



An introduction to Health Insurance for Low Income Countries

Catherine P Conn

Veronica Walford

The Health Systems Resource Centre is managed for the UK Department for International Development by the Institute for Health Sector Development

Contents

1. What is health insurance?
2. Types of health insurance and comparison with other funding mechanisms
3. Why consider health insurance?
4. Issues in deciding whether social insurance is appropriate
5. Design of health insurance – some lessons
6. Conclusions

References

Copyright © 1998 by IHSD Limited. London, except where otherwise indicated.

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means without the written permission of IHSD Limited.

An Introduction to Health Insurance for Low Income Countries

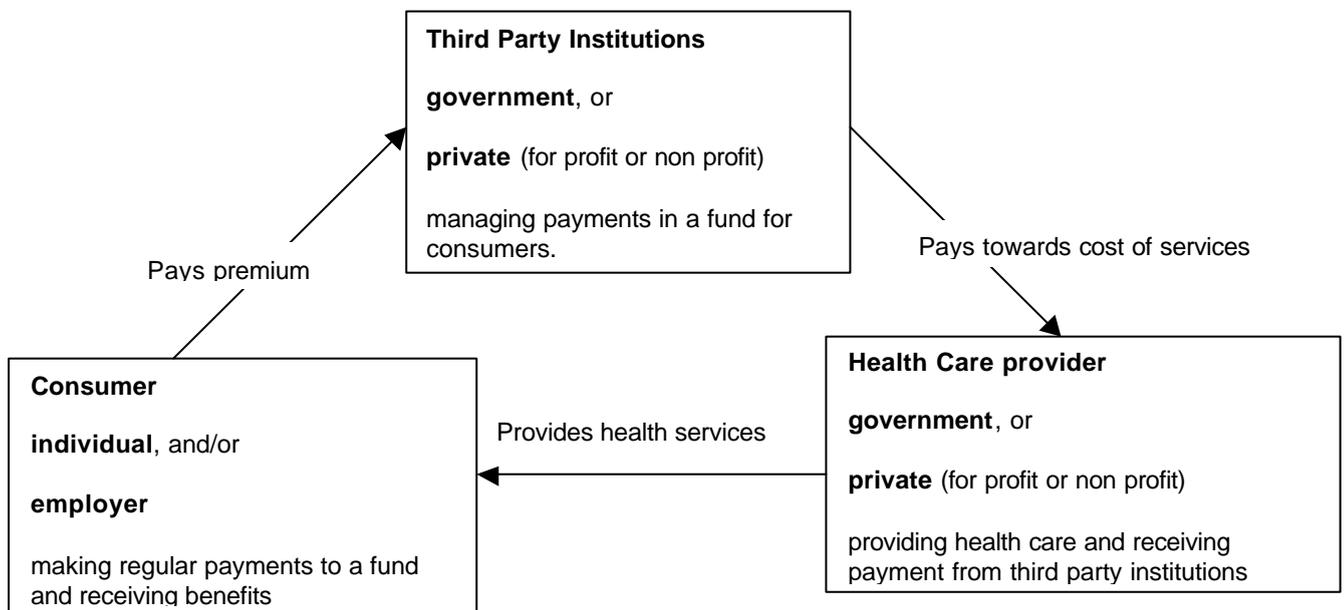
This is a brief introductory guide to health insurance. It is written primarily for people thinking about introducing health insurance, including senior staff of Ministries of Health and in development agencies. The purpose of the guide is to explain the concepts and terms used in health insurance and to identify key issues for those considering its introduction as a means of financing health care.

The guide starts by introducing basic insurance terms and principles (**section 1**) and compares it with other funding mechanisms (**section 2**). The guide goes on to identify the advantages and the possible problems and drawbacks (**section 3**). **Section 4** focuses on social insurance – a type of health insurance set up by the Government which offers specified services to those who contribute, typically those in employment. The section identifies the key issues in deciding whether or not to proceed with social insurance. **Section 5** briefly reflects on some lessons for the design of health insurance and **Section 6** gives conclusions.

1. What is Health Insurance?

- 1.1 Health insurance is a way of paying for some or all of the costs of health care. It protects insured persons from paying high treatment costs in the event of sickness
- 1.2 The basic health insurance process is as follows: a **consumer** makes a regular payment to a **managing institution**. This institution is responsible for holding the payments in a fund and paying a **health care provider** for the cost of the consumer's care.
- 1.3 This process seems straightforward. There are three main groups involved: consumers; managing institutions (usually described as third party institutions – see figure 2); and health care providers. The outcome of the process is that the costs of an individual consumers' health care needs are met.

Figure 1 The health insurance process



- 1.4 Yet when looking at actual country examples of health insurance funds, a more complex picture emerges. There are various players at each stage of the process – individuals and institutions, governmental and private. Insurance funds are managed by different types of third party institutions. In some systems the managing organisation may also own or manage the service provider. There are variations in the range of care provided under insurance – it may be limited to treatment for serious illness only, or include routine treatments and preventive care, leading to different outcomes. Figure 1 (above) summarises the process.
- 1.5 Before discussing health insurance for low income countries, it helps to define some basic principles and terms. **Figure 2** does this using car insurance as an example

- 1.6 To summarise **figure 2**, the main principle of insurance is sharing risk as an advantageous way of meeting high and unpredictable costs. However, this principle may be undermined by the way consumers and providers behave in response to shared risk.
- 1.7 The same principle and concepts apply to health insurance as to car insurance, but the case of health insurance is more likely to experience problems because:
- moral hazard and cost escalation are particular problems, as patients are not able to identify what treatment they really need;
 - the risk of adverse selection means that insurers want to exclude high risk cases or charge them higher premiums, yet for social policy reasons, governments want all their population to have access to health care.
- 1.8 These factors have led to governments taking an active role in the health insurance sector, through regulating the private sector and/or developing social insurance schemes.

2. Types of Health Insurance and Comparison with Other Funding Mechanisms

2.1 Categorising health insurance is made difficult because there are several different models of insurance, and because insurance can share a number of features with other kinds of health funding. The main features are:

- whether risk is shared or not;
- whether health care benefits are specified (often with proof of payment required for use of specified providers);
- whether funding is managed by profit-making or non-profit making (government or non-government) institutions;
- how the premium paid by individuals is calculated – whether on a ‘progressive’ basis (so that richer members pay more as a proportion of their income than the poor), or based on an individual’s risk status and the benefits chosen;
- whether membership is voluntary or compulsory.

2.2 As **figure 3** illustrates, health insurance differs from other types of health funding because it features risk-sharing and specific benefits for members in return for payments. Entitlement requires proof of payment.

2.3 **Figure 3** also shows that funding health services from general taxation shares many of the characteristics of health insurance, particularly compulsory social insurance.

2.4 **Figure 4** and **figure 5** give a more detailed definition for each category of health insurance and non-insurance funding.

2.5 In practice, many countries have a mix of categories of health insurance, often in combination with other forms of health funding. Whilst models from other countries provide useful lessons, a Ministry of Health will need to assess the suitability of a model and design its own system of health insurance.

2.6 **Figure 3** describes the relationship between these features and different categories of health funding commonly found in developing countries.

Figure 2 Principles and terms used in insurance – illustrated by car insurance

Risk

A car accident is a rare and unpredictable occurrence. When it occurs repair or replacement is very costly for the car owner. If large number of car owners pay small, regular amounts into a fund, this fund can be used to meet the high cost of such rare accidents (or 'catastrophe'). Thus, the individual experiencing an accident does not bear the full burden of the cost. Instead it is shared. Sharing or 'pooling' of risk is the fundamental reason for insurance.

Member

The term used to describe the consumer joining the insurance fund

Third Party Insurance

The first party (insured member) does not pay directly for the activities of the second party (in the car example this is the repairers). Payment is through the institution responsible for managing the fund, known as the third party.

Cover/Provision/Benefit/Entitlement

The terms used to describe what the member can receive from the insurance fund. For example, the car insurance member is often covered for 'accident, fire and theft' subject to certain conditions (such as paying the first \$50 of a repair or replacement – see 'Deductibles' below).

Adverse Selection

If a high proportion of people with a high risk of catastrophe join an insurance fund then 'adverse selection' can result. If, for example, a large number of high-risk young men take up car insurance – relative to the number of low-risk members, say middle-aged women – this would be adverse selection. Young male car owners are a high risk as they are more likely to have accidents.

Adverse selection will mean more claims and expenditure and hence will lead to an increase in premiums or a reduction in the cover provided. This will tend to discourage lower-risk people from taking up insurance, if membership is voluntary.

On the other hand, it is in the interest of the insurer to exclude high-risk individuals from the fund altogether, or charge them higher premiums for entry, and to have as many low-risk members as possible. This is a problem in the case of health, since insurers want to deter or exclude those who are most likely to get sick and have chronic illnesses – i.e. those most in need of health care.

Moral Hazard

People are less fearful of catastrophe once they are protected by insurance and this affects their behaviour. For example, car owners may become more careless and increase risk of theft by leaving car door unlocked. Paying part of the cost of the loss – say the first \$50 of replacing the car – may reduce carelessness or 'moral hazard' (see 'Deductibles' below). In the case of health insurance, moral hazard tends to manifest itself as overuse for minor complaints).

Cost Escalation

Moral hazard can lead to 'cost escalation' because the increased claims on the insurance fund tend to push up costs. Using the car insurance for example, cost escalation can also occur because of the behaviour of the mechanic. For example, when repairing a smashed car, the mechanic, knowing that the insurer will meet repair costs, may increase the car repair bill. Therefore controls on the behaviour of the mechanic are required. If adverse selection occurs will also push up costs, as noted above.

Premium

The term used for the regular payments made by the consumer.

Deductibles and Co-payments

Part payment by the consumer on use of insurance (e.g. paying the first \$50 of any claim under car theft insurance) which is intended to discourage overuse and carelessness, and hence cost escalation.

Figure 3 Key features of common categories of health funding

Funding Categories	Common Features				
	Risk Sharing	Specific benefits	Profit making	Progressive	Voluntary
Insurance					Usually Not
<i>Social Insurance</i>	Yes	Yes	No	Yes	
<i>Private-for-profit Fund (individual and employer based)</i>	Yes	Yes	Yes	No	Yes
<i>Private-non-profit (e.g. community fund)</i>	Yes	Yes	No	No (although exemptions may help the poor)	Yes
Non Insurance <i>General tax</i>	Yes	No	No	Yes/No	No
<i>Direct payments</i>	No	Yes	Yes/ No	No	Yes
<i>Pre-payments</i>	No	Yes	Yes No /	No	Yes

Figure 4 Categories of non-insurance health funding

<p>General Tax</p> <p>Tax is deducted from employees' pay and other sources such as customs duties and sales tax. The funds collected are then used by government for various activities including health care, but without guaranteeing any specific benefits. Taxation can be 'progressive' – i.e. favour the poor – where the amount paid rises as a proportion to income (for income taxes). Use of services is usually not dependant on proof of payment of tax.</p> <p>Earmarked Tax</p> <p>An earmarked tax ('health tax') is clearly identified within the taxes paid by the individual and the revenue collected is earmarked for health rather than forming part of general tax revenues. Use of services is generally not dependent on proof of payment of tax.</p> <p>Direct Payments/User Charges/Cost Recovery/Fees</p> <p>These are payments made by the consumer at the time of using health care. Sometimes these payments cover the whole cost of health care but in most government systems they only cover about 10-15% because otherwise the fees would be prohibitively high for the consumer. The government usually subsidises the remainder of the cost of care from general tax.</p> <p>Pre-payment Schemes</p> <p>Users pay for care in advance, which entitles them to a specific value of volume of treatment. For example, health cards in Thailand entitle the purchaser to a set number of visits. As with direct payments, pre-payment schemes do not involve risk sharing, where the funds from all those contributing to insurance are pooled for treating those who get sick. However, it should be noted that health insurance often involves pre-payment in the sense that members pay their premiums or contributions in advance.</p> <p>Often with both direct payments and pre-payment schemes the amount paid is not based on an assessment of income. There for these categories tend to be regressive.</p>
--

Figure 5 Types of health insurance

Social Insurance

Social insurance is an earmarked fund set up by government with explicit benefits in return for payment. It may be called National Health Insurance. It is usually compulsory for certain groups in the population and the premiums are determined by income (and hence ability to pay) rather than related to health risk.

Private for Profit

The key distinction here is that premiums are set at a level which provides a profit to third party and provider institutions. Premiums are based on an assessment of the risk status of the consumer (or of the group of employees) and the level of benefits provided, rather than as a proportion of the consumer's income.

Private-non-Profit) e.g., a Non-Government, Community-based Fund)

Premiums are usually flat rate (not income-related) and therefore not progressive. Making a profit is not the purpose of these funds, but rather improving access to services. Often there is a problem with adverse selection because of a large number of high-risk members, since premiums are not based on assessment of individual risk status.

Exemptions may be adopted as a means of assisting the poor, but this will also have adverse effect on the ability of the insurance fund to meet the cost of benefits.

Managed Care

Managed care plans have been developed to provide cover for health care expenses in ways which help to control the costs and quality of health care. The approaches and mechanisms used in managed care vary, but typical mechanisms to inhibit cost escalation include: agreeing prices with health providers and encouraging consumers to use those providers; having 'gatekeeper physicians' in order to limit access to specialist care; utilisation reviews to measure the amount and appropriateness of service used; a limited drug lists; and paying providers in ways that minimize incentives to over-treat (e.g. by salary or capitation rather than fee per service). Note that these mechanisms can also be used in other types of health insurance to maintain cost control and hence affordability.

Managed care was developed in the USA in response to the rising cost of private health insurance. There are two main types of schemes in the USA, known as 'health maintenance organisations' and 'preferred provider organisation'.

3. Why Consider Health Insurance: Advantages and Drawbacks

3.1 This section looks at the broad rationale for health insurance in low income countries. There are three arguments that are made in favor of health insurance.

- attracting additional money for health;
- getting better value for money (or increasing efficiency); and
- improving the quality and targeting of health care (increasing effectiveness).

3.2 The 'Additional Money for Health' Argument

3.2.1 First, health insurance is attractive because it is perceived as additional source of money for health care.

3.2.2 Additional resources may be available through insurance because:

- consumers are more enthusiastic about paying for health insurance than paying general taxation as the benefits are specific and visible;
- consumers are more able and prefer, to pay regular, affordable premiums rather than paying fees for treatment when they are ill.

However, since insurance usually at least partially replaces payments through other mechanisms – tax or fees – it is important to check whether in fact the insurance will result in more funding for health, once administration costs and collection difficulties are taken into account.

Figure 6 Perceived advantages of health insurance for low income countries

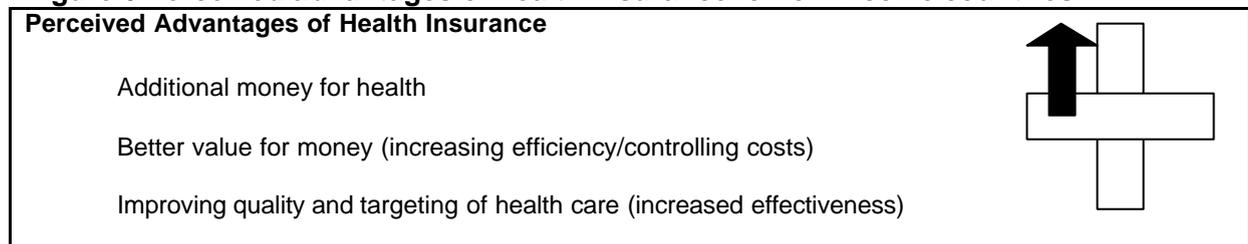
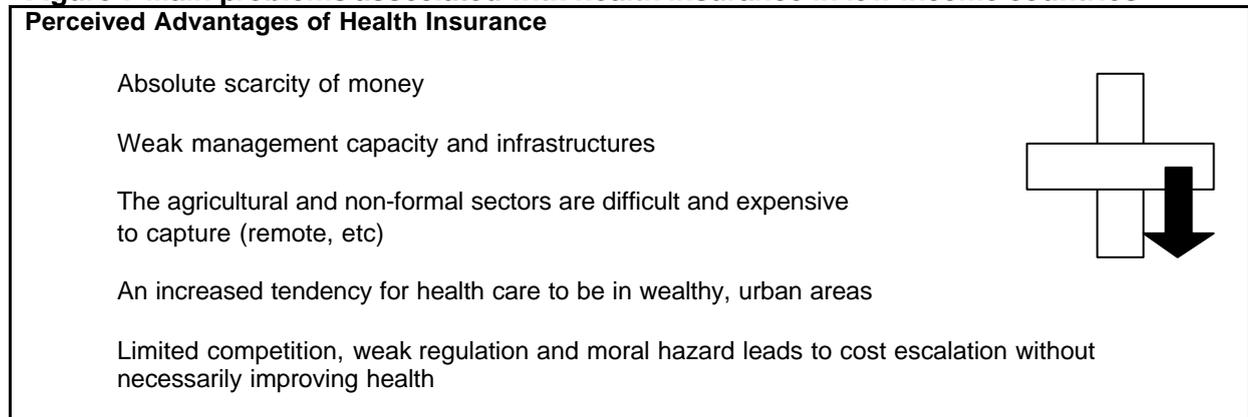


Figure 7 Main problems associated with health insurance in low income countries



3.3 The 'Increased Efficiency and Effectiveness' Argument

3.3.1 Insurance is claimed to be a way of getting better value for money – that is, increasing efficiency by 'doing things better for less cost' and of improving the quality and targeting of health care – that is, increasing effectiveness by 'doing the most appropriate or important things better'.

3.3.2 The arguments for this are that:

- A greater explicitness and visibility of spending on health services occurs as a result of insurance. Often contracts are introduced for the supply of services and the greater independence of the third party institutions and providers can lead to greater accountability in terms of expenditure and mechanisms for monitoring efficiency.
- The third party institution can specify in contracts the kinds of health care that are to be provided and can therefore concentrate on providing cost effectiveness.
- Consumers, and their representatives, will demand better quality care because they can see a definite link between their payments and services.
- If members have a choice of providers, this leads to competition between providers which can lead to lower costs and better quality care.
- Third party institutions can make a strong link between quality and efficiency of services and payment to providers. For example, providers' budgets can be linked to targets for health outcomes.

3.4 However, consideration of the principles of insurance (see **figure 2**, on page 5) and actual country experiences indicate that there are flaws in these arguments, so the advantage of insurance may not be realised:

- In a poor country it may be an unrealistic aim to attract additional money because of the absolute scarcity of resources – people cannot afford to pay more towards their health care.
- The high costs of insurance administration and the difficulty of collecting payments are crucial issues in low income countries. This is partly because there may be weaknesses in the infrastructure and management capacity. Also the population is often in informal employment or in agriculture and scattered geographically, which makes it more expensive to collect premiums.
- Whether insurance is a more secure and sustainable source of funding than general taxation depends on a number of factors, including fluctuations in employment, the nature of the labour market and the state of the economy in general. These factors may be particularly problematic for low income countries.
- To realise efficiency gains there is a need for a sophisticated management infrastructure for establishing and managing contracts, monitoring service use, avoiding fraud, introducing performance measures and regulating providers. In low income countries management and regulatory capacity may be weak and would take time to develop.
- Insurance tends to make health care more expensive because of the behaviour of providers and members. Knowing that costs will be met from insurance, doctors may provide inappropriate or unnecessary care or raise their prices, and thus push up the costs of services. Members are likely to use health services more often and expect more treatment.
- Insurance can encourage the growth of hospital services in urban areas and of high technology care because it is easier to manage insurance, and more profitable, than

- in rural areas. This may be inappropriate use of health resources in low income countries where basic services for rural residents are still inadequate
- in many low income countries there is little scope for competition between providers because there are few of them, so improved efficiency due to competitive pressure is less likely.

3.5 The previous paragraph indicates that it is certainly not a foregone conclusion that health insurance will bring benefits in terms of more funding and more efficient and effective health services, and hence better health, in low income countries. Whether the advantages of health insurance will outweigh the potential problems in a particular country will depend on how far each potential problem applies in that country and how well the insurance system is designed and regulated to minimise the problems.

4. Issues in Deciding Whether Social Insurance is Appropriate

- 4.1 Social insurance has already been defined in the guide (see figure 5, on page 7) as an earmarked fund set up by government with explicit benefits in return for payment.
- 4.2 Social insurance can take different forms. It can be large or small scale; part of a wider social security system or specific to health care; and it can require voluntary or compulsory membership.
- 4.3 Typically however, social insurance schemes are large scale and compulsory for those in employment. Usually they require contributions paid as a proportion of salary by both employer and employees. Some from part of a wider social security system. The funds are usually managed independently of government, for example by a parastatal or regional boards, which work within a tight framework of regulations.
- 4.4 Social insurance can offer advantages over finance from taxation:
- it provides a **visible** and clearly defined flow of funds into the health sector;
 - it acts as a means of establishing **patients' rights** as customers;
 - funds can be managed by an institution **independent** from government, which may protect the funds for health and make it easier to introduce efficiency measures.

However, it is also subject to the potential drawbacks discussed in the previous section.

- 4.5 The first step is for a government to ask whether social insurance is appropriate at the current stage of development of the health system and the economy. **Figure 8** sets out a framework for deciding whether social insurance is appropriate. It identifies two main criteria:
- desirability in relation to national health goals and the policy environment; and
 - feasibility taking into account possible practical constraints to implementation, such as high administrative costs and inability to meet entitlements.

Is Social Insurance Desirable?

- a Equity issues: will social insurance facilitate improved access to services for the poor?
- 4.6 The poor are likely to be excluded from insurance because they are too poor to pay, do not have regular employment for meeting regular payments, and may not be easily accessed for the purposes of collecting payments. While some richer countries fund insurance for the general tax revenue, this is unlikely to be affordable in the poorest countries.
- 4.7 Since the health goal of most low income countries is to improve the health of the whole population, by expanding coverage of the poor and rural populations, social insurance which initially covers the employed and better off will not benefit these target groups directly. The key issue is whether social insurance can be designed in ways which help to achieve national health goals. This raises questions of:
- whether government can shift general tax funding to basic, rural services, leaving insurance to fund urban hospital care;
 - how to ensure the social insurance will not undermine services for the poor, e.g. by attracting trained staff from rural areas to insurance-funded hospitals;

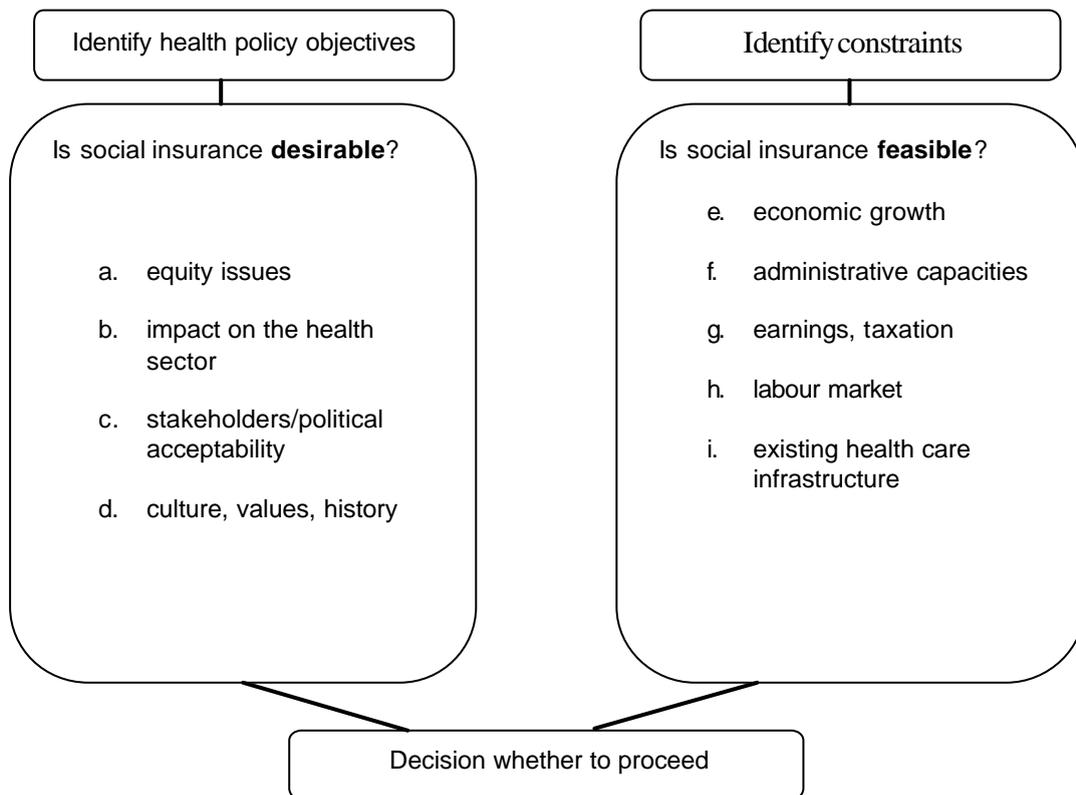
- whether the poor will use the same services, particularly hospitals, rather than having a separate and better funded system for the insured.

b Will insurance have a positive impact on the health sector?

4.8 Will the resources raised by insurance be used to enhance service quality and effectiveness? Issues here include:

- The additional resources should enable an increase in the volume of health care, improved standards, more appropriate services and increased coverage. But this will not happen automatically – contracts for services will need to specify these outcomes.
- In some countries development of social insurance has led to a widening gap between services for the covered and those for the rest; increasingly sophisticated technology; and rising costs. In order to avoid this problem, the design of the system is critical in this, particularly provider contracting and payment arrangements.

Figure 8 National Health Insurance Decision Phase
(adopted from Normand and Weber 1994)



c Stakeholders and political acceptability: will there be resistance?

4.9 Various interest groups have had a voice in the health insurance debate in low income countries:

- **Governments** see it as a way of increasing and earmarking resources for health. However, social insurance will only increase resources if other funding sources are maintained and the costs of administration are not too high.

- The **Health Professionals** will be keen if they expect low salaries to be improved and professional opportunities to increase. However, if the additional funds are absorbed by higher pay then there will be limited impact on the health objectives.
- Many **donors** are keen on insurance, partly because they have experience of it in their own countries as a funding mechanism for health, and because they anticipate benefits in terms of efficiency.
- The **population** who will be insured (e.g., those in stable employment) will support the proposals if they believe the health services they use will improve in quality and/or cost less than direct fee payments.
- **Private insurers** may oppose a well regulated social insurance scheme. It is likely to be easier to start social insurance early, before private health insurers become a large and influential group.

d Do historical or cultural conditions allow the introduction of social insurance at present?
 4.10 Are there other factors which would affect prospects for insurance? For example, in some countries, unofficial payments by patients to health worker has become the norm. Paying for insurance may only be acceptable if these can be eliminated.

Is Social Insurance Feasible?

e Is the economy able to support significant development of health services?
 4.11 In countries where the economy is in recession or growth is very slow and incomes are low, the introduction of insurance will have little impact in mobilising additional resources. It would be better to wait until growth and development allow for higher health expenditure.

f Is administrative capacity sufficient for insurance?
 4.12 Insurance arrangements tend to be more complex and more expensive to administer than tax funding. The scheme will require:

- contracts between the third party institutions and service providers;
- systems for assessing incomes and collecting contributions;
- systems for making agreements with providers, paying them and monitoring their performance;
- information systems for recording payments, details of individual contributors and service providers, etc;
- management of the insurance fund itself.

4.13 It is critical to assess the costs of setting up and running these systems and whether there is the capacity and skilled staff to manage them.

g Is there an adequate earnings base to provide a stable revenue?
 4.14 Typically social insurance is provided through a system of payroll contributions calculated as a percentage of income. This is normally split between employer and employee, for example 3% of salary paid by the employer and 5% by the employee.
 4.15 A key question is whether the contribution rate required to fund services would be acceptable. The contribution rate required at current salary levels can be estimated based on estimated service costs for a family per year. If most salaries are low, it may require an unrealistically high proportion of salaries to fund a reasonable level of services.

- 4.16 Even if the level is acceptable, payroll contributions may not be the best source of funds for health care:
- further payroll charges may discourage employers from retaining or taking on staff, reducing employment;
 - they could also deter investors;
 - in the event of recession, as unemployment rises revenue to the social insurance fund will fall (employment-based contributions can thus be a less stable source of funding than general tax revenue);
 - if government is the major employer, the government budget will be the main source of funding for the health insurance scheme, raising public sector running costs.
- h Is the labour market structure suited to contributory insurance?
- 4.17 In low income countries most people work in the non-formal and agricultural sectors. Since their incomes are variable, regular payments are a problem and income assessment is difficult. It is more difficult and expensive to operate a contribution system under these conditions.
- 4.18 In addition, if casual labour is common (where people move in and out of formal employment), this makes collection more difficult and entitlement of individuals hard to define.
- i Does a health service infrastructure exist to provide the services to which insured people are entitled? Will the fund be able to offer advantages to members without denying access to emergency and essential care for the rest of the population?
- 4.19 Health insurance gives the insured population entitlement to services. It is therefore important to ensure that the health infrastructure exists to provide those services. It is also desirable for there to be an advantage for the insured (such as better access to care), even if the insurance is compulsory, since it helps to ensure that contributions are paid.
- 4.20 However, there may be problems in meeting entitlements in low income countries:
- If services are already under-funded, the insurance may not raise enough extra funding to improve services significantly or to develop services in unserved areas.
 - There is a potential conflict between the desire to provide essential services to the whole population, and the need to offer advantages to the insured population. Advantages which might be offered are quicker access to non-emergency care and better quality hospitality/hotel services

Deciding Whether to Introduce Social Insurance?

- 4.21 The decision whether to proceed depends on the assessment of desirability and feasibility. The core question is whether the advantages of having a separate health insurance fund outweigh the extra costs of setting up such a system. This requires assessment of the additional revenue to be raised and other potential benefits against the administrative costs of establishing and running a new system.
- 4.22 Three possible decisions are:

Decision 1: Go ahead

Conditions are favourable, government goes ahead to design the system, set up the institutions, legal framework and procedures.

It is unlikely that a poor country will decide to set up comprehensive social insurance. Some countries may decide to proceed with a partial system for those employed in larger formal sector enterprises.

Decision 2: Not ready, but prepare

Conditions are not favourable now but may become so in the medium term.

Government decides to address some of the constraints. Steps to prepare for introducing insurance in the future can include:

- identify how social insurance might eventually be introduced, for example whether it can be linked to plans for pensions provision and gradually phased in;
- introduce or raise fees for services and eliminate unofficial fees so that consumers are more prepared to join insurance schemes (they will not want to join if services are nominally free and they have to make unofficial payments);
- prepare the health service, which will probably involve major health sector reform – for example developing experience of performance management agreements between funding agencies and service providers;

The government should also consider other options for generating resources, while also regulating private health insurance (see Decision 3).

A decision not to proceed may be sensible because:

- introducing insurance is expensive;
- the dissatisfaction resulting from failure would make it more difficult to introduce insurance at a later date.

Decision 3: No to social insurance, work on alternatives

Conditions are not favourable. The government decides not to proceed. It may look at other options for generating resources to meet health goals;

- focusing other forms of financing on services aimed at the poor;
- experimenting with small scale social insurance funds – such as local funds;
- encouraging private insurance to widen its coverage while introducing regulation to avoid cost escalation;
- encouraging other forms of health funding, such as pre-payment arrangements, saving for health care;
- health sector reforms to improve the effectiveness and efficiency of services.

5. Design of Health Insurance: Some Lessons

- 5.1 This section looks at the design and planning of health insurance. The start is the decision made as a result of assessing desirability and feasibility (see section 4). This section assumes that the decision has been made to investigate health insurance further. It briefly sets out the main issues to be tackled in designing social insurance (figure 9,). It then summarises some lessons from experience in social insurance (figure 10,) and community insurance (figure 11). It also identifies issues for consideration in regulating private insurance.

Design of Social Insurance

- 5.2 When preparing for introduction of social insurance, a Ministry of Health needs to work through the issues described in figure 9. This process is well described in Normand and Weber (1994) and key issues are discussed further in Ensor and Witter (1997). Those responsible for implementation are recommended to look at these detailed sources.
- 5.3 Some of the lessons from experience of social insurance are summarised in figure 10.

Design of Community Insurance

- 5.4 A country will also wish to consider the other options available for generating resources including other types of insurance. The design issues described in figure 9 for social insurance are relevant to a large extent for either community or private insurance schemes. Figure 11 sets out some lessons which have been learned from implementation of community insurance.

Regulation of Private Insurance

- 5.5 Another issue is regulation of the development of private insurance. This is important whether or not social insurance is planned. Without regulation the problems of adverse selection, moral hazard and cost escalation tend to mean that private insurance is restricted to a small number of the better off and relatively healthy groups in society, and encourages high cost medicine. Regulation can help to ensure that coverage is broader and to limit costs escalation in health care. Figure 12 identifies some options for regulation.

Figure 9 Social insurance: key steps in the design and planning phase
(adopted from Normand and Weber 1994)

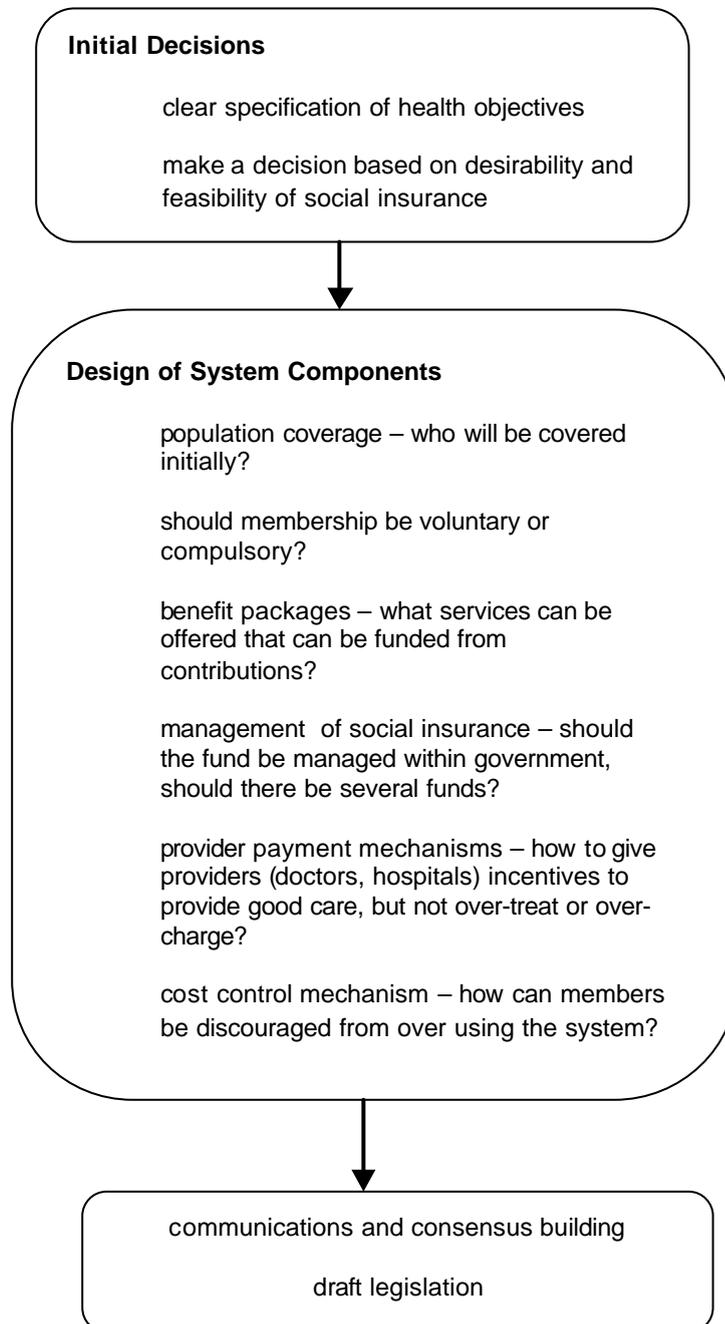


Figure 10 Lessons for design of social insurance

Most social insurance schemes are compulsory for the employed population, as this is the easiest place to start, other groups may join on a voluntary basis.

Coverage of dependants is popular but as it will push up the costs and hence contributions, careful definition of who is covered is required.

The challenge is to balance the service package promised with the funding available from contributions. Low wages in low income countries mean only a limited package can be funded. Extra benefits can be offered at an extra cost to those who can afford them, possibly by private insurers, although this is less desirable on equity grounds.

Provider payment arrangements are critical; fee for service is not advisable as it leads to cost escalation; capitation and budget systems with performance agreements are preferable.

It is common to separate the organisation which manages the health fund from the Government (i.e. outside the civil service) but non-profit, so it has more flexibility in management and less political influence. There can be several funds, competing or on a regional basis.

Careful design of management and monitoring systems will make a huge difference to the financial viability of the scheme, e.g. for monitoring provider performance and verifying eligibility of members. Quality of care also needs monitoring.

Figure 11 Some lessons from community insurance (adopted from Ensor)

The difficult balance between encouraging people to join and bankrupting the scheme because of adverse selection and high expectations about benefits. Therefore benefits should be :

limited

attractive

clear to all

Rules are needed to prevent consumers joining when they are already ill, (for example, one month pre-registration, one year for pregnancy related services).

Local schemes can work well but may be difficult to replicate.

Management capability is likely to be low.

Figure 12 Possible areas for regulation of private health insurance

Inclusion – whether individuals can be refused cover e.g. by requesting employer-based schemes to cover all employees.

The types of organisations which can offer health insurance (e.g. mutual funds rather than private insurance companies).

The types of health insurance schemes which are allowed, e.g. managed care approaches rather than open ended indemnity insurance; specifying provider payment mechanisms.

Encouraging schemes to cover dependants.

Setting a minimum package of services to be offered, (while allowing additional cover at additional cost).

6. Conclusions

- 6.1 This guide has focused on the basic principles of insurance and on the major issues concerning social insurance for low income countries. The main conclusions are:
- Insurance can be a useful mechanism for attracting resources to health care, and increasing the efficiency and effectiveness of health care.
 - However the characteristics of insurance generally, and health in particular, mean that there is a danger that health insurance will lead to escalation in costs without necessarily much improvement in health care, and result in increasing inequity in provision.
 - Government led social insurance and regulation of private insurance are means of limiting the problems from health insurance. Social insurance can even be a tool for channeling resources to primary health care/priority services; however, it requires strong management and careful design to achieve these aims.
 - The large informal and rural sectors in most low income countries make collection of insurance contributions more difficult and costly and many of these groups will find it difficult to pay. This may lead to development of partial social insurance covering only some groups of the population. The danger of this strategy is that the system never moves beyond the employed to broaden coverage.
 - Social insurance requires development of substantial institutions, systems and management capacity. This will take time and has substantial set up and administrative costs. To proceed with such a scheme, governments must therefore be convinced that it will lead to better results in terms of health service performance and equity/health outcomes, to be worth the effort and costs of moving from a system financed from general taxation. For many which already have a tax funded health system, it is not clear that there is an advantage in moving to an insurance approach.
 - If there is a decision not to pursue social insurance, there is still a strong case for regulating private health insurance to maximise its benefits to health and avoid the problems of cost escalation and increasing inequity.
 - Tight management, effective contracting and appropriate provider payment arrangements are of critical importance to successful implementation of health insurance. Countries which are not ready to move to social insurance can still benefit from introducing management reforms in these areas.
 - There are a number of detailed choices to be made in the design of social insurance schemes and regulation of private schemes. These design issues will have wide ranging effects on the results of the insurance system. It is therefore important to have a thorough design and planning stage which draws on international experience.

References

- Abel-Smith B, 1992
Health Insurance in Developing Countries: Lessons from Experience
Health Policy and Planning, Vol 7 (3):215-226
- Ensor T, 1997
Macro Issues in the Development of Health Insurance:
World Experience and Lessons for Transitional Asia
Unpublished paper, Centre for Health Economics, University of York, Heslington
- Goodman H, and Waddington C, 1993
Financing Health Care
Oxford: Oxfam
- Griffin C S, 1991
Insurance Basics
Unpublished paper, Health Financing and Sustainability Project,
Urban Institute and The University of Oregon
- Normand C, and Weber A, 1994
Social Health Insurance: A Guidebook for Planning
Geneva: World Health Organisation
- Vogel RJ, 1990
An Analysis of Three National Health Insurance Proposals in Sub-saharan Africa
International Journal of Health Planning and Management, Vol 5: 271-285
- Witter S and Ensor T, (eds), 1997
An Introduction to Health Economies for Eastern Europe and the Former Soviet Union
Chicester: Wiley and Sons