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Swiss Agency for Development and Cooperation SDC

E+E | Economy and Education

Guidance Sheet

Health Insurance

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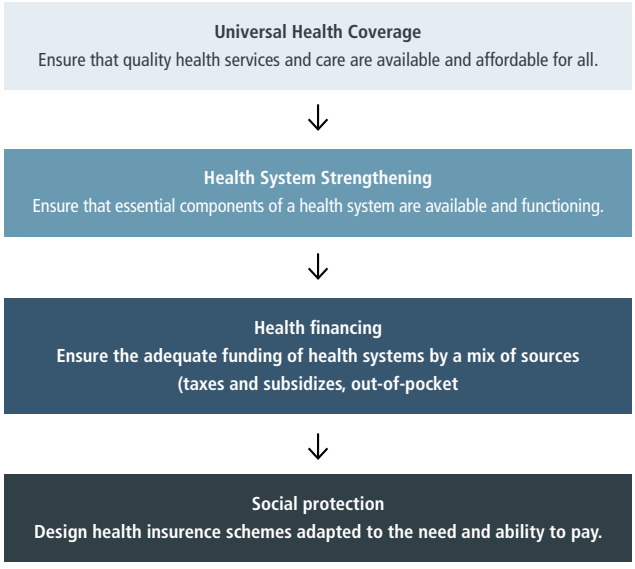
In a nutshell

- Health financing is a core function of health systems that can enable progress towards universal health coverage by improving effective service coverage and financial protection.[1]
- Today, millions of people do not access services due to the cost. Many others receive poor quality of services even when they pay out-of-pocket.
- Financing Universal Health Coverage (UHC) in developing countries has been a G20 priority since 2019. The SDC is supporting global initiatives to promote health insurance.[2]
- Multiple examples exist where national health insurance programmes have facilitated improvements in increasing the base for resources/revenues to finance healthcare costs through diversified sources, especially those originating domestically. The SDC has supported the setting-up of health insurance schemes in Tanzania (Community Health Fund), Chad and South Kivu (DRC).



1. Why is health insurance important?

In most low and middle income countries (LMICs), access to social security systems is reserved for workers in the formal sector. There is no health insurance for the rest of the population, which is the poorest and often the most at risk. Low-income households are three times more likely to fall into poverty in a given year as a result of outpatient expenditures (i.e. a single important health intervention) than they are from hospitalisation. This is the well-known poverty trap that costly and needed interventions can generate.

The SDC has identified one of its priority areas as social protection, which through its redistributive function is seen to play a key role in addressing health inequalities. Social health protection plays an important role in increasing access to health services in an equitable manner.

In international health cooperation, the SDC orients its action towards two pillars: 1. Advancing universal health coverage (including interventions on infrastructure, health workforce, availability and quality of health services, health financing, and health insurance mechanisms; and 2. Addressing the determinants of health, which means engaging in sectors that influence health status such as climate change (air pollution), nutrition and healthy diet, WASH (hygiene and sanitation), education and social inclusion.

Investing in social protection is a direct contribution to advancing universal health coverage (UHC). It has direct consequences on both the demand side (patients' financial protection) and on the supply side (better funded health delivery centres). Health insurance mechanisms strengthen national health financing strategy. Local health centres are better equipped and provide better quality services and care.

While external development aid in a number of LMICs forms a significant share of health expenditure, expanding the domestic resource base is key to sustainable financing for health systems. Health insurance providing avenues to channel and pool funds through diverse sources offers a credible approach in this regard.

Health insurance programmes can hence have a significant impact on improving access to care for the population in an equitable and efficient manner.

1 Global monitoring report on financial protection in health 2021. Geneva: World Health Organization and International Bank for Reconstruction and Development /The World Bank; 2021. Licence: CC BY-NC-SA 3.0 IGO. Link: https://www.who.int/publications/i/item/9789240040953

2 https://p4h.world/en/

2. How to implement health insurance projects

There is no single approach that proves successful everywhere. Innovative approaches should thus be explored in the context of health insurance project implementation, with tools and channels that are known and accepted in the community.

Context matters for implementing a health insurance project, and different economic, political and social environments provide different starting points for successful implementation of health insurance projects. Populations in all contexts have their own priorities, risk perception and ways of managing their own risks, and while health insurance might be a known concept in some contexts it is not a given that it is seen as a risk management approach against healthcare costs in all contexts. This leads to an important hurdle for health insurance projects which need as well to first improve the understanding of health insurance concepts in the target population and subsequently change their behaviour positively towards the uptake of health insurance.

A basic functioning healthcare system with basic workforce/ healthcare staffing, a functioning supply chain, availability of medicines, and availability of healthcare providers (public and/ or private), are all aspects that go hand in hand with any health insurance implementation project.

In designing a health insurance scheme, you need to identify the following key components jointly with local or national health regulators:

1. The beneficiary group (e.g. formal/informal sector, under 5s, pregnant women, children, etc.);
2. The benefit package (e.g. what kind of services are covered at what price);
3. The cooperating health facilities (e.g. public/private health centres; local, regional or national level; 1st, 2nd 3rd level hospitals);
4. The cost sharing among insurers, public sector;
5. An operating and monitoring tool.

If designed well, health insurance interventions provide an opportunity to impact all these aspects, where a payer (ideally a public entity) assumes the role across these dimensions while purchasing care from healthcare providers in an efficient manner.

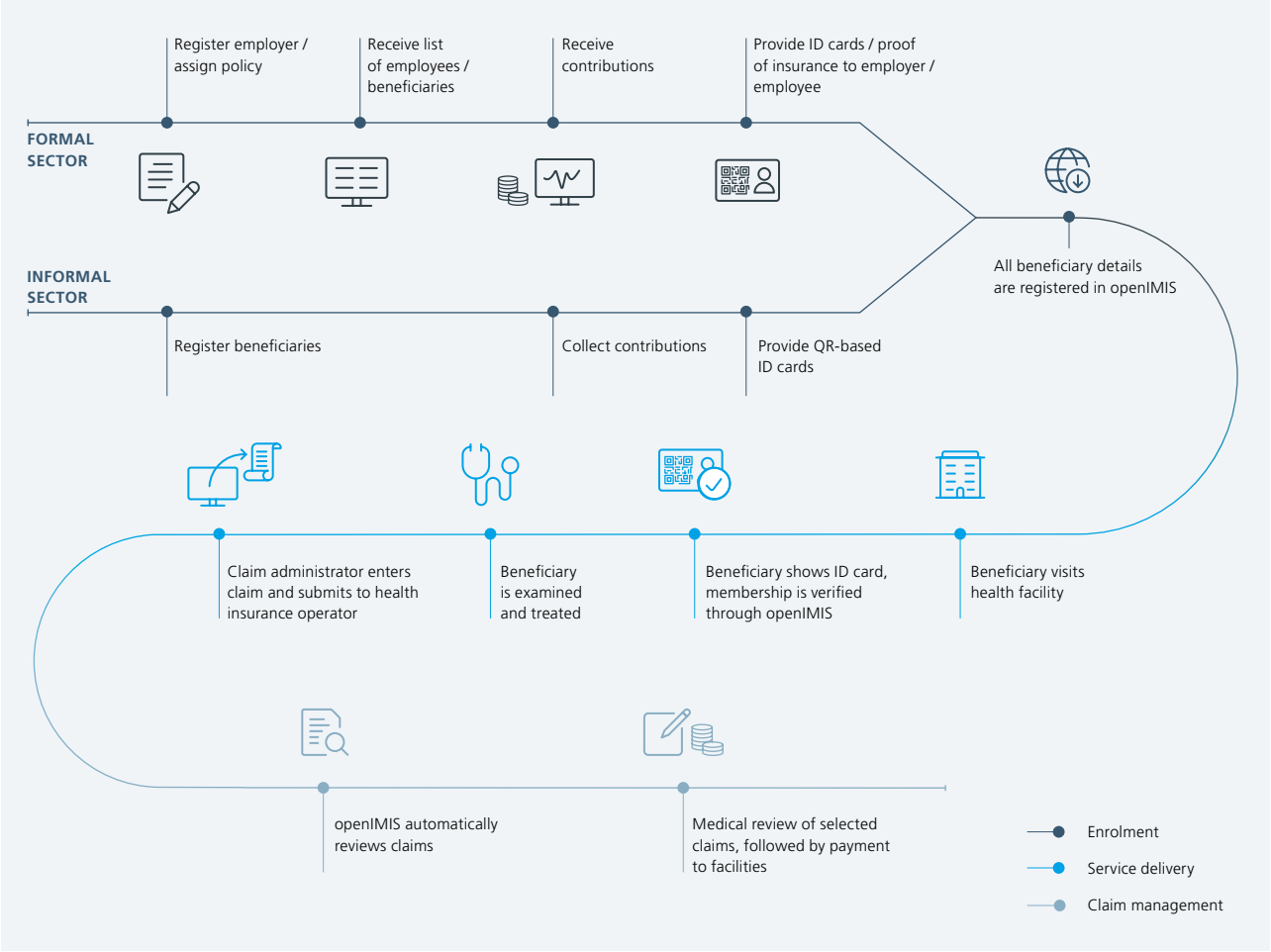
The Health Promotion and Systems Strengthening Project (https://www.hpss.or.tz/) **in Tanzania** supported by the SDC since 2011 not only includes a health insurance intervention (reform of the Community Health Funds) but also has interventions in the areas of medicine management, health promotion and health technology – all aspects strengthening the health service provision side. The interventions are entwined and allow for complementary effects with the ultimate aim of improving access to care for the population. For example, the medicine management intervention provided an alternative channel for health facilities (alternative private drug supply vendor) to order drugs when their primary public drug supplier failed to deliver their requests. At the same time the health financing intervention through the health insurance was able to provide the financial resources and build financial management capacity of the health facilities to purchase these drugs from this alternative drug supplier directly when they had shortfalls. The join impact led to improved access for the insured population by offering financial protection from healthcare costs and drastically reducing drug stock outages in public facilities. Hence health insurance projects need to go hand in hand with reforms to healthcare services provision.

In terms of operational management, the set-up of a health insurance scheme requires looking at three essential features:

1. Enrolment (how to);
2. Service delivery (what kind of services; from which health actor);
3. Claim management (calculation of reimbursements and disbursement of funds to health service providers).

The SDC has developed licence-free software (openIMIS) for the management of health insurance.[3] By 2022, OpenIMIS is supporting 11 health and social protection schemes that cater to almost 10 million people in 8 countries (Nepal, Tanzania, Cameroon, The Gambia, Chad, DRC; latest: Mauritania, Niger). The graph below summarises features to be considered.

Example Workflow



Video on implementation

openIMIS: The open source software for health financing (04/2020)

Podcast

openIMIS: How a digital global good is transforming the delivery of social protection around the world (04/2021)

3 openIMIS: the open source software that facilitates access to healthcare (08.2021); OpenIMIS Health Insurance (05/2021)

2.1 Inclusive health insurance models

Health insurance interventions if not well designed can also cause further exclusion of vulnerable groups. For a health insurance intervention which is expected to be inclusive, a clear definition is first needed identifying the vulnerable population that should not be excluded. A number of health insurance programmes with a voluntary enrolment approach tend to end up enrolling those who want to join because they are sure to benefit (adverse selection[4]) and especially those who can afford to join.

Cambodia (Health Equity Funds) and **Arogyashri Health Insurance** programme in Karnataka state of India, where exclusive schemes for the poor lead to the health facilities discriminating against those carrying the insurance programme cards (due to lower payment rates), at the same time some families not using the insurance cards for fear of being stigmatised and labelled as poor.

Similarly insurance programmes for a smaller/better off subset of the population (e.g. National **Health Insurance Fund in Kenya and Tanzania** covering the formal sector) that pay better rates to health facilities than patients that are not insured under such a programme, have led to reported experiences of such patients been pushed back in the queue or even refused treatment, leading to exclusion of these groups who also happen to be poor and vulnerable. Design of the health insurance intervention hence needs to take into close consideration such impacts on the insured as well as the spillover effects on those left out of the insured group.

Health insurance programmes can provide a way for development programmes to channel subsidies directly to beneficiaries (concern for all development partners) by paying for the set insurance premium, though in the longer run subsidies for the vulnerable groups need to be taken over by domestically raised sources to ensure sustainability and continuity of the inclusive nature of health insurance schemes. Such an approach is also observed in Tanzania with the National Health Insurance Fund now administering a product for pregnant women with development partner funds which initially were channelled through a separate voucher programme, making the health insurance scheme more inclusive by channelling subsidies through the same system.

2.2 Roles and responsibilities of stakeholders

A facilitating environment is essential and political will[5] in a country can highly influence the success of national health insurance systems.

Increasing fiscal space and budget allocations are an underlying challenge for various public health insurance projects. These are key facilitating factors for the implementation of health financing approaches like public health insurance programmes, which require accurate estimations of income, expenditure and financial flows to enable regular planning.

The SDC supports such movements by facilitating consultations and lobbying efforts among all stakeholders and building momentum for an acceptance of national health insurance reforms in the respective country.

Providing for Health (P4H) network, in which the SDC already participates, can potentially offer a basis for engaging in dialogue, including with development partners, on national health financing reforms and inclusion and alignment of health insurance project designs accordingly. The P4H network deploys health financing advisers to health and finance ministries in 14 countries.[6]

4 Provide definition

5 Cashin C, Dossou JP. Can National Health Insurance Pave the Way to Universal Health Coverage in Sub-Saharan Africa? Health Syst Reform. 2021 Jan 1;7(1):e2006122. doi: 10.1080/23288604.2021.2006122. PMID: 34965364.

6 Senegal, Niger, Chad, Ethiopia, Kazakhstan, India, Russian Federation, Cameroon, Tanzania, Mozambique, Madagascar, Cambodia, Myanmar, Vietnam.

2.3 Role of innovation

Targeting the informal sector is a huge challenge in LMICs as this population subset is quite large and forms the majority of the countries' population. Health insurance projects hence have to find innovative ways to tap into such population segments. The SDC-funded PSPH project in Somalia tries to apply an innovative Market Systems Development (MSD) approach to increase access to care for the population through private sector actors. Within this project, one intervention focuses on supporting private sector actors (private health insurers), in the absence of a strong state and public actors, to offer a health insurance product that is aligned to the needs and ability to pay of the population through a successful business model that helps them penetrate the mass market. The project is exploring health insurance product distribution through innovative channels (remittance, mobile money companies, etc.) with an expected result that this hard to reach population segment can be reached and has financial protection through health insurance.

Distribution channels that allow for the active **marketing and sale of health insurance policies** are a challenging component for health insurance projects in LMICs. Mobile wallets (M-Tiba, etc.), mobile money platforms[7] and broader e-payment solution aggregators introduced in a number of countries to date have shown alternative distribution channels for health insurance schemes.

Digital tools can go a long way to help insurers **manage their operations,** as well as open doors to more innovative possibilities that technology can provide. An example of this has been openIMIS which is an open source tool to manage health insurance scheme operations, using mobile apps to enable efficient decentralised data collection in low resource settings. The software has a cost-free license, allowing use by any insurance operator wishing to use the tool. The tool is developed in a modular manner to enable easy deployment of the whole or parts of the application that are easily compatible (through internationally accepted data exchange standards) with other applications. The tool was developed as part of an SDCfunded project in Tanzania (HPSS project) and subsequently shared by the SDC with other development projects in other countries before turning it into a global initiative called the openIMIS Initiative, run jointly with the German Federal Ministry for Economic Cooperation and Development (BMZ).

3. How to measure results in health insurance projects

The SDC is applying Aggregated Reference Indicators (ARIs) and Thematic Reference Indicators (TRIs) to better report and communicate overall results and against Switzerland's International Cooperation Strategies (2017–21; 2021–24).
When preparing a project, cooperation or global programme, review the list carefully, taking into consideration each sub-objective of the strategy, theme or SDG target which is either included or touches on the intended outcomes.

All ARIs/TRIs are therefore listed here.

Specifically on health financing, the SDC recommends the following TRI:

Out-of-pocket payment for health services and care
a) Out-of-pocket expenditure on health per capita
b) Domestic general government health expenditure per capita

A factsheet on this indicator is available here:
https://www.shareweb.ch/site/Health/publiclibrary/Documents/ARIs-TRIs/HLT_TRI_2.pdf

7 Business Call to Action (BCtA), 2016. Advancing Bottom of the Pyramid (BoP) Access to Healthcare: A Case Study on Mobile Money Platforms. Nairobi, Kenya. https://www.yumpu.com/en/document/view/55453962/advancing-bottom-of-the-pyramid-bop-access-to-healthcare

Glossary of Key Terms

Health financing	Health financing refers to the "function of a health system concerned with the mobilisation, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system … the purpose of health financing is to make funding available, as well as to set the right financial incentives for providers, to ensure that all individuals have access to effective public health and personal healthcare" (WHO definition).
Revenue raising	Revenue collection is what most people associate with health financing: the way money is raised to pay health system costs. Money is typically received from households, organisations, or companies, and sometimes from contributors outside the country (called 'external sources'). Resources can be collected through general or specific taxation; compulsory or voluntary health insurance contributions; direct out-of-pocket payments, such as user fees; and donations. (WHO definition)
Pooling	Pooling is the accumulation and management of financial resources to ensure that the financial risk of having to pay for healthcare is borne by all members of the pool and not by the individuals who fall ill. The main purpose of pooling is to spread the financial risk associated with the need to use health services. If funds are to be pooled, they have to be prepaid, before the illness occurs – through taxes and/or insurance, for example. Most health financing systems include an element of pooling funded by prepayment, combined with direct payments from individuals to service providers, sometimes called cost-sharing. (WHO definition)
Purchasing	Purchasing is the process of paying for health services. There are three main ways to do this. One is for government to provide budgets directly to its own health service providers (integration of purchasing and provision) using general government revenues and, sometimes, insurance contributions. The second is for an institutionally separate purchasing agency (e.g., a health insurance fund or government authority) to purchase services on behalf of a population (a purchaser-provider split). The third is for individuals to pay a provider directly for services. Many countries use a combination. (WHO definition)
Cross-subsidisation	Cross-subsidisation is the practice of charging higher prices to one group of consumers in order to artificially lower prices for another group. In the healthcare financing context, this approach is applied to ensure individuals with a higher ability to pay contribute more in order to reduce (or eliminate) the burden for individuals who have a lesser ability to pay. This helps promote equity in a healthcare system (pay according to need, irrespective of ability) while ensuring cost of care is adequately covered.
Out-of-pocket payment	Out-of-pocket payments are expenditures borne directly by a patient where insurance does not cover the full cost of the health good or service. They include cost-sharing, self-medication and other expenditure paid directly by private households. In some countries they also include estimations of informal payments to healthcare providers.

Abbreviations

HTA	Health Technology Assessment
NGO	Non-governmental organisation
P4H	Providing for Health
Swiss TPH	Swiss Tropical and Public Health Institute
SDC	Swiss Agency for Development and Cooperation
WHO	World Health Organization

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