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Policy Insights No. 11

Private Health Insurance for the Poor in Developing Countries?

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Introduction

This *Policy Insight* assesses the potentials and risks of private health insurance markets for the poor. It gives an overview of the penetration of private health insurance in insurance markets of different regions, discusses its pros and cons in terms of efficiency and equity in providing access to health care and elaborates on how regulation of this growing market can improve outcomes.

Health care financing continues to be a key challenge in the developing world. Despite efforts to improve the provision of health services, many low- and middle-income countries are still far from achieving universal health coverage. An estimated 1.3 billion people do not have access to effective and affordable health care, including drugs, surgeries, and other medical facilities. As documented by the World Health Organisation, developing countries bear 93 per cent of the world's disease burden, yet merely account for 18 per cent of world income and 11 per cent of global health spending.

The critical question is hence how to improve the access to health care and financial protection of the poor in developing countries. Whereas formal statutory health insurance schemes have largely failed to reach the poor, private for-profit and not-for profit schemes are emerging in different regions of the world offering a potential improvement in risk sharing for a larger part of the population.

Health Care Financing in Developing Countries: What´s New?

Developing countries rarely have the financial means and institutional capacity to provide state-based health insurance. A large amount of health costs is, thus, directly borne by patients. So-called "out-of-pocket-payments" account for one third of total health expenditure (THE) in two thirds of all low-income countries. This situation became even more prevalent after the introduction of cost sharing mechanisms in many developing countries (e.g. user fees, co-payments, or deductibles).

Low-income families, in particular, suffer from these conditions as direct payments pose severe risks of impoverishment. Without sufficient social protection, many households are threatened by catastrophic health expenditures, especially considering the impact of indirect costs associated with illness (e.g. a loss of productive capital).

In view of these perils, the current debate on health sector reform clearly emphasises the need to move away from excessive reliance on point-of-service-payment to pre-payment and risk-sharing. Private health insurance (PHI) offers a potential alternative to insure against the cost of illness and lately has been receiving increasing consideration from policy makers around the world. This trend is being further accelerated by:

- the inclusion of an insurance component into micro-finance-institutions;
- health sector reforms and decentralisation;
- increasing recognition of the importance of health security for pro-poor growth.

PHI in the Developing World: An Inventory

So far, the contribution of PHI towards universal health coverage remains limited. Of all 154 low- and middle-income countries, only 11 (7 per cent) channel at least 10 per cent of total health expenditures through private risk-sharing programmes. However, this picture is gradually changing as insurance markets are on a rise. Measured in terms of premium volume, the insurance industry in developing countries grew more than twice as fast as in industrialised economies during the ten years to 2004 (10.4 per cent as compared to 3.4 per cent in the life insurance sector and 7.3 per cent as compared to 2.6 per cent in the non-life insurance sector[1] respectively). The area of health has also witnessed the development of new and innovative ways in which the poor can obtain private insurance.

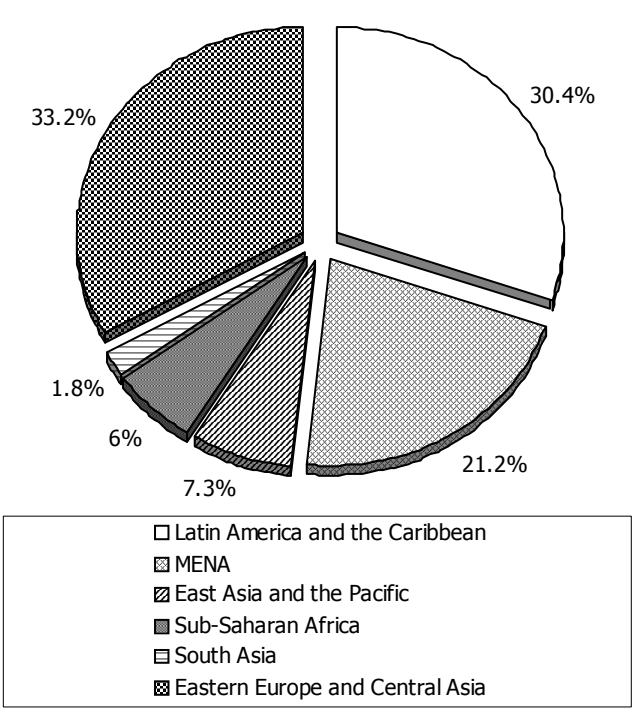
It is nevertheless essential to note that low- and middle-income countries comprise a very heterogeneous group. Particularly striking is the large disparity of expenditure for insurance premiums among individual countries, reaching from per capita values of $1 064 in Barbados to $3 in Bangladesh. Similarly, insurance penetration [premium income relative to Gross Domestic Product (GDP)] varies from 0.5 per cent in Saudi Arabia to 15.9 per cent in South Africa, which is the highest penetration rate in the world (Swiss Re-Insurance Company, 2005).

Regional Overview

Looking at the financial volume of non-life insurance markets, the significance of private (health) insurance varies widely across developing countries. The industry is relatively well established in Latin America and Eastern Europe, while premium income is exceptionally low in sub-Saharan Africa as well as South and East Asia.

Similar differences can be observed in PHI coverage. While private pro-profit schemes are generally limited to the wealthy minority, a few countries reach coverage rates of more than 50 per cent of the total population (e.g. Uruguay, Colombia). Levels of 25 per cent and above are reported for Brazil, Chile, and Thailand, though this last can primarily be attributed to public subsidies to the Thailand Health Card Programme. Finally, coverage rates of 18 per cent in South Africa and 5-8 per cent in Jordan, Lebanon, and Zimbabwe are remarkable as they clearly exceed their region's norm.

Figure 1. **Non-life Insurance Markets around the Developing World**



Pros and Cons of Private Health Insurance

PHI rests upon a private contract between the insurance company and its clientele which sets the level of an insurance premium in exchange for a given benefit coverage. Except for a few countries (e.g. Switzerland, Uruguay), participation in these schemes is usually voluntary.

The spectrum of PHI in developing countries ranges from large, commercial to small, non-profit schemes, which can be run by private entities (including health care providers), Non-Governmental Organisations, or even communities. Furthermore, insurance programmes may offer individual contracts or cover particular groups of people, which is often the case with employer-based schemes that rarely extend beyond the formal labour market.

Personalised Coverage and Innovation

Depending on the specific design of a scheme, PHI offers certain advantages over other forms of health financing. In general, PHI will offer personalised insurance packages[2] and competitive premiums, particularly to good-risk

1. In accordance to EU and OECD conventions, health and accident insurance are considered to belong to the non-life insurance segment, although some countries or insurance companies may employ a divergent classification (Swiss Re-Insurance Company, 2004: 28).

2. Jack (2000: 27) reports that insurance companies in Chile offered close to 9 000 distinct PHI policies in 1995, "reflecting a near continuum of vertical differentiation".

individuals. Due to small company sizes and reduced bureaucratic processes, PHI can potentially work more efficiently than social insurance schemes, although insurers often face higher administrative costs due to product development as well as advertising and distribution activities. Alternative ways of premium collection expand coverage beyond formal sector employment. The non-profit PHI sector, in particular, offers room for innovation to include individuals who would otherwise be left outside insurance-based programmes.

Market Failure and Market Exclusion

The voluntary nature of the insurance contract means that the risk-pool of PHI is often relatively small, which can have negative implications for the financial stability of schemes. Owing to information asymmetries between insurance providers and insurance takers, PHI is also prone to market failure and market exclusion.

Premiums in risk-rated schemes are primarily based on individual health risks rather than a person's income. In community- or group-rated schemes, on the other hand, the comparatively small risk-pool will make cross-subsidisation between different risk-groups more difficult than in social insurance schemes.

Furthermore, providers of PHI have an incentive to be selective about whom to insure. Beyond raising premiums for bad-risk individuals, providers can simply refuse to insure high-risk/high-treatment patients (*discrimination*). Evidence of market exclusion of bad-risk patients is manifold and difficult to prevent (*cream-skimming*). Sometimes, public regulation even deteriorates market outcomes; e.g. in the case of community-rated schemes (i.e. schemes that are based on the risk profile of a community and not the individual), general enrolment obligations for insurance providers will mainly attract bad-risk individuals. This will lead to premium escalation, which further discourages good-risk patients from joining a scheme (*adverse selection*).

Finally, as health risks are not shared in a large risk-pool, but are spread among few individuals or across time, mismanagement can cause bankruptcy of schemes. Given these perils and the particular nature of health as a partially public good, PHI requires an efficient institutional and regulatory framework to prevent market failure.

Policy Options

Regulatory requirements for PHI vary largely between regions or across countries. Depending on *i)* the development stage of a country, *ii)* the expansion of the health insurance industry, and *iii)* a state's institutional capacity, policies should aim at establishing, consolidating, or regulating the insurance sector. This can be illustrated by discussing policy options for an already well developed insurance market (Latin America), a quickly evolving market (East Asia), and a still insignificant market (sub-Saharan Africa).

Latin America

In Latin America, the insurance industry has grown tremendously in recent years. Regulation should now aim at improving market performance of PHI and at increasing health care coverage. After drastic reforms in the 1990s (Chile, 1981), large parts of the health sector have been privatised. However, the introduction of PHI and the increased presence of foreign insurance providers have not yet materialised in better products and lower premiums. Severe inequities in health coverage have been reported for Argentina, Brazil, Chile, Colombia, and Peru.

More efficient regulation is needed to prevent social schemes from being the insurer of last resort. Otherwise existing inequities in health care coverage will not disappear and public funds will be overburdened with bad-risk individuals. Solutions especially need to be found to provide insurance for the poor and the elderly who are often excluded from PHI (e.g. mandated membership, compensation mechanisms between private and public schemes).

East Asia

Health coverage in East Asian countries has traditionally been provided by the state. In fact, all East Asian countries except Hong Kong have mandatory public health insurance. However, increased consumer demand and rising health care costs will probably promote the development of PHI. Already, households are responsible for a high percentage of total health expenditure, mostly in form of direct payments. Ideally, these payments could be channelled to prepaid programmes. Furthermore, high levels of household saving help to underpin the growth of the insurance market.

If countries decide to shift resources to private insurance further, public subsidies can help increase the supply and demand of PHI. Thailand's Health Card Programme offers an illustrative example of how a state programme can foster the growth of private risk-sharing. Since its initiation as a pilot in 1991, this government-promoted voluntary risk-sharing scheme has attracted 28.2 per cent of the Thai population (WHO, 2004). So far, the programme depends upon public subsidies – a situation that must not persist in the long run. Future regulation should thus guarantee that schemes are financially sustainable and meet certain performance standards.

Sub-Saharan Africa

Apart from rare exceptions (notably South Africa, Namibia, Zimbabwe), private health insurance in sub-Saharan Africa occurs on a low membership, contributions, and coverage

scale. The increasing emergence of community-based health insurance during the past couple of years has been particularly strong in this region (Jütting, 2004). Micro-insurance schemes were recently implemented in Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Ghana, Guinea, Mali, Nigeria, Senegal, Tanzania, Togo, and Uganda. Owing to the non- or low-profit nature of most schemes, premiums are relatively moderate, which explains the low level of PHI expenditure in sub-Saharan Africa.

Although coverage is limited to a few people (generally below 1 per cent of the population) and services (moderate coverage for only certain types of treatment), community-based health insurance might become a building block in future health financing; especially considering that – due to financial and institutional constraints – private (community-based) health insurance is often the only available form of risk-pooling. However, community programmes will only provide a real alternative to state health schemes if they extend coverage to more people and services. Beyond encouraging the establishment of new schemes, public regulation should thus try to facilitate the professionalisation of existing programmes. This could include requirements for adequate financial standards and performance mechanisms as well as policies aimed at promoting co-operation between schemes.

Outlook

In many developing countries, PHI is on a rise. Various factors contribute to this development: growing dissatisfaction with public health care, liberalisation of markets and increased international trade in the insurance industry, as well as overall economic growth allowing higher and more diversified consumer demand. This last aspect in particular is expected to put pressure on the supply side of the system to increase choices and improve the quality of health care coverage.

This development presents both opportunities and threats to the health care system of developing countries. If PHI is carefully managed and adapted to local needs and preferences, it can be a valuable tool to complement existing health-financing options. In particular non-profit group-based insurance schemes could become an important pillar of the health-financing system, especially for marginalised individuals who do not have access to formal insurance.

The introduction of PHI is not an end in itself, but ideally an element in a process towards achieving universal coverage. It is neither the only alternative nor the definitive solution to addressing alarming health care challenges in the developing world, but it is an option that warrants growing consideration by policy makers around the globe. Thus, the question is not if this tool will be used in the future, but whether it is applied to the best of its potential to serve the needs of a country's health care system. It is the responsibility of policy makers in developing countries as well as the international donor community to assist this process and to support countries in their endeavour to improve health coverage.

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