty in the South', *Journal of International Development*, No 14.

Bijlmakers et al. (2006) The Role of User Fees and Health Insurance in Health Care Financing.

Blanchet (2007) 'Health Situation Analysis: Rwanda', Save the Children, January 2007.

Carrin et al. (2005) 'Community-based health insurance in developing countries: a study of its contribution to the performance of heath

financing systems' in *Tropical Medicine and International Health*, Vol. 10, August 2005.

Carrin and James (2005) 'Social health insurance: key factors affecting the transition towards universal coverage', International Social Security Association (2005)/International Social Security Review, Vol. 58, 1/2005, WHO, Geneva.

Coheur et al. (2007) 'Linkages between Statutory Social Security Schemes and Community-Based Social Protection Mechanisms: A New Approach', Technical Commission on Medical Care and Sickness Insurance, ISSA. World Social Security Forum.

Doetichem et al. (2006) 'The Benefits and Challenges of Social Health Insurance for Developing and Transitional Countries,' published with financial support from the Federal Ministry of Economic Cooperation and Development (BMZ), Germany.

J. Jütting and D. Drechsler (2005) 'Private Health Insurance for the Poor in Developing Countries?', OECD Policy Insights No. 11, 2005.

D. Drechsler and J. Jütting (2005): Private Health Insurance in Low and Middle Income Countries: Scope Limitations and Policy Responses.

Dror (2007) Presentation at Microinsurance Conference, Mumbai, 14 November 2007. www.munichre-foundation.org/NR/rdonlyres/DDB44E68-1A01-4BBE-8051-0F40BF5D34D0/0/MIC2007_WG4_Dror.pdf

GTZ (2005) 'Social Health Insurance, A Contribution to the International Development Policy Debate on Universal Systems of Social Protection'.

Homedes and Ugalde (2004) 'Why neoliberal reforms have failed in Latin America', in *Health Policy* No. 71 (2005).

Hsiao and Shaw (2007) 'Social Health Insurance for Developing Nations'. Authors are linked to Harvard University School of Public Health and World Bank Institute.

International Finance Corporation (2007) 'The Business of Health in Africa: Partnering with the Private Sector to Improve People's Lives'.

International Labour Organization (2007) 'Social Health Protection: An ILO Strategy towards Universal Access to Health Care'.

ILO (2005) 'Insurance Products Provided by Insurance Companies to the Disadvantaged Groups in India', working paper.

Kumaranayake and Lilani (1998) 'Effective Regulation of Private Sector Health Service Providers', Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, London.

La Concertation (2004) 'Inventaire des mutuelles de santé en Afrique, Synthèse des travaux de recherche dans 11 pays'.

Leal (2008) 'El IMSS bajo el Foxismo', in *Imagen Médica*, February 2008.

Lethbridge, J. (2002) 'Forces and Reactions in Healthcare', PSIRU, December 2002.

Meessen, B. (2006) 'Reviewing institutions of rural health centres: the performance initiative in Butare, Rwanda.', in Tropical Medicine and International Health, august 2006.

Ministry of Health Ghana (2007) 'Health Sector 5 Year Programme of Work 2002 – 2006'; Independent Review of POW-2006

NCBA (2007) Literature Review for the West Africa Health Cooperative Project (NCBA is supported by USAID).

NCHC (2007) Health Insurance Cost, Facts on the Cost of Health Care

Ooms and Melody (2006) 'Do we Need a World Health Insurance to Realise the Right to Health?'

Oxfam International (2006) 'In the Public Interest: Health, Education, and Water and Sanitation for All'.

PAHO/WHO (2001) 'Genero y sistema ISAPRE'.

Pathe Diop and Damascene Butera (2005) 'Community-based health insurance in Rwanda', *Development Outreach*, May 2005.

Poletti et al. (2007) 'Options for Scaling Up Community Based Health Insurance for Rural Communities in Armenia',

Health Systems Development Programme, London School of Hygiene and Tropical Medicine, Oxfam, and HSD.

Reuters (2008) US doctors support universal health care – survey, March 31, 2008

Roth and McCord (2007) 'The Landscape of Microinsurance in the World's 100 Poorest Countries'.

Rusa and Fritsche (2007) 'Rwanda: Performance-Based Financing in Health'. *In The Sourcebook on Emerging Good Practice, second edition may 2007.*

Sakunphanit (2007) 'Universal Coverage for Health Care: From Policy to Implementation'.

Schneider and Hanson (2006) 'The impact of micro health insurance on Rwandan health centre cost'

Social Watch Report 2007: In Dignity and Rights, Making the Universal Right to Social Security a Reality.

Scott (2007) 'Seguro Popular Incidence Analysis'.

SPS (2008) Seguro Popular Salud; Statistics: www.ssa-sin.gob.mx/SEGUROPOPULAR

Towse et al. (2004) 'Learning from Thailand's health reforms' in British Medical Journal, January 2004.

UNDP (2005) Human Development Report

United Nations Research Institute for Social Development (2007) 'Commercialization and Globalization of Health Care: Lessons Learned from UNRISD Research,' Research and Policy Brief 7.

Waelkens et al., ILO-STEP (2005) 'The Role of Social Health Protection in Reducing Poverty: The Case of Africa'.

Wagstaff (2007) 'Social Health Insurance Reexamined', Development Research Group, World Bank.

WHO (1948) Constitution of the World Health Organization, 1948.

WHO (2000) World Health Report 2000: Health Systems; Improving Performance

WHO (2003) 'Community-Based Health Insurance Schemes in Developing Countries: Facts, Problems and Perspectives'.

WHO (2005) 'Social Health Insurance, Selected Case Studies from Asia and the Pacific.

WHO (2005) 'Achieving Universal Health Coverage: Developing the Health Financing System', Technical Brief for Policy-Makers, Number 1.

World Bank (2007) 'Healthy Development, The World Bank Strategy for HNP Results'

Notes

[1] UNCTAD website and ILO (2007). The Declaration of Alma-Ata was adopted at the International Conference on Primary Healthcare, held in September 1978. The declaration confirmed health as a fundamental human right, and in particular urged governments to launch and sustain primary health care as a core element of comprehensive national health systems. It also expressed the belief that an acceptable level of health care for everyone in the world could be attained by 2000 through fuller and better use of the world's resources.

[2] Relevant rights include the Universal Declaration of Human Rights (1948), Articles 22 and 25 (1), the International Covenant on Economic, Social and Cultural Rights (1966), Articles 9 and 11 (1), and the Convention on the Rights of the Child (1989), Articles 26 (1) and 27 (1 and 3).

[3] A 2004 study showed that in sub-Saharan Africa, only 32 per cent of children on average in the poorest quintile had been fully vaccinated, compared with 62 per cent in the richest quintile. D. Carr (2004) 'Improving the health of the world's poorest people', *Health Bulletin* 1, Washington, DC: Population Reference Bureau.

[4] Oxfam International (2006).

[5] ILO (2007).

[6] This calculation is based on the percentage of births assisted by skilled health personnel, mortality among children under five, and the percentage of children in first grade who reach the fifth grade. *Social Watch Report* (2007).

[7] This underfunding continues, despite numerous commitments made by governments and donors – for instance, the Abuja Declaration adopted by African heads of state in 2001, which included a commitment to allocate at least 15 per cent of their national budgets to health care. See also the Paris Declaration on Aid Effectiveness and the G8 commitments. The next High-Level Forum on Aid Effectiveness will take place in Accra in September 2008. Health is one of the tracer sectors in which donors will be assessed on the implementation of the Paris principles.

[8] Bijlmakers et al. (2006). Even the World Bank stated in its 2007 HNP strategy (World Bank, 2007, § 105) that 'upon client-country demand, the Bank stands ready to support countries that want to remove user fees from public facilities'.

[9] WHA58.33 Resolution on Sustainable Health Financing, Universal Coverage and Social Health Insurance', which was adopted at the World Health Assembly in 2005, called for member states to ensure that health financing systems include a method for pre-payment of financial contributions for health care. Other important moments on health insurance and/or social health protection were the Berlin conference and recommendations for action (2005); the Paris conference on health coverage in developing countries (2007); and the presentation of the Providing for Health Initiative at the G8 in 2007. Also in 2007, the EU and Africa agreed the Africa–EU Strategic Partnership action plan, in which they pledged to work towards building social health protection systems and strengthening district and national health systems, including the elimination of fees for basic health care.

[10] The ILO strongly advocates a rights-based approach to social health protection, with particular attention to sections of the population who are currently not covered: 'All options of financing mechanisms should be considered if they contribute to universal coverage and equal access' (ILO, 2007). The International Finance Corporation, the private-sector finance arm of the World Bank, advocated in its 2007 private-sector strategy that public and donor funds should be channelled through the private health sector, including private insurance schemes. Donor countries such as Germany, France, and the Netherlands have also shown increasing interest in health insurance. For instance, in 2006 the Dutch Ministry of Development Cooperation approved a €100m grant to subsidise private insurance coverage for lower-income groups. However, neither the Netherlands nor France have defined a clear policy on health financing.

[11] In some cases the consideration seems to be that a shortage of resources justifies inequitable packages of benefits, such as lower levels of access for poor people, by first concentrating on expanding coverage to the population that is able to contribute, such as formal sector workers and those who are better off.

[12] www.who.int/hhr/activities/Report%20indicatorsmtg04%20FINAL.pdf

[13] WHO (2000).

[14] Based on WHO country statistics (2001).

[15] As indicated in the IFC strategy 'The Business of Health in Africa: Partnering with the Private Sector to Improve People's Lives', and also by the Netherlands' funding of the Health Insurance Fund in Nigeria; see, for instance, Jütting and Drechsler (2005).

[16] Jütting and Drechsler (2005). The countries with PHI coverage levels of 20 per cent or above are Uruguay, Colombia, Brazil, Chile, Thailand, Namibia and South Africa.

[17] See for instance the data listed by NCHC, 2007.

[18] UNDP, Human Development Report (2005) in Oxfam International (2006)

[19] Reuters, 2008.

[20] See, for instance, Jütting and Drechsler (2005) and Barrientos and Sherlock (2002).

[21] Jütting and Drechsler (2005).

[22] Homedes and Ugalde (2004) argue that the main beneficiaries of neoliberal reform include transnational corporations, health maintenance organisations, consultancy firms, and World Bank staff. UNRISD has warned that inclusive health policies are particularly likely to require strong constraints on private health insurers (UNRISD, 2007).

[23] In Egypt, the National Committee in Defence of People's Right to Health, consisting of 50 different civil society organisations and political parties, is currently fighting a legal and civil battle to stop a proposed reform to privatise the health insurance system that is being supported and financed mainly by the WB, EU and USAID.

[24] PAHO/WHO (2001).

[25] Lethbridge (2002) in Oxfam International (2006).

[26] Jütting and Drechsler (2005).

[27] Kumaranayake and Lilani (1998).

[28] Mahal, in Jütting and Drechsler (2005).

[29] Roth and McCord (2007[0]).

[30] Fragmentation of risk pools is a common phenomenon in most low- and middle-income countries. The term refers to a situation where multiple public and private insurance options are present: this limits pool sizes, increases administrative costs, and creates equity and risk selection problems – for instance, when high-income and low-income groups and high-risk and low-risk populations each have their own risk pool. As the case of Ghana shows, countries wishing to achieve universal coverage (through SHI, for instance) face serious challenges when trying to integrate these fragmented pools into a single system.

[31] Ibid.

[32] Dror (2007).

[33] Examples of CBHI in Central Asia include the Revolving Drug Fund Schemes in Armenia, Azerbaijan, and Georgia.

[34] Waelkens et al. (2005).

[35] World Population Prospects: The 2006 Revision, United Nations Population Division. Population Medium variant for 2005: 922 011 000

[36] La Concertation (2004).

[37] WHO (2003).

[38] By comparison, the administrative costs of West European health insurance funds amount to approximately five per cent of fund revenue.

[39] WHO (2003) and Dror (2007). Some authors suggest, however, that high utilisation rates can also reflect the high level of adverse selection in voluntary health insurance.

[40] Waelkens (2005) and Carrin et al. (2005).

[41] Carrin et al. (2005).

[42] Ibid; NCBA (2007).

[43] Poletti et al. (2007)

[44] WHO, 2005 (technical brief)

[45] Poletti et al. (2007), with reference to health funds in Germany, the Netherlands, France, and Japan.

[46] Poletti et al. (2007), Coheur et al. (2007); Waelkens et al. (2005); Wagstaff (2007).

[47] Pathe Diop and Damascene Butera (2005).

[48] Rusa and Fritsche (2007).

[49] Blanchet (2007).

[50] 'Child Rights Situation Analysis – Mutuelle Burera District', presentation by Save the Children, October 2007.

[51] Schneider and Hanson (2006).

[52] See for instance Meessen (2006).

[53] GTZ (2005); Doetichem et al. (2006).

[54] There are exceptions: in some countries (for example, Mexico), SHI is voluntary, while in other countries (the Netherlands) premiums are not related to income, or are paid mainly by the government out of tax revenues (Ghana).

[55] Of the 30 members of the OECD, 15 have a system funded predominantly from contributions that are pooled in social health insurance funds.

[56] Doetinchem et al. (2006).

[57] Carrin and James (2005).

[58] See, for instance, Hsiao and Shaw (2007) and Wagstaff (2007).

[59] Wagstaff (2007).

[60] Ibid.

[61] ILO, GTZ, WHO (2007). Protection of poor people through exemption mechanisms is expensive and inefficient. See, for instance, WHO (2005).

[62] ILO (2007).

[63] Sakunphanit (2007).

[64] Towse et al. (2004)

[65] 'CL vital so long as healthcare lacks funds', *Bangkok Post*, 2 April 2008.

[66] Wagstaff (2007).

[67] Appiah-Denkyira and Preker (2005).

[68] Ministry of Health, Ghana (2007).

[69] Oxfam (2006)

[70] WHO (2000).

[71] Action for Global Health (2007). The Abuja Declaration, adopted by African heads of state in 2001, stipulates that governments should allocate at least 15 per cent of their national budgets towards health.

[72] Those five countries are Sweden, Norway, Luxembourg, Netherlands, and Denmark. France, Germany, and the United States have achieved only 0.39 per cent, 0.37 per cent and 0.16 per cent respectively of spending on aid as a percentage of GNI (OECD data for 2007).

[73] Supported by clear indicators to monitor spending and civil society scrutiny and consistent implementation of policies (Action for Global Health (2007)).

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