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# Microinsurance NOTE 6

## Health Microinsurance

*Of all the insurance products that could benefit low-income families, health insurance is the most obviously beneficial and yet quite likely the most difficult to deliver. Excluding one large scheme in China, identified coverage is a dismal 10.2 million low-income people across the 100 poorest countries. Affordable access to quality healthcare services through a dependable pre-paid financing mechanism is extremely desirable. Health microinsurance offers the promise of helping communities pay for quality healthcare by optimally pooling their own limited resources.*

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When Mary Anyango contracted typhoid in Kisumu Kenya, her family simply took her to her home village to die. Across Lake Victoria in Kampala Uganda, when Betty Waswa was bleeding to death after the birth of a child, she was taken to a top level hospital where she was treated and released in good condition to return home. Why the difference for these two, who both lived on about USD 2 per day? Health microinsurance. While Mary has passed, Betty insists that she would have died if it had not been for her health microinsurance policy.<sup>1</sup>

Of all the insurance products that could benefit low income families, health insurance is the most obviously beneficial and yet quite likely the most difficult to deliver. For low income people, the decision to seek healthcare is often primarily guided by financial considerations. Thus there is a tendency to delay seeking proper medical attention in the hope that things will get better by themselves. Next is a tendency to seek cure through a progression of low, but increasing, cost options. These options include self medication with whatever is readily available from within the household. When that is ineffective low-income people turn to over the counter purchases from local shops or drug stores. Then they may resort to traditional healers or visits to low quality, local health service providers that do not necessitate expenditure on transport.

In low-income communities the disease burden is dominated by infections. These include malaria, respiratory infections (including TB), gastro-intestinal infections (including worms and acute diarrhea), sexually transmitted diseases (STDs), and

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<sup>1</sup> From an editorial by Michael J. McCord published in *Entwicklung und Ländlicher Raum*, May 2007. Names have been changed for privacy purposes.

HIV/AIDS with its associated opportunistic infections. Particularly in children and those of marginal nutritional status the unfortunate tendency is for infections to get worse rather than better without appropriate treatment. Consequently, inappropriate or inadequate initial treatment often leads to disease progression and general deterioration. This inevitably results in requiring more aggressive and more expensive medical treatment than would have been needed if the disease had been appropriately treated when symptoms first appear.

Given the above background, affordable access to quality healthcare services through a dependable pre-paid financing mechanism is extremely desirable. Health microinsurance offers the promise of helping communities pay for quality healthcare by optimally pooling their own limited resources.

Understanding health microinsurance can be challenging. However, by addressing a few key characteristics such as who is covered, who takes on the insurance risk, and what is covered, this will help to clarify some of the key considerations in implementing successful health microinsurance programs.

## WHO IS COVERED IN HEALTH MICROINSURANCE?

There are two levels of the market for health microinsurance:

**1. The target group:** As a general rule health microinsurance schemes deal with groups rather than individuals. This is in order to control against adverse selection, and provide an efficient mechanism of premium collection and scheme handling. Typically schemes will cover members of a group (for example, MFI clients, traditional societies, women's groups or co-operative members). Since it is important to use pre-existent groups who have come together for a purpose other than just to access health insurance, there should be a mechanism of verifying that group members are genuine, with a historical membership list and established group governance.

**2. The household:** Commonly households of the primary members of the group are also covered. This again helps to control against adverse selection while expanding the risk pool. Adequate mechanisms of social control are still exercised to guarantee that family members are genuine. To avoid overuse by high risk individuals, schemes should have clear definitions of family membership; for example only spouse and dependent children of the primary member being covered. Others, for example aged parents, may not be desired in the scheme because of the impact they would have on increasing the premium.

## WHO CARRIES THE RISK OF HEALTH MICROINSURANCE?

Insurance is ultimately about the pooling and management of risk. Typically risk can be carried by one of three parties:

**1. The Community:** In community based health microinsurance schemes, the community pools money and manages this fund to pay for health services provided to the community members by one or more health service providers. Typical examples of such schemes are the community health insurance schemes supported by International Labor Organization under the [STEP](#) program, most widespread in West Africa. These schemes have the benefit of group ownership and therefore social control of abuse, since members are accountable to the group. Additionally, they are thought to reach down potentially to very poor people. However, without some external re-insurance support such schemes are ill prepared to deal with any catastrophic event (e.g. epidemic) that would affect a high proportion of members. It is also difficult for such groups to govern the program, assess risks, set realistic premiums, manage funds, build up and maintain adequate reserves, and control against member and manager fraud. A fundamental difficulty with such programs is that insurance demands numbers and as these programs scale up their local management is less able to manage. There are

a number of initiatives that attempt to meet these limitations through external technical assistance and re-insurance support, such as Social Re.

## **2. The Health Service**

**Provider:** In several areas, health care providers have recognized the need to create structures that assist potential patients with financial solutions to their health care needs. Typical examples of provider based schemes are those run by private non-profit ‘mission’ hospitals in East Africa. In these cases, the hospital collects premiums from the local community and provides services for an agreed coverage period to these members. Often, hospitals enter into such schemes in the hope of improving their cost recovery and reducing the burden of unpaid medical bills from the community. Since these hospitals are closely integrated into the local community or church networks there is some blurring of definition and these schemes may view themselves as ‘Community Schemes’. However the reality is that whenever the funds collected are inadequate to meet the medical expenses for the period of coverage, it is the medical service provider that ends up absorbing the losses. Such schemes often have more professional management capacity than community schemes and are more able to access technical and donor support including sources of “reserves”. Various methods of

community representation in the scheme governance can help to ensure community needs are met.

## **3. A Regulated Insurer:**

Given that health microinsurance may be the most challenging insurance to provide the low-income market, a regulated insurer may be the most well placed organization to handle the technical insurance issues of such a product. In this model, a regulated insurer manages the scheme and carries the risk, acting as one intermediary between one or more community groups and one or more health service providers. An example of such an insurer is Microcare Health Ltd, a Uganda based organization that started out as a non-profit research group working with MFI’s and traditional burial societies but has evolved into a successful licensed insurance company servicing low-income people through both community and commercial client groups with health, accident, and burial insurance. Such insurers need to be reliable and have the trust of both the community and the health service provider in order to be successful. If the community fears that the insurer will run off with their money or the hospital fears that they will not get paid, then the scheme will not be successful. It takes time to build such confidence with these key stakeholders and establish a critical mass of business.

**Reinsurance:** Any of the above three risk carriers will

benefit from the additional financial security of reinsurance. Reinsurance is where an external larger ‘insurer’ comes in to relieve the primary insurer of some of the risk burden in exchange for an agreed premium and, usually, a direct input into the design and pricing of the product. In the case of donor-supported initiatives the re-insurance premium may be negligible.

## **WHAT DOES HEALTH MICROINSURANCE COVER?**

Microinsurance schemes provide various levels of coverage by design, to meet the needs and payment capacity of the policyholder, as well as the management capacity of the provider.

### **Hospitalization only:**

Insurance, by its nature is best suited to deal with relatively high cost unpredictable events. Such events would typically require admission to hospital as an inpatient. Thus, most health insurance packages will cover hospitalization services to a greater or lesser extent. Within the general category of hospitalization insurance there can be substantial variations ranging from very limited coverage, for example emergency surgery only, to all causes of admission including surgical, medical and maternity services.

## **Hospitalization and outpatient**

**(comprehensive):** It is desirable to cover outpatient services, so that deterioration in condition is effectively prevented early on in the disease progression. Many issues, and especially the infections discussed above, can be easily and inexpensively cured early in the disease cycle if someone does not have to wait to be hospitalized, and can go to a clinic immediately upon symptom onset. This inevitably requires a much higher premium than inpatient only coverage if the scheme is to be self-financing. In several comprehensive programs, outpatient costs are about 70% of the total claims costs. To market such a scheme is initially difficult due to the cost. Some health microinsurers, like [Cruz Salud](#), offer a range of products from a basic to fully comprehensive cover.

**Chronic illnesses:** Inclusion of chronic illness (for example, diabetes, hypertension, asthma, and epilepsy) will inevitably cause a substantial increase in cost, even without adverse self-selection of members. If adverse selection control is weak this cost increase can be massive. Many schemes therefore exclude coverage of chronic illness. For new schemes it is advisable to exclude coverage of chronic illnesses until controls are well established.

**HIV/AIDS:** Particularly in Sub-Saharan Africa HIV/AIDS is a challenge for schemes. Exclusion of HIV is often difficult from

ethical, legal, and practical viewpoints. Certain insurers (e.g. Microcare in Uganda) have been able to include coverage of first line anti-retroviral drugs in community schemes. However this may not be feasible in other countries with higher incidence of HIV (for example in Southern Africa) or where treatment is more expensive.

### **Limited outpatient/ community health services:**

Some schemes with very low premiums operate with very restricted locally available services only. While such schemes can have easy uptake due to their affordability, the limited benefits can be self-defeating, since diseases can be identified but the scheme lacks the resources to properly treat them. [GRET's health insurance program](#) in Cambodia restricts its policy as a means of providing at least some coverage under the low-premiums its policyholders are able to pay.

### **Preventive health services:**

It is in the financial interest of the insurer to integrate prevention into product design. Examples of viable preventive interventions include the distribution of insecticide treated bed nets to prevent malaria and education on HIV prevention, safe motherhood, clean water and sanitation. These interventions have the added advantage of providing clients with definite tangible benefits within what is otherwise an intangible product. Preventive health care methods were used within the [K-Rep Development Agency/AAR](#)

[Health Services](#) program in Kenya.

## **HOW IS HEALTH MICROINSURANCE FINANCED?**

Health microinsurance is typically funded from policyholder premiums. Donor support is also an important aspect of funding with health microinsurance. In some countries, such as India, government subsidies have been considered important for microinsurance expansion. Also within the structure of the product itself, some health microinsurers will include co-payments.

**Premiums:** Insurance by definition requires the payment of a premium in exchange for the promise of a defined package of services for a set period of time. Generally speaking short periods of coverage (less than 1 year) create difficulties of administration and leave the scheme open to seasonal adverse selection (people join up for the malaria season, for example). However one year premiums can be hard for people to afford in a single payment. Sometimes a third party gets involved in the premium financing, such as K-Rep did with loans in the example above, or could be provided through a special savings mechanism.

**Donor support:** In donor funded schemes, there will usually be an element of scheme

subsidy to complement external technical support. There can be a wide range of donor subsidized interventions including:

- Paying for the administration costs of the scheme for a limited period
- Creating a 're-insurance fund' that covers excessive losses of the scheme
- Targeted subsidy for needy groups (e.g. orphans/widows)
- General subsidy of a percentage of premium for all members
- A combination of the above.

DfID's Financial Deepening Challenge Fund managed by Enterplan has been an important donor in the development of health microinsurance in [Kenya](#) and [Uganda](#).

In their enthusiasm to get schemes up to scale, there is a temptation for scheme managers and donors to take the easy route of heavily subsidizing schemes. This has two negative consequences. First it makes it difficult for the donor to have an effective exit strategy since the scheme will collapse once the donor money stops. Secondly it sets a bad precedent, undermining the market for other better disciplined schemes. Donor interventions should always be carefully planned to limit such distortions, and should also come with an exit strategy that leaves a healthy microinsurer.

### **Government subsidies:**

Government subsidies to microinsurance have been common in India since at least 1991 when the government provided subsidies to the Life Insurance Company (LIC) and SEWA to cover one-third of the premium costs of [SEWA's](#) life coverage. Crop insurance has commonly been subsidized by governments. These subsidies carry the same potential problems as donor subsidies. Many argue that especially with health microinsurance where premiums are relatively high and, it is argued, even the wealthy are subsidized in various ways, that subsidies for health microinsurance are appropriate. Indeed it is conceivable that such subsidies could be a cost effective means of improving public health and productivity in developing countries. However, such subsidies would require great care, and history has shown limited success with subsidies for insurance. One must only look at the failure of crop insurance around the globe for a stark example.

**Co-payments:** In addition to paying premiums, clients may be required to pay a fee per visit to the health facility. This co-payment should act as a gatekeeper mechanism to dissuade clients from frivolous over utilization of services. It also makes some contribution towards scheme income. It is important to set the level of this fee low enough to not dissuade genuine cases from seeking early attention.

## **THE IMPORTANCE OF SOUND MANAGEMENT AND CONTROLS**

Without adequate control systems and management capacity, health insurance schemes tend to go badly wrong! Capacity is needed to manage three key components: Data, Money and Risk.

**1. Data:** Because of the volume and variety of information that must be tracked in health microinsurance, it is important for any significant health microinsurance program to operate with computerized systems. It is not likely that anything beyond a very basic product could be adequately managed without such a system. The data that is managed includes membership profiles, premium payment details, claims information, and information for performance monitoring.

- **Membership Profile:** Unique identification of members is necessary whether using family or individual photos with members having some form of identity number/code, preferably some form of client identification card. Particularly if multiple service providers are being used this system needs to be robust.
- **Premium payment:** It is essential to know that the member is current on paying their premium and, if there are a variety of scheme options, what

coverage they are eligible for.

- **Claims information:** Claims information needs to be captured on a claim form and preferably signed by the member and the provider. This data needs to be accurate and of adequate detail.
- **Monitoring performance** is a primary means of understanding the results of the health microinsurance product and activities. Data on, among other things, claims ratios, premium and policyholder growth, administrative cost ratios are all fundamental to understanding the success of the health microinsurance activities.

**2. Money:** In view of the importance of trust in insurance it is essential that money is handled with transparency, accountability and integrity. Appropriate procedures and systems are therefore essential and Independent external supervision/audit is desirable. Staff needs to be both reliable people of integrity and have adequate training and professional capacity to do their jobs properly. It is also important that data on collections, outstanding debts owed and expenditure be kept up to date. It is particularly important to recognize the problem of Incurred but Not Reported losses (IBNR). These are claims that have not yet come through the system. If a scheme starts falling behind in

receiving, processing and paying claims it can become insolvent easily.

**3. Risk:** Ultimately insurance is about managing risk. In insurance schemes it is important that adequate actuarial input and oversight is provided. This will assist in the design and implementation of any product and premium structures, as well as reinsurance. It is also important that the scheme management have a sound understanding of risk management, adverse selection prevention control and containment of abuse.

## WHAT IS HAPPENING WITH HEALTH MICROINSURANCE?

A recent [microinsurance landscape study](#) conducted by the MicroInsurance Centre showed that health care, and especially hospitalization, was the clear request from most available demand studies. The study identified almost 38.5 million people covered by some health microinsurance. Most of that coverage, as seen in Table 1, is from primary out-patient care. Of the 31.8 million covered by primary products, 28.3 million come from a single scheme, the All China Federation of Trade Unions, with very basic coverage. Excluding this large scheme, identified coverage is a dismal 10.2 million low-income people across the 100 poorest countries.

Development and expansion of health microinsurance is relatively slow because of four core issues.

1. Insurers have had very little interest in health microinsurance. In fact, in developing countries, they hardly offer health insurance to the wealthier markets. Health insurance is much more complex, and even when done well does not offer the same levels of profit that insurers are currently enjoying from such products as credit life microinsurance. Additionally, insurers are not being effectively pushed by MFIs or others to offer health microinsurance products. A combination of little interest and limited demand side push leads to hardly any health microinsurance. MFIs and others in [Bangladesh](#) have been particularly good at pushing insurers in this direction.
2. Accessibility to health care services, both in terms of proximity and quality are critical hindrances to health microinsurance expansion. People must be able to get to the facility without excessive costs. Additionally, the lack of quality health care facilities is a clear hindrance to health microinsurance expansion. Without the ability to get reasonably easy access to good facilities to obtain care, people will not

purchase health microinsurance.

3. The lack of risk data for the low-income market makes it much more difficult to properly price health microinsurance products. This is a disincentive to insurers, and even when they are willing to offer such products, the premiums are significantly inflated in order to protect the insurers from the unknown. These higher premiums make the products more difficult to sell to the low-income market, further disincentivising the insurer.
4. Product quality in health microinsurance has also been a problem. Products that are too restrictive, or do not respond to client needs, have limited appeal to this market. For example, in many areas organizations offer reimbursement coverage. This requires that a policyholder must first generate the funds to cover

**TABLE I: HEALTH MICROINSURANCE VOLUMES BY SUB-TYPE**

| Product sub-type  | Number of Products | Covered Lives     |
|-------------------|--------------------|-------------------|
| Comprehensive     | 38                 | 786,342           |
| Health (Other)    | 8                  | 1,797,861         |
| Hospitalization   | 66                 | 3,343,752         |
| Outpatient        | 79                 | 31,778,723        |
| Targeted Benefits | 40                 | 789,634           |
| <b>Total</b>      | <b>231</b>         | <b>38,496,312</b> |

their care, facing all the risks and delays of someone who does not have insurance. Indemnity cover allows people to obtain care without generating the funds. Though it is clearly more complex to manage, if the goal is better care for low-income people, indemnity cover will be a key component.

It is too late for Mary Anyango. But with a greater understanding of the key considerations of health microinsurance, coupled with addressing key hurdles mentioned above, and action to implement quality health microinsurance programs, maybe her children will have access to quality health microinsurance products.

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