

## **SUMMARY**

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#### **The challenge of universal social health protection coverage**

During the last 20 years, micro-insurance has come to play an important role in extending access to health care services for poor and vulnerable individuals in developing countries. Private insurers, NGOs, governments and international agencies have actively participated in the consolidation of micro-insurance products, in particular, to cover risks that have catastrophic consequences on poor households.

Health Protection remains a challenge in many poor countries, where the vast majority typically is not adequately covered and has to face out-of-pocket-payments when accessing health services. The role that Community-based health insurance and Micro-Insurance schemes can play to close this gap is discussed in several articles of the September 2009 issue of the Journal “Alternatives Internationales”. The articles describe the status quo as follows:

- poor health due to accidents or diseases is the single most important risk that poor and vulnerable sections of the population are confronted with.
- Health systems in poor countries are severely under-financed and services are inequitably distributed, favouring urban centres and to the disadvantage of poor and rural areas.
- The introduction of user fees by many countries in the 1980ies, aiming for (partial) cost-recovery, create obstacles to access services and constitute the most inequitable mechanism to finance health services
- The re-introduction of “free services” during the past decade, has exacerbated the problem of under-funding of facilities and drug dispensaries in many countries
- Micro-insurance schemes aiming at reducing the risk of the poor of catastrophic health expenditures developed in many countries in the 1990ies.

#### **Squaring the circle**

Commercial insurers by nature have to be concerned about profitability. In light of the limited capacity of the poor to contribute, commercial insurers have developed micro-insurance policies at affordable prices that provide very

reduced benefit packages: They often only cover inpatient treatment up to a ceiling, thus only insuring a small fraction of the overall health risks and related health care costs of the average household. These products have created limited business opportunities as insurers face the constraints of high administrative costs, limited purchasing power and small risk pools. More importantly, the resulting products are usually insufficient to respond to the health protection needs of the people they 'cover'.

On the other hand, predominantly in Africa, micro-insurance schemes are run by NGOs or cooperatives on a not-for-profit basis. These schemes usually aim at providing a comprehensive benefit package at low contribution rates. However, even these schemes need to charge a contribution rate that ensures financial viability, which inevitably has exclusionary effects for the poorest who are unable to afford even modest membership fees. In sum, the primary target group for micro-insurance schemes are not the "poorest of the poor" but rather low-income groups that can afford to pay a certain level of contributions. The dilemma is difficult to resolve: charging contribution rates that reflect the ability and willingness to pay will attract more people to the scheme but often does not cover the cost for the micro-insurance scheme to supply a benefit package that corresponds to the needs of the population. Reducing the benefit package or increasing the contribution level will mean that less people want to/are able to join but below a certain number of members, the scheme will not be able to recover its operational costs.

During the first phase of setting up the micro-insurance scheme, where the membership base is gradually building up but investment needs for training and infrastructure are considerable, it is particularly difficult for schemes to break even. Many schemes therefore rely on additional funding from the government or donors to cover administrative and management costs in the first few years and for covering the contributions of the most vulnerable sections of the population. In the absence of measures specifically catering for the poorest parts of the population and often limited availability of health services, exclusionary effects can also result from the side of providers who may be unwilling to treat non-insured patients.

The high costs associated with the setting up and running of health insurance schemes (both national health insurance or micro-health-insurance schemes) are often seen as unjustified and it is argued that the money would be better spent on building hospitals, buying drugs and hiring health staff. Against this view, arguments are held that the administrative cost of insurance schemes is justified where insurance organizations play the role of an active purchaser of health services, contracting with providers for certain services leading to increases in the quality of services if the insurer has sufficient negotiating powers.

In countries like Bangladesh, Micro-finance institutions, in recognition of the fact that the main reason why members failed to re-pay their loans were related to

health problems or catastrophic health expenditures, started health micro insurance activities. By encouraging their members to purchase health insurance coverage, the micro-credit institutions hope to increase the repayment rates for their micro-credit products. Faced with low take-up rates, some micro-credit institutions even started charging a higher interest on their loans and providing automatic health insurance coverage for their members. In contrast to this quasi-compulsory insurance, micro-health-insurance schemes generally operate on a voluntary basis, most of the time only covering a small fraction of the population. As such, they usually complement national efforts to extend social health protection coverage to certain parts of the population but cannot substitute other sources of financing and means to provide access to health care. However, governments of some countries like Rwanda and more recently Ghana and Tanzania, have achieved remarkable success in establishing a nation-wide system of compulsory micro-insurance schemes, reaching coverage rates of about 50% (Ghana) to 70% (Rwanda).

In sum, micro-insurance schemes are struggling to square the circle and achieve financial sustainability at scheme level, a wide coverage of the population, providing a comprehensive benefit package at affordable contribution rates.