

How can the poor be better integrated into health insurance programs in Africa ?

An overview of possible strategies

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This document is one in a series of four policy briefs on mechanisms to promote access to health services for the poor in low-income countries (abolition of user fees, health equity funds, special health insurance provisions, and targeting of the poor).



Health insurance is among the solutions promoted in developing countries since the 1990s to improve access to health care services because it avoids direct payment of fees by patients and spreads the financial risk among all the insured. Many mutual health insurance organization have been developed in sub-Saharan Africa, and over the past several years some African countries have set up national health insurance systems. However, in those countries that elect to give an important role to health insurance, it remains to be verified whether such insurance really reaches those who are most vulnerable in terms of access to services: the poor. In fact, lack of funds creates problems at two levels: when it comes time to pay the premium, and when the insured need to use health care services. On these two levels, this policy brief assesses the situation of the poor, examines the problems they encounter and presents measures taken by some insurance organization to remedy these problems.

METHODS

Outline of the topic :

- All types of health insurance are considered (national, private and community-based insurance).
- The situation of the poor is considered in relation to insurance, but not the protection provided by insurance against impoverishment related to health care costs.
- The financial dimension of poverty (lack of money) is considered, but not its social dimensions (subject too vast).
- For information on criteria and methods for identifying the poor, refer to our policy brief on targeting.

Approach :

Scientific publications and reports published between 1988 and 2008 were researched. However, almost none of them were directly focused on the situation of the poor in relation to health insurance. Information on the poor was too rare and spread out over too many documents about health insurance to be able to undertake a systematic review (based on all the documents). This policy brief therefore provides only an overview of the possible strategies for better integrating the poor into health insurance programs. For purposes of comparison, we present primarily African experiences with insurance, but also some experiences among very poor populations in India and Bangladesh.

1st LEVEL: HEALTH INSURANCE MEMBERSHIP

→ Observation: The poor are under-represented among the insured

In Africa, when health insurance programs do not make specific efforts to facilitate membership for the poor, they are under-represented among the insured. This has been shown by studies in Burkina Faso (Nouna district) [1]; in Mali (Bla and Sikasso districts) [2, 3]; in Senegal, in the Thiès region [4-6] and nationally [7, 8]; in Ghana (districts of Dangme West, Nkoranza, West Gonja and Kwahu South) [9-11]; in Kenya and South Africa at the national level [8]; in the Democratic Republic of Congo (Bwamanda district) [12]; and in Burundi [13].



Some statistics : In Senegal, 31% of households in the wealthiest quintile* are insured, in contrast to 8% in the poorest quintile [7]. In Burkina Faso's Nouna district, in 2004, only 11% of the insured were in the poorest quartile (if the poor were insured as much as the others, they would represent 25% of the insured) [1].

* **Quintile :** A 20% slice of a statistical whole that is organised in increasing order. Example: In a group of 100 households, the 20 poorest households make up the poorest quintile.

➔ Problem: Difficulties paying the premium

To enrol in an insurance program requires paying a premium. The combined premiums constitute the funds upon which the insurance draws in order to compensate members who use insured health care services.

However, the **lack of money** to pay the premium is the main reason why some people do not become insured, as shown by surveys in Burkina Faso's Nouna district [14, 15]; in the district of Kissidougou in Guinea-Conakry [16]; in the region of Thiès in Senegal [4, 6]; in the district of Nkoranza in Ghana [11, 13]; in Burundi [13]; and in Uganda [17, 18].

Payment modalities can also present problems. If the annual premium must be paid in a lump sum (instead of payments spread out over the year), households find it more difficult to pay [13, 19]. In Burkina Faso, the households surveyed emphasised that a single payment is even more problematic in rural areas, where it is hard to obtain credit [14, 15]. Another element is the time at which the payment is due, because the incomes of workers in the informal or agricultural sectors vary over the course of a year. In Ghana, households in Nkoranza complained that the premium is due at a time of year when their financial situation is poor [13]. In Rwanda, the premium must be paid at the start of the civil year, when families also have to pay school fees [20].

➔ Measures to promote health insurance membership among the poor

The measures are summarised in the following table and presented in detail below.

Measure	Examples	Does it increase membership among the poor ?	To remember
a. Premium subsidised 100%	Rwanda, Ghana, Tanzania	Yes, when the subsidy is really applied.	Sufficient funds must be available to compensate for premiums not paid by the poor. The population must be informed of the subsidy.
b. Premium partially subsidised	Burkina Faso, Ghana	Yes, for some of them.	Even "minimum" premiums that households must still pay are obstacles for the poorest.
c. Premium varies based on income	Bangladesh	Yes, if the level of premium is well established	Premium levels must accurately reflect the levels of wealth in the population.
d. Premium paid in kind or by work	Ethiopia, India	Indications that this is acceptable for the poor	The "amount" of the payment in kind or in work must be clearly defined to avoid exploitation.
e. Loans to help pay the premium	Rwanda	Yes, for the moderately poor	Institutional support is important to facilitate access to loans for moderately poor households.
f. Dividing the premium into smaller payments	Uganda, Mali, Senegal, Tanzania	Yes, for the moderately poor	
g. Payment of the premium at harvest time	Burkina Faso, Guinea-Conakry	Indications that it can work for the moderately poor	It is important to know the annual periods of resource availability.



a. Premium subsidised 100%

Principle: The poor are insured without having to pay; their premium is paid by a third party.

In **Rwanda**, when the first health mutuals appeared in 1999, there were local initiatives to pay premiums for the indigent by certain churches [21] or by the other insured members [22]. In the following years, funding agencies began to intervene, but the initiatives remained circumscribed. For example, in one commune, the German cooperation agency gave the poorest households \$32 US, of which \$7.9 US corresponded at that time to the annual premium for a household, and the rest was to buy cattle to produce income to pay the premium in subsequent years [23]. At the time of these localised initiatives, the poor remained under-represented among the insured [21, 24].

In 2006, subsidising the premiums of the indigent became national policy. The premiums (about \$3.6 US per person per year) were funded by the Rwandan government with the help of funding agencies, notably the Global Fund to Fight AIDS, Tuberculosis and Malaria, that provided around \$30 million US over five years. The district mayors submitted requests to the Ministry of Health that listed, for each mutual, the number and names of the indigent and the amount required to pay their premiums. Part of the funding went directly to the mutuals (insurance for primary care services); and the rest, to the district (common funds for hospital services) [20]. The number of indigent beneficiaries increased dramatically, going from 45,000 in 2005 to around 1.8 million in 2006 (of which 800,000 were supported by the Global Fund), i.e., 20% of Rwanda's population. Nevertheless, there are still 1.85 million indigent Rwandans who today receive no subsidy for insurance premiums [20].

In **Ghana**, the law on national health insurance exempts the poorest from paying the premium. However, the proportion of the poorest among the insured decreased, going from 30% in 2005 to 1.8% in 2006. One explanation that has been suggested is that the central government does not transfer enough financial resources to cover their premiums [25].

In **Tanzania**, in the framework of the Community Health Fund (CHF) that insures the rural population, districts are supposed to pay the premiums of the poorest households. Some districts received technical assistance from partners such as the German cooperation agency to find the means to fund this shortfall [26]. However, most district managers do not provide exemptions from premiums, for fear this will jeopardise the CHF's financial viability; they also lament the central government's lack of consideration for this problem [27]. Moreover, a survey showed that the poor are unaware of the possibility of this exemption from premiums [27]. Also, even in the first district to have implemented the CHF, only 33% of the poor are insured, in contrast to 60% of the non-poor [28].

To remember

- Sufficient funds must be available to compensate for premiums not paid by the poor.
- The population must be informed of the subsidy.

b. Premium partially subsidised

Principle: The poor pay part of the premium, and the rest is paid by a third party.

In Nouna district in **Burkina Faso**, in response to the under-representation of the poor among the insured (mentioned above), a subsidy of 50% of the premium for the poorest households was instituted in 2007. This affects the 20% of households that are the poorest, as defined by the community. These households can thus insure themselves by paying only the remaining 50%, i.e., \$1.14 US per adult and \$0.47 US per child for the year. Funding for the subsidy comes from a German foundation and was allocated for a period of five years. By the end of the first year, 186 of the 1,666 eligible households (i.e. 11.1% of them) were insured, as opposed to 18 (1.1%) in the year prior to the subsidy [29].

In **Ghana**, before the implementation of national health insurance, a project of the International Labour Office with the mutual in Dangme West consisted of paying 75% of the premiums for the poor, who could then obtain coverage by paying the remaining 25%. The subsidy also paid for the identification photo required for the insurance card, because households refused to pay this additional cost. At the end of the first year of the project, 700 of the 1,622 eligible households were insured (i.e., 43%). It appears that the indirect costs of membership (taking time off work



to go complete the procedures at the mutual) dissuaded the others. In addition, although normally the enrolment period coincides with the harvest, the beneficiaries were identified later, at a time when households had less money available [30].

To remember : Even “minimum” premiums that households must still pay are obstacles for the poorest.

c. Premium varies based on income

The Gonosasthya Kendra (GK) Insurance of Bangladesh offers four different levels of membership for the same insured services:

Group	Premium (in taka)	% insured in each group
Indigent *	5	80,2 %
Poor	15	46 %
Middle class	40	19,9%
Well-off	50	9,7 %

* Widow, abandoned woman, beggar, mentally or physically disabled person

This insurance succeeds in including the very poor, since 80% of indigents are insured. But it does not adequately look after the poor, nor the more modest minority that constitutes the “middle class”, as defined by this insurance; many of them do not enrol because of the cost of premiums. In fact, surveys have shown that the differences among the four premium levels are exaggerated in terms of the real differences in income among the socio-economic groups [31].

To remember : Premium levels must accurately reflect the levels of wealth in the population.

d. Premium paid in kind or in work

Small farm workers live in a local economy that often is not very money-based. Thus, some insurances in India have accepted to have premiums paid in the form of rice or sorghum; one of them employed a worker once a year, at harvest time, to collect the households’ payments and sell them at the market [13]. Another possibility is to pay the premium by giving work time to the insurance (for example, in a field from which the harvest is then sold). Of course, the work required must be reasonable and should not become an exploitation of already vulnerable households. Goalpara Insurance in India adopted payment in the form of work [13]. A survey in Ethiopia showed that, the poorer the households were, the more they were interested in paying their premium with work, and that the “amount” they agree to give as work was higher than what they were prepared to pay in money [32].

To remember : The “amount” of the payment in kind or in work must be clearly defined to avoid exploitation.

e. Loans to help pay the premium

This strategy is not directed at households who are permanently without money, but rather to those who are moderately poor and able to pay the premium, although not all at once. When mutuals first started in Rwanda, 7% of household paid their premium thanks to a tontine* [21]. In the following years, the mutuals signed agreements with credit cooperatives so that the latter would make loans in the amount of the annual premium. Community associations guaranteed loans taken out by their members [33], and some mayors guaranteed loans for their constituents [23]. Under this system, membership in the mutuals in Gakoma district went from 18% in 2000 to 63% in 2003; 61% of the insured at that time took out loans to pay their premium [23].

* **Tontine :** System in which a group of people create a pool into which everyone deposits the same amount on fixed dates and from which, at every date of deposit, one participant is designated to receive all the deposits.

To remember : Institutional support (insurances, community associations, administrations) is important to facilitate access to loans for moderately poor households.



f. Dividing the premium into smaller payments

A survey of the members of a Ugandan mutual revealed that spreading their premium payments over the year greatly facilitated their membership [17]. Another study showed that the level of household wealth had more influence on insurance membership in Ghana, where the mutual being studied collected the premium in a lump sum, and less influence in Senegal and Mali, where payments were spread over the year [34]. However, in Tanzania, despite the possibility of installment payments, there were far fewer insured among the poor than among the others [28]. In effect, like loans, installment payments mostly benefit the moderately poor.

g. Payment of the premium at harvest time

According to a study in the region of Thiès (Senegal), households in the poorest quintile use primarily harvest earnings to pay the premium [6]. If a lump-sum payment is required, it must at least be after the harvest. Households in the Nouna district of Burkina Faso have recently requested that memberships in mutuals be paid in this period [14]. However, a study in Guinea-Conakry points out that even at harvest time, some are too poor to gather together the necessary sum [16].

To remember : It is important to know the annual periods of resource availability.

2nd LEVEL: USING HEALTH CARE SERVICES

Having insurance is not an end in itself. It is also important that the poor not encounter even greater obstacles when it comes to using health care services.

→ Observations on the use of health care services by the insured poor


There are as yet very few studies on this subject, and they do not all come to the same conclusions (even among studies done in the same region, such as Thiès in Senegal [4, 6]):

No difference in utilisation between well-off and poor insured	No clear relationship between income and utilisation	Lower utilisation among the poor insured
Senegal (Thiès region) for hospitalisations [6]	Senegal (Thiès region) for visits [6]	Senegal (Thiès region) for hospitalisations [4]
India (SEWA Insurance) among the urban insured [35]	Senegal (Thiès), Mali (Bla and Sikasso), Ghana (Nkoranza) [34]	Burkina Faso (Nouna district) [36]
	Mali (Bla and Sikasso districts) [3]	Ghana (Dangme West) [9]
		India (SEWA Insurance) among the rural insured [35]

Some statistics : In Ghana (Dangme West) [9] we observe 3.11 visits per person per year in the insured from the wealthiest quintile, as opposed to 2.61 in those from the poorest quintile. Among the rural insured of SEWA in India, the wealthiest 30% make 2.3 more requests for reimbursement for hospitalisation than do the poorest 30% [35]. More research is definitely needed to shed light on the subject of service utilisation by the poor insured. In all cases, there are suggestions that often this utilisation is problematic.

→ Problems: non-insured health expenses, co-payments and post-payment reimbursement

Health care services utilisation depends on numerous factors. Many are outside the control of the insurance companies. Some, however, have to do with the way insurances work, which allows certain financial obstacles to persist.



Non-insured health expenses: These remain entirely the responsibility of the insured. According to the insured of SEWA in India, an important obstacle to hospitalisation is the cost of transportation to the hospital, often very high for those in rural areas, and not covered by SEWA [37].

Co-payments : Often, even for insured services, the insurance reimburses only part of the expenses and the remainder (co-payment) must be paid by the insured. In Rwanda, co-payments (10% of the cost of services) are a problem for the poor, especially in the case of expensive hospitalisation [25]. In Senegal (Thiès region), mutuels pay the health care expenses of their members, who then must reimburse them for the co-payment. However, among the insured in the three poorest quintiles, the difficulty of reimbursing the mutual for the co-payment is the primary cause of indebtedness to their mutual [6].

Post-payment reimbursement : Some insurances let the insured pay the costs of services and then reimburse them afterward. This is the case for SEWA in India. Yet lack of money is the greatest obstacle for their members when they require hospitalisation [37]. People know that if they borrow the money required, the interest will grow while they are waiting for reimbursement from the insurance, which can take weeks or months [38]. Moreover, there are costs associated with the reimbursement process: to obtain the required supporting documents (transportation to the health facility, payment charged by the doctor to produce the documents); to submit the reimbursement request (transportation to the insurance office); to deposit the reimbursement cheque (transportation to a bank); and all of this, without counting the hours of work lost for these activities [37].

➔ Measures to reduce obstacles to service utilisation for the poor insured

We present below some measures that health insurances can adopt, as well as service utilisation observed among the insured (as a rough guide only, since utilisation also depends on other factors besides insurance).

a. Reduction of, or exemption from, co-payment

In Bangladesh's GK Insurance, co-payment varies according to the insured's income:

		Insured				Non-insured
		Indigents	Poor	Middle Class	Well-off	
Co - P.	Visit (in taka)	3	5	10	10	20
	Medicine	Free	Free	25% of cost	75% of cost	100% of cost
	Caesarean (in taka)	50	500	1500	3000	3500
Utilisation	Visits (per person, per year)	1,74	0,80	0,60	1,01	0,004
	Hospitalisations (per 100 persons, per year)	2,00	2,30	3,72	10,70	0,41
	Surgeries (per 100 persons, per year)	0,25	0,50	0,73	2,27	0,05

Adapted from Desmet et al., 1999 [31]

The insured, even the indigent, use many more services than do the non-insured. However, comparisons of the insured in different socio-economic groups are ambivalent. Those who are less well-off have higher rates of visits, but lower rates of hospitalisation and surgery, than those who are better-off [31]. Another option would be to exempt the indigent from all co-payments. This is theoretically the case in Rwanda, but according to recent observations in the field, this exemption is rarely respected [20]. There are no recent studies on this question.

b. Financial agreement between insurance and health care provider

In Senegal, the mutuels in Thiès have an agreement with a hospital in the region. In cases of hospitalisation, the insured present the hospital with a letter of guarantee from their mutual, and they are treated without having to pay. If the total cost for services exceeds the maximum ceiling for coverage, the insured will reimburse the overage to the mutual in several instalments. However, despite this measure, the probability of using a hospital is still largely determined by the income of the insured [4].



c. Simplified reimbursement procedures

SEWA Insurance in India experimented with prospective reimbursement in certain designated hospitals. Upon arrival at the hospital, the insured has the hospital contact the local SEWA representative, who goes to the hospital within 48 hours and reimburses the insured for costs already incurred. Then, on the day the insured is discharged, the SEWA representative reimburses the remainder of the health expenses and collects, himself, the required supporting documents. In this way, the insured is reimbursed without delay and without complicated procedures. We note that the insured who opt for this system are poorer than those who choose to be reimbursed later. They appreciate that the reimbursement procedures does not cost them anything. Nevertheless, they still experience difficulty in finding the money to pay for the services before reimbursement, even if it is accelerated [39].

It is not surprising that service utilisation among the poor insured is sometimes constrained even when insurances adopt supportive measures. This does not mean that these measures are ineffective, but rather that they act upon only some of the utilisation-limiting factors.

CONCLUSION

After this overview of strategies for including the poor in health insurance programs, we see that it is not a question of deciding which strategy is “better”. Situations vary from one insurance to another and each should be studied to find the most appropriate solution(s) among the range of possibilities. What is important to remember is, on the one hand, that among measures aimed at promoting insurance membership, we need to distinguish carefully between those that respond to the needs of the very poor and those intended for the moderately poor; and, on the other hand, that the measures for reducing obstacles to health services utilisation only target those internal to insurances; external obstacles persist and must be addressed with other interventions.

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