

# Comparing Kenya's private health markets with neighbouring markets: A focus on healthcare financing

Private Sector Innovation  
Programme for Health (PSP4H)



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## Foreword

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During the period January 2014 through March 2014, PSP4H commissioned a study on private health financing as it is usually misunderstood in low and middle income countries. In Kenya health care costs are enormous and financing mechanisms are critical in order to have a productive nation. Despite this, challenges still exist in tackling health financing. The key theme for this study is the provision of universal health coverage, which is defined as all people who need health receive this without undue financial hardship especially for the working poor population.

The study was undertaken in March 2014 and involved a comprehensive secondary literature review of various global database and reports.

This study has come at a very opportune time for Kenya where several discussions and forums on devolution and topic of Universal health care for the 47 counties are on-going. The WHO health report of 2010 focused on health systems financing as a key pathway to universal health and private health financing is core to this.

The report highlights several innovations taking place in Kenya and other countries as well as in the region to improve delivery of health services for the poor and enhance accountability for results. The reproductive health voucher programme and performance based financing are some of the good examples while some countries have made remarkable progress in improving access for their citizens through client-responsive incentives. Kenya can build on these experiences. Similarly, many countries have devolved health systems and lessons learnt from such countries would be useful for Kenya.

Given the current difficulties and limited scope of private health financing schemes in developing countries, it is equally valid to question the extent to which such schemes can provide coverage for the poor. The alternative of investing more in larger-scale prepayment schemes (whether government schemes or social health insurance, or some combination of the two) may well be a more feasible way to provide financial protection for the poor, as well as hasten the transition to universal health coverage.

Finally the community based health insurance and micro insurance model is of interest and using this with mobile technology has gained momentum and has the potential of being used to increase the scope and population coverage of other health insurance mechanisms. PSP4H will seek to explore further these initial findings to develop health financing interventions for the working poor populations.

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## Executive Summary

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The role of private health financing in low- and middle-income countries is not well understood, with little documentation on what does and does not work. Accordingly, private health markets are often poorly regulated, with high prices and inconsistent quality of care. At the same time, many households pay directly for health services, and visit private health facilities.

This literature review aims to contribute to our understanding of the global private health financing sector, with a particular focus on low-cost private health financing approaches for poor populations in developing countries. We base the scope of our literature review on the international System of Health Accounts methodology and definitions (WHO 2011). Note that we are interested in private health financing mechanisms, rather than private sector delivery of health services.

In general terms, health financing schemes can be defined as “the main types of financing arrangements through which people obtain health services” (WHO 2011). The private health financing schemes analysed, whilst varying in design and implementation, share the characteristic of being based on prepayment funding mechanisms.

We explore the literature on the following private health financing schemes:

1. Risk-rated private health insurance
2. Employer-based health insurance
3. Enterprise financing schemes
4. Community-based health insurance (including health micro insurance)

We pay particular attention to *innovative private sector solutions* that have successfully boosted the development of these financing schemes. Given the purpose of this review was to review private approaches, we excluded government-run schemes and compulsory contributory schemes (e.g. social health insurance).

**Risk-rated private insurance** has been much more prevalent in high-income countries, where it has been used to fill gaps in publicly funded systems and to pay for an increasing demand for health services. We find that, in sub-Saharan Africa, whilst risk-based private health insurance schemes may offer relatively comprehensive financial protection for the individual insured, when taken as a whole, risk-based PHI schemes do not constitute a large share of overall health expenditure. For example, in South Africa, private insurance schemes accounted for an estimated 81% of private health expenditure and 42% of total health expenditure in 2011 while covering only 16% of the population (Di McIntyre and Ataguba 2012).

There are a few examples of **employer-based health insurance schemes** in a few developing countries. In Yemen, they represent the most prevalent source of third-party coverage of health services. We also found an innovative way of delivering employer-based health insurance by DomestiCare in South Africa which caters for domestic workers.

We also found that some companies have **enterprise financing schemes** as part of their corporate social responsibilities, and/or as extensions of work injury compensation schemes (Biquand and Zittel 2012). AngloGold Ashanti, a mining company, is a good illustration of this. It provides free healthcare for its employees and their dependants, and is subsidized for the local community, at the Obuasi Edwin Cade Memorial Hospital. Just like AngloGold Ashanti, private agricultural plantations in Malaysia are engaged in malaria control efforts in their localities.

**Community-based health insurance** (CBHI) exists in many low- and middle-income countries, especially in Africa and Asia (Guido Carrin 2003; ILO 2005). In terms of population coverage, these schemes exist within localised communities, most often in rural areas: members make small payments to the scheme, often annually and after harvest time, and the scheme covers the fees charged by local health services” (McIntyre, 2007 p4). Scheme participation, which is linked to cost-recovery, varies considerably across schemes and also within schemes across different sites (Mebratie et al. (2013)).

Our review finds that CBHI schemes are often unable to raise significant resources because of the limited income of the community, and the pool is often small, making it difficult to serve a broad risk-spreading and financial protection function. The schemes' size and resource levels make them vulnerable to failure. They are also placed at risk by the limited management skills available in the community, and they have limited impact on the delivery of health care, because few negotiate with providers on quality or price. At the same time, CBHI has reduced household's out-of-pocket expenditures on health.

**Micro-insurance for health** is a particular form of CBHI where micro health insurance is included in microfinance schemes. It has shown promise in providing some financial risk protection for poor families in developing economies. However, they have rarely been able to represent a perfectly balanced portfolio, between risk and return, either because their client volume is too small (either due to enrolment demand or capacity), or because the relatively large risks they cover among low-income populations represents a disproportionate impact on the portfolio as a whole (Dror et al. 2009). The case of Microcare Uganda is instructive in looking at the successes and failures of micro-insurance schemes for health.

Assessing the examples of voluntary private health insurance schemes overall, we find that even from the experiences in high-income countries, it is difficult to draw generic, empirically based, policy lessons. The system-wide impact of voluntary health insurance appears to be influenced by a variety of factors, including its functions, the nature and extent of mandated financing, and the extent to which there are binding (and relatively inelastic) constraints on key inputs (such as the number of doctors practicing in a country). What is more, there is a paucity of data on the experiences of developing countries.

Nevertheless, for all the types of private health financing schemes discussed, the following recommendations could be useful in increasing their scope, effectiveness and impact:

1. Mandating core benefits is important if the various forms of private health insurance are intended to be a primary source of coverage for large segments of the population.
2. If coverage restrictions exclude care for common high-cost conditions in developing countries, like AIDS and cancer, then the financial protection provided will be insufficient.
3. It is important to strike a balance between providing effective financial protection and assuring affordable premiums.
4. Policy-makers need to remember that methods used to calculate premiums have an important effect on equity and affordability.
5. There is scope for donors and other non-state actors to promote and ensure that countries are openly vigilant regarding the potential for fraud, abuse and corruption.

For the PSP4H programme, these findings are important to understand exactly what can and cannot be achieved by private health financing schemes in Kenya context.

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# 1 Introduction

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The role of private health financing in low and middle-income countries is not well understood, with little documentation on what does and does not work. Accordingly, private health markets are often poorly regulated, with high prices and inconsistent quality of care. At the same time, many households pay directly for health services and visit private health facilities.

This literature review aims to contribute to an understanding of the global private health financing sector, with a particular focus on low cost private health financing approaches for poor populations. In doing so, this review is intended to inform the Private Sector Innovation Programme for Health in Kenya.

The specific objectives of the report are as follows:

1. To synthesise available information on global data, knowledge and experiences of low cost private sector health financing approaches for poor populations;
2. To extract lessons learned and best practices from the global and regional experiences of the low cost private sector health finance markets;
3. To recommend future research and programme directions for PSP4H based on the information gathered in the synthesis.

The rest of this report is structured as follows. In Section 2, we detail our methodology for the literature review, describing the scope of the review and our search strategy. In Section 3 we present our findings from this literature review. Section 4 highlights some key discussion points, including lessons learned and best practices; Section 5 concludes by highlighting key policy implications, including recommendations for PSP4H.

## 2 Methods

### 2.1 Scope of the literature review

The overall goal of this literature review is to better understand the current landscape of pro-poor private financing models for health in developing countries. We base the scope of our literature review on the international System of Health Accounts methodology and definitions (WHO 2011). This is because health accounts offer a comprehensive set of internationally agreed definitions for the range of health financing schemes that occur across the globe.

Health accounts are designed to analyse and track health expenditures on the three axes of consumption, provision and financing. Our interest is in the financing axis, given that we are reviewing private health sector financing approaches. We specifically focus on those private health financing schemes that exist to enable the poor to utilise both private and public providers of healthcare. That is, our review takes health financing schemes as the starting point, rather than health providers or consumption patterns of health services. At the same time, it is important to remember that such an approach comprehensively describes a health system, since the three health accounts axes are interconnected, reflecting the underlying principle of health accounts that "what is consumed has been provided and financed" (WHO 2011).

In general terms, health financing schemes can be defined as "the main types of financing arrangements through which people obtain health services" (WHO 2011). Private health financing schemes, whilst varying in design and implementation, share the characteristic of being based on prepayment funding mechanisms. This is in contrast to direct out-of-pocket payments by households. Section 2.2 discusses these different private schemes in more detail, including how they differ from government or external health financing schemes, and a clear specification of which type of health financing schemes we include in our literature review.

As much as possible, we review and assess the literature on private health financing schemes in relation to the three dimensions of universal health coverage, namely:

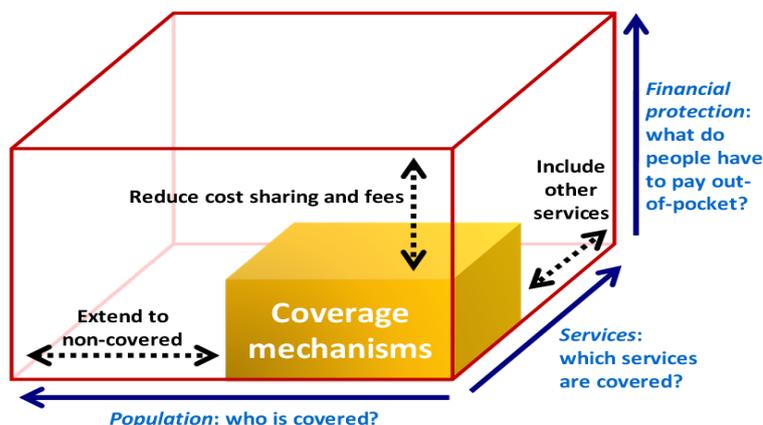
Population coverage: who is covered by the financing scheme (including the size and composition of risk pools)?

Service coverage: which health services are covered (or excluded) by the financing scheme?

Cost coverage: to what extent are the costs of health services covered by the financing scheme?

These are illustrated in Figure 1.

**Figure 1: The WHO 'cube': three dimensions for universal health coverage**



Source: WHO: Health systems financing - the path to universal coverage (2010)

When reviewing the literature on private health financing schemes, we pay particular attention to *innovative private sector solutions* that have successfully boosted the development of these financing schemes. For example, we included mobile micro-insurance like Linda Jamii, offered by Changamka, underwritten by

Britam Insurance company and Kenya's Safaricom, and Hospital Benefit Plan, offered by Globe in the Philippines, that have successfully increased enrolment in micro-insurance schemes with a health component. Note that we exclude innovative global financing initiatives, like airport levies, the Tobin tax and more traditional ones like the Global Fund for AIDS, TB and Malaria since they are more international in their fund-raising, enforcement and management (Taskforce on Innovative International Financing for Health Systems 2009).

Note finally that whilst the focus of our literature review is on *private health financing schemes*, it is useful to briefly summarise here the evidence on *private health providers*. A number of papers have assessed the role of private health providers in low- and middle-income countries, including systematic reviews that have compared private and public providers (key references include Basu et al. 2012; Berendes et al. 2011; Prata, Montagu, and Jefferys 2005).

These studies find that private providers are a heterogeneous group, ranging from formal for-profit entities such as large independent hospitals through to more informal entities. It is the informal entities, such as unlicensed providers or drug salespeople, that typically serve the lower-income population groups – and indeed poor families utilise such informal providers more than public facilities. In contrast, when one only considers formal, licensed health providers, the poor more often utilise public facilities, with private providers servicing higher socio-economic groups.

There are, though, some important examples of formal private facilities successfully servicing a wider population group, particularly non-profit faith-based providers in a number of African countries (Leonard 2002). Further, there are examples of private facilities and social franchises contracted by governments to provide services, with the Cambodian experience a notable example (Loevinsohn and Harding 2005). However, these private providers have been *financed* by governments and donors, with a specific remit to service a wider population group that includes the poor.

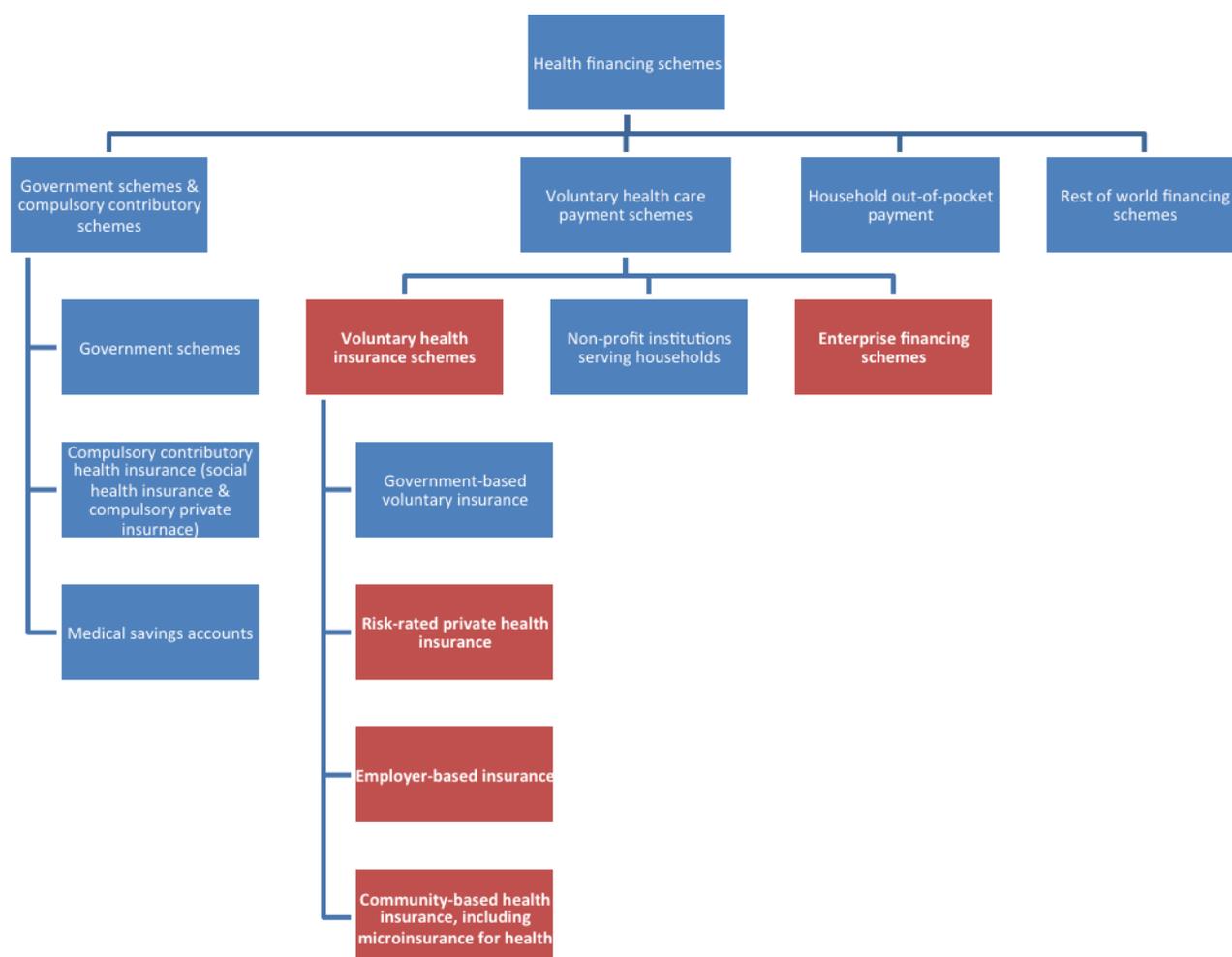
These studies also found that private providers are more responsive to patients (e.g. shorter waiting times, more courteous staff), and have better availability of supplies than public providers. On the other hand, private providers had greater risks of delivering low (clinical) quality care; and were less efficient than the public sector, primarily because of higher drug costs, and unnecessary testing and treatment (arising from fee-for-service payment).

## **2.2 Understanding the different types of private health financing schemes**

In this section, we map out the different types of private health financing schemes that operate across the world, based on System of Health Account classifications. In doing so, we specify exactly which types of private financing schemes we include in our literature review, and why. Moreover, we also include brief definitions of government and other health financing schemes that are not covered by our literature review. This enables us to have a better understanding of how private schemes fit into the broader set of health financing schemes.

Figure 2 illustrates the full classification of health care financing schemes, as defined in the international System of Health Accounts (including relevant sub-categories). Private health financing schemes covered within our literature review are shaded in red.

**Figure 2: System of health accounts classification of health care financing schemes**



Derived from WHO (2011). System of Health Accounts.

As illustrated in Figure 2, we included four types of voluntary health insurance schemes and enterprise financing schemes in our literature review of private health financing schemes. The rationale for including or excluding each health financing arrangement in our review is described below, together with a brief description of each scheme derived from the SHA manual.

### 2.2.1 Government schemes and contributory compulsory schemes

#### Government schemes [excluded]

In government schemes, participation is automatic and universal, or less commonly targeted towards a specific category of people (like Medicaid in the United States of America and the Civil Servants Benefits Scheme in Thailand). They are excluded from our review since they are government-based.

#### Compulsory contributory health insurance schemes

1. *Social health insurance schemes [excluded]*: these are government-initiated schemes (often run on a tripartite basis), based on mandatory enrolment. They have been established in over 60 countries worldwide (Gottret and Schieber 2006) including Kenya, which has the the National Hospital Insurance Fund (NHIF) Membership is compulsory for all salaried workers in the formal sector (both public and private) and voluntary for informal sector workers (Stone et al. 2014). Social health insurance schemes are excluded from our review since they are government-based.

2. **Compulsory contributory private insurance schemes [excluded]:** in such schemes, all residents (or a large group of the population) are required to take out health insurance with an insurance company or fund. The most oft-cited example is that of the Netherlands. Through the Affordable Care Act, there is a push for the USA to follow the Dutch model of private insurance (van Weel, Schers, and Timmermans 2012). These are excluded from our review because there are no known examples in low and middle-income countries, although Uruguay (which recently became a high-income country) has a mandatory, private insurance system that covers over 60% of the population (Sekhri and Savedoff 2005).
3. **Medical savings accounts [excluded]:** when compulsory, such schemes are closely regulated or run by government. Singapore's *Medisave* is a classic example of a compulsory medical savings account (McKee and Busse 2013). There are also a few examples of voluntary medical savings accounts, piloted in Malaysia, South Africa and the USA, but these have been limited in scope (Hsu 2010). Further, when voluntary they are essentially indistinguishable as a "scheme" from other types of out-of-pocket spending, since the "source" of funds for such spending is household savings (WHO 2011).

## 2.2.2 Voluntary health care payment schemes

### Voluntary health insurance schemes

1. **Government-based voluntary insurance [excluded]:** these schemes are initiated and subsidised by government. For example, in China the New Rural Co-operative Medical Scheme and the Urban Basic Health Insurance schemes are government subsidised voluntary schemes. Such schemes are excluded from our review since they are government-based.
2. **Risk-rated private health insurance [included]:** here we refer to voluntary private health insurance organisations where premiums are risk-rated (rather than being based on ability-to-pay). Such schemes are typically operated on a for-profit basis.
3. **Employer-based health insurance [included]:** these are a type of group insurance purchased by employers for all employees. The premium paid by the employer is usually risk-related at the group level, but contributions paid by individuals are usually not risk-related.
4. **Community-based health insurance [included]:** one model seen in many sub-Saharan African and South Asian communities is often referred to as community-based health insurance (CBHI). Whilst there is much variation in the community-based model, they all are voluntary, and premiums are not usually risk-rated. In practice, three forms of CBHI are most commonly found: First, CBHI can be organized and executed by communities themselves, as is seen in the *mutuelle de santé* (or mutual health organizations) that are most common in West Africa (Tabor 2005). Second, CBHI can leverage local cooperatives that organize informal sector workers. Third, CBHI can be layered on top of an existing, trusted microfinance organization's offerings, as is seen most commonly in South Asia (Lagomarsino and Kundra 2008). This latter type of CBHI, which we label **micro health insurance**, has recently had some interesting innovative approaches associated with it.

### Non-profit institutions financing schemes [excluded]

This is an eclectic set of schemes which are predominantly financed using donor, NGO or hospital funds. They are excluded from our review because the basic method for fund-raising is donations from the public, governments (budget of national government or foreign aid) or philanthropic groups, rather than private organisations.

Still, one noteworthy type within this classification are health equity funds. These create a "third-party payer" system that guarantees payment to health facilities for services provided to the poorest patients (Noirhomme, Ridde, and Morestin 2009). Health equity funds have been operated by an NGO/civil society partner who is independent of the healthcare provider, with funding coming from both international donors and governments. Probably the best known example comes from Cambodia, where studies have found that the health equity funds there have had a large impact on reducing out-of-pocket payments, but less of an impact on health-related debt and healthcare utilisation (Flores et al (2013), Hardeman et al. 2004).

**Enterprise financing schemes [included]:** these schemes describe arrangements whereby (private) enterprises directly provide or finance health services for their employees without the involvement of an insurance scheme.

### **2.2.3 Household out-of-pocket payments [excluded]**

These are direct payments for services from the household. They are still the main method of paying for health services in most low- and middle-income countries, often posing an enormous burden on poor households (WHO 2010). The costs are frequently so high that households are unable to recoup them from existing resources, and, hence, ultimately slip deeper into poverty. Protecting households in developing countries from catastrophic health expenditure continues to remain a formidable challenge, particularly for countries with high levels of poverty (Xu et al. 2007).

### **2.2.4 Rest of world (external) financing schemes [excluded]**

These are financial arrangements involving institutional units (or managed by institutional units) that are resident abroad. They can include foreign-funded donor schemes. Funds are collected and pooled abroad and foreign entities usually have the freedom to design the benefits. We therefore excluded these financing schemes.

## **2.3 Search strategy**

We conducted a desk-based literature review by searching for published and unpublished studies or accounts on the role of the private sector in developing countries in pro-poor financing for health. We put an emphasis on interventions and programmes that are pro-poor, private sector and for-profit. Pro-poor means the working poor, also known as the economically active poor, in line with the definition used by the Private Sector Innovation Programme for Health (Cardno 2014).

The following electronic databases were searched to find publications produced in the last ten years in English: PubMed, Google, Google Scholar, Stanford Social Innovation Review (SSIR), World Health Organization Library Information System (WHOLIS) and Harvard Health Policy Review.

Key words for electronic database searches included: pro-poor financing for health, health private sector, innovative private financing for health, health financing for the economically active poor, private health insurance, enterprise financing schemes, community based health insurance, free-market private health insurance, for profit health insurance, medical cooperative (source MeSH, NLM).

We also accessed the following grey literature resources:

Websites and online resources of USAID, DFID, AusAid, NORAD, UNDP and the World Bank and Dalberg Global Development Advisors

Websites and online resources (working papers) of the Results for Development Institute, the Microfinance Innovation Facility, Harvard School of Public Health, University of Cape Town, BRAC, Grameen Bank, the Institute of Development Studies at the University of Sussex and the Center for Health Market Innovations

In addition, snowball data collection strategies were used to identify further studies of interest by perusing the reference lists of resources identified.

We included evidence from low and middle income countries and excluded evidence from high-income countries. However, where relevant and in the interest of providing a context, we cited examples from high-income and upper-middle income countries. The classification of countries is based on the World Bank Atlas method (World Bank 2014).

## 3 Findings

### 3.1 Risk-rated private health insurance

#### 3.1.1 Introduction

Risk-rated private health insurance is the form of voluntary private health insurance that is typically least regulated by governments. The most important difference of these to other forms of insurance is on premium calculation: premiums are risk rated. This means that higher-risk groups, such as the elderly and people with chronic conditions, will be charged higher premiums or not offered insurance if their health needs are perceived to be too costly. This is in contrast to the public system, where contributions are, to varying degrees, related to an individual's income (Grunow and Nuscheler 2013).

Based on the 2011 System of Health Accounts, risk-rated private health insurance schemes have the following characteristics:

Mode of participation: voluntary, at the discretion of an individual or a firm;

Benefit entitlement: contributory: based upon the purchase of the voluntary health insurance policy (usually on the basis of a contract);

Basic method for fund-raising: directly or indirectly risk-related;

Mechanism and extent of pooling funds: individual scheme level.

#### 3.1.2 Examples of risk-rated private health insurance schemes in low- and middle- income countries and their impact

In Sub-Saharan Africa, whilst some risk-based private health insurance schemes may offer relatively comprehensive financial protection for the individual insured, when taken as a whole, risk-based PHI schemes do not constitute a large share of overall health expenditure. That is, for most African countries private health insurance accounts for less than 20% of private health expenditures (based on the WHO Global Health Expenditure database). See Table 1 below for a comparison of private health expenditure derived from the most recently available National Health Accounts data for selected African countries. The exceptions are Namibia, South Africa and Zimbabwe. Of these countries, the South African experience is well documented, but no recent articles were found on the experiences in Namibia and Zimbabwe.

Indeed, Spaan et al.(2012) observed that no systematic reviews were available on the impact of private health insurance (and social health insurance) in low- and middle-income countries. Sekhri and Savedoff (2005) contend that since little systematic data have been collected on insurance markets in developing countries, and that evidence tends to be anecdotal, there could be a certain bias in reporting on health insurance schemes, possibly driven by national government, donor or research priorities, data availability and difficulty in publishing negative impact results.

**Table 1: Health financing by country, using the most recent NHA tables**

	S Africa <sup>1</sup>	Zimbabwe <sup>1</sup>	Namibia <sup>2</sup>	Kenya <sup>2</sup>	Uganda <sup>2</sup>	Nigeria <sup>2</sup>
Private health expenditure (PvtHE) as % of total health expenditure	52.3	61.6	38.3	61.9	76.1	68.9
Private health insurance expenditure as % of PvtHE	81.1	28.8	61.2	9.4	0.2	3.1
Out-of-pocket health expenditure as % of PvtHE	13.8	50.3	17.9	76.9	64.8	95.7

Source: WHO Global Health Expenditure Database

In South Africa, the government initially moved to regulate its private health insurance industry in 1967, but then deregulated it in 1989. The deregulation permitted risk-rated rather than community-rated premiums, effectively restricting access of high-risk groups such as the aged to the private market or making the premiums very costly (Hopkins 2010). Macha et al. (2012) found that contributions to private medical insurance schemes were progressive, in the sense that contributions are made by wealthier groups. However, only these groups benefit from such funds; and among those enrolled, premiums were regressive as they were not income-related. Further, private voluntary insurance schemes cover only about 16% of the population. This leaves the majority uninsured and dependent on under-resourced, tax-funded services (Di McIntyre and Ataguba 2012). Yet these private insurance schemes accounted for an estimated 81% of private health expenditure and 42% of total health expenditure in 2011 (WHO Global Health Expenditure database). A similar inequitable outcome was found in a study on the Zimbabwean experience in the mid-1990s (Zigora 1996).

The major difficulty in South Africa has been that healthcare practitioners are attracted to the more lucrative private system, where fee-for-service and per visit reimbursement is common (McLeod and Grobler 2010). Further, whilst all insurers must operate on a not-for-profit basis, in practice this can be circumvented as many for-profit insurance entities act as a third party administrator and risk-taker for the not-for-profit insurers. Despite calls for revision, there is a tax subsidy for private healthcare which favours the highest income but gives no subsidy to those that earn below the tax threshold. It has been argued that the for-profit status may be a significant motivator of the insurer engaging in risk selection as any profits made will be passed back to the shareholders of the insurer (Armstrong et al. 2010). There has been important policy discussions to find solutions for so-called "low income medical schemes", but little practical progress (Broomberg 2007).

### **3.1.3 Selected examples from high-income countries**

Risk-rated private insurance has been much more prevalent in high-income countries, where it has been used to fill gaps in publicly funded systems and to pay for an increasing demand for health services, according to Sekhri and Savedoff (2005). They go on to say that grouping through employers and labour unions has been the historic basis of private insurance in many countries. Further, many Latin American countries have adopted PHI schemes that are based on the principles of managed care. In this respect, these private insurance markets are primarily influenced by U.S.-type health maintenance organizations (Drechsler and Jütting 2007).

In its study of OECD countries' markets for private health insurance, the OECD concluded that, on balance, private insurance makes the following positive contributions (OECD 2004):

1. Affords financial protection (compared with out-of-pocket expenditure)
2. Enhances access to health services (when mandated financing is incomplete)
3. Increases service capacity and promotes innovation
4. Helps finance health care services not covered publicly, in the case of supplementary private health insurance.

On the other hand, the OECD work concludes that private health insurance markets have generally posed these challenges:

1. They have not reduced certain financial barriers to access (such as affordability and price volatility).
2. They have increased differential access to health care in some countries (but decreased it in others).
3. They have not served as an impetus to quality improvement, with some exceptions.
4. They have removed very little cost pressure from public health financing systems.
5. They have increased total health expenditure in several OECD countries.
6. They have not been able to achieve value-based competition.
7. They have generally incurred high administrative costs.

## **3.2 Employer-based health insurance**

### **3.2.1 Introduction**

Employer-based insurance is purchased by employers, through a contract between the employer (the company) and the insurance entity. The premium paid by the employer is usually risk-related at the group level, but the contributions paid by the individuals are usually not risk-related.

Looking at the 2011 System of Health Accounts, employer-based health insurance has the following characteristics:

Mode of participation: voluntary, at the discretion of a firm;

Benefit entitlement: contributory;

Basic method for fund-raising: risk-related at the group level;

Mechanism and extent of pooling funds: individual scheme level.

### **3.2.2 Examples of employer-based health insurance schemes in low- and middle- income countries and their impact**

In Yemen, employer-based health insurance schemes represent the most prevalent source of third-party coverage of health services. The scope of these company schemes goes far beyond the coverage of labour-associated health problems to include general health problems and coverage of employees' family members. Private company schemes show a wider variation in the scope of benefits, as compared with public enterprises. Public enterprises also tend to grant a relatively more comprehensive benefit package (Holst and Gericke 2012).

In South Africa, DomestiCare is noteworthy in its innovation in protecting the working poor from catastrophic health expenditure. It offers premium, private, day-to-day healthcare for South African domestic workers. It is an occupational health solution offered through the private medical practitioners of the CareCross Health Group (Domesticare 2014). It has been designed for domestic workers in South Africa to help keep employees – who were previously excluded from any form of private healthcare – healthy and productive at work. It is offered to all domestic workers employed in a role for a private household.

According to the DomestiCare website, the coverage DomestiCare offers is not just simple primary care services but also radiology and pathology tests, if requested by the doctor, as well as some maternity and HIV benefits. With DomestiCare Plus there are the added benefits of dentistry and optometry, after the required waiting periods. However, medication for chronic illnesses (such as asthma and diabetes) is not covered. According to its website, premiums for DomestiCare range from R170 (£9.50) to R235 (£13) per month. However, there have not yet been any studies on the impact of DomestiCare.

### **3.2.3 Selected examples from high-income countries**

A classic example of an employer-based scheme comes from the USA, where nearly two-thirds of adults under age 65 and three-quarters of all full-time workers have health insurance through employers (Fairlie, Kapur, and Gates 2011). Here, employers implicitly choose who to sponsor when they hire workers, and hence employers play a key role in redistributing the costs of health care between young and old, healthy and sick, or small and large families. In the US consumers and their sponsors (employers) are allowed to choose not to purchase any insurance at all (Ellis, Chen, and Luscombe 2014). However, the 2010 US Affordable Care Act, will start imposing tax penalties on consumers and employers in 2014 if they do not purchase insurance (Department of Health and Human Services 2013).

According to Buchmueller and Monheit (2009) in their analysis of the American system, there are significant savings associated with employer-based health insurance. These savings flow from three main sources. First, because important administrative costs vary with the number of contracts, rather than the number of individuals covered by a contract, there are substantial economies of scale associated with purchasing insurance through a group. Second, because employer-sponsored groups were formed for reasons other than purchasing insurance and because they tend to be stable over time, employer provision greatly reduces the problem of adverse risk selection, which is a significant concern in the individual market. As a result of these two factors, the administrative load for employer-based insurance is roughly half that for individually purchased policies: 15 to 20 percent compared to 30 to 40 percent (Swartz 2006). The third source of cost

advantage comes from the fact that employer payments for health insurance are exempt from federal and state income and Social Security payroll taxes in the US.

### **3.3 Enterprise financing schemes**

#### **3.3.1 Introduction**

According to the 2011 System of Health Accounts, this category primarily includes arrangements where enterprises directly provide or finance health services for their employees (such as occupational health services), without the involvement of an insurance-type scheme. Therefore, this excludes employer-based insurance schemes. Enterprise financing schemes have the following characteristics:

Mode of participation: voluntary choice of particular enterprise/corporation, with coverage based on employment at the firm (e.g. compulsory occupational health care);

Benefit entitlement: non-contributory, discretionary with regard to the type of services, though may sometimes be specified by law;

Basic method for fund-raising: voluntary choice of the firm to use its revenues for this purpose;

Mechanism and extent of pooling funds: at an individual enterprise level.

Companies usually have enterprise financing schemes as part of their corporate social responsibilities, and/or as extensions of work injury compensation schemes to comply with occupational health and safety regulations (Biquand and Zittel 2012). Occupational health services to protect the worker against sickness, disease and injury arising out of his or her employment have been a cornerstone of workplace recommendations ever since the establishment of ILO Convention No. 161/1985 and the 1996 WHO Global Strategy on Occupational Health for All (Kopias 2001).

Occupational health and safety concerns in developing countries are mainly a key concern among large high risk industries such as mining, oil and gas. This reflects conspicuously in the practice of occupational health and safety programmes being priority areas for such industries; whilst instances of such programmes are rare amongst SMEs, and service sector (e.g. banks), and the informal sector, suggesting that the issue of occupational health and safety is not a core issue amongst the 'low risk' companies (Amponsah-Tawiah and Darthey-Baah 2012).

#### **3.3.2 Examples of enterprise financing schemes in low- and middle- income countries and their impact**

AngloGold Ashanti, a mining company, provides free healthcare for its employees and their dependants, and is subsidized for the local community, at the Obuasi Edwin Cade Memorial Hospital. AngloGold is also engaged in the fight against HIV/AIDS and malaria, especially in the Obuasi mines which has most of its employees. An integrated multi-million malaria control campaign was started in 2005 to help reduce the incidence of malaria in the region. AngloGold Ashanti even developed a satellite mosquito research centre employing a resident entomologist to oversee affairs (Jain 2012). This programme successfully reduced malaria cases in the Obuasi mining community from 6,600 to 1,150 cases a month by 2006 (Mouzin, Sedlmayr, and Miller 2011). Similarly, in 2002 a branch of the Marathon Oil company in Equatorial Guinea identified malaria as a key health issue for employees, and launched a multi-year project to decrease malaria incidence amongst its worker population and nearby villages.

A recent survey to describe provision of medical services for TB and HIV in South African mines found that 40% of visited mines provided health services on site, with 16% outsourcing services and the remainder relying on government health care (Kielkowski et al. 2011).

In Malaysia's Sabah region, a number of agricultural plantations private on-site clinics that are capable of treating malaria cases. Clinicians employed by the plantations and National Malaria Control Programme (NMCP) officers work closely together, with frequent communication. NMCP officers noted that clinicians are often able to act as liaisons between patients and plantation management to ensure appropriate treatment of cases, reporting of cases to the NMCP and in bolstering malaria prevention efforts (Sanders et al. 2014).

### **3.4 Community-Based Health Insurance**

#### **3.4.1 Introduction**

Community-based health insurance (CBHI) is a subcategory of voluntary private health insurance that exists in many low- and middle-income countries, especially in Africa and Asia (Guido Carrin 2003; ILO 2005). CBHI implicitly provides complementary or supplementary coverage in some lower- and middle-income countries, often in contexts where the individuals are legally entitled to the services of government health schemes, but where such schemes are not fully effective.

According to the 2011 System of Health Accounts, key characteristics of CBHI include:

Mode of participation: voluntary;

Benefit entitlement: based upon contribution;

Basic method for fund-raising: defined at local level;

Mechanism and extent of pooling funds: typically at individual scheme level, often described as being "local community" level. While schemes may operate on a local community level, some may not be geographic in nature but instead be organised on another basis (e.g. the health insurance scheme of the Self-Employed Women's Association of India)

According to Mebratie, Sparrow, Alemu and Bedi (2013), the most common forms of CBHI schemes are (i) Community prepayment health organizations (ii) Provider based health insurance and (iii) Government-run but community-involved health insurance. These schemes differ in terms of design and the involvement of the community in setting up the scheme, mobilizing resources, management and supervision.

#### **3.4.2 Examples of community-based health insurance schemes in low- and middle- income countries and their impact**

CBHI schemes took root in Africa in the 1990s in response to user fees, which were introduced in many countries as part of structural adjustment programmes (Guy Carrin, Waelkens, and Criel 2005). They were more common in West and Central Africa especially in Senegal, Benin, Burkina Faso, Cameroon, the Democratic Republic of Congo, Mali and Togo, reflecting a strong Francophone tradition of mutual health associations (Tabor 2005) and later spread to Eastern Africa. About 900 CBHIs existed in sub-Saharan Africa in 2009 (De Allegri et al. 2009).

Referred to by different names (community-based health insurance, mutual health organization, community health funds), many CBHIs were initially implemented with support from international donor organizations with little community initiative, although some were initiated by faith-based health facilities (Ekman 2004). More recently, some governments – for example Ghana, Rwanda and Tanzania – are supporting their existence as part of universal coverage initiatives (Chuma, Mulupi, and McIntyre 2013). More successful examples have included subsidies by government, as is currently the case in Rwanda (Lu et al. 2012).

In terms of population coverage, CBHI schemes exist within localised communities, most often in rural areas: members make small payments to the scheme, often annually and after harvest time, and the scheme covers the fees charged by local health services" (McIntyre, 2007 p4). Scheme participation, which is linked to cost-recovery, varies considerably across schemes and also within schemes across different sites (Mebratie et al. (2013)).

CBHI schemes are often unable to raise significant resources because of the limited income of the community, and the pool is often small, making it difficult to serve a broad risk-spreading and financial protection function. The schemes' size and resource levels make them vulnerable to failure. They are also placed at risk by the limited management skills available in the community, and they have limited impact on the delivery of health care, because few negotiate with providers on quality or price. Without government subsidies, they also have not been able to cover the poorest, since even small premiums may be out of reach for the poor.

The financial stability of community-based health insurance schemes is also affected by problems of adverse selection inherent in voluntary prepayment schemes. Benefit packages are very seldom defined precisely.

The tendency has been to include all services that could be delivered by the facilities participating in the scheme. This broad approach makes it easier for people with pre-existing conditions to join, thus creating severe adverse selection issues (Gottret and Schieber 2006).

A set of analysis by Mebratie et al. (2013) is instructive in understanding the service coverage by CBHI. They find that while community prepayment CBHI schemes often rank high in terms of community involvement, they tend to cover a limited geographical area and often cover only cheaper outpatient care services due to difficulties associated with mobilizing a large enough population. Furthermore, 75 percent of the studies analyzed by Mebratie et al. (2013) were seen to have an effect on outpatient care while the corresponding figure for inpatient care was 64 percent. This led them to conclude that CBHI schemes are somewhat more effective in extending access to outpatient care, as compared to inpatient care.

As far as cost coverage in CBHI schemes is concerned, there is evidence that such schemes reduce out-of-pocket spending and contributed to greater use of health resources. They may also fill gaps in existing schemes (as for informal workers in Tanzania) and form part of a transition to a more universal health care coverage system (Gottret and Schieber 2006). In the 2013 literature review by Mebratie et al., sixteen studies examined the impact of the schemes on out-of-pocket payment and seven papers looked at the effect of the schemes on catastrophic health expenditure. 56 percent of such studies concluded that the schemes had been successful at reducing OOP healthcare payments and in 86 percent of the cases in preventing catastrophic health expenditure. For those papers where the effect is statistically significant, the reduction in OOP expenditure ranged between 12 to 35 percent.

### **3.4.3 Health insurance as part of micro-insurance (health microinsurance)**

In general, microinsurance operates like any other insurance by utilizing risk pooling, but it is tailored to those who cannot afford conventional insurance (Churchill 2007). More specifically, health micro insurance is a microinsurance product that provides a defined set of health benefits and services. This link with microfinance institutions distinguishes micro health insurance from the other forms of CBHI discussed earlier.

A relatively new phenomenon, approximately 40 million people worldwide have some form health microinsurance coverage, principally in India (Leatherman, Christensen, and Holtz 2010). Micro-insurance for health has shown promise in being able to provide some financial risk protection for poor families in developing economies, and it is generally offered through microfinance institutions that also offer other microcredit loans to individuals for small business development. However, they have rarely been able to represent a perfectly balanced portfolio, between risk and return, either because their client volume is too small (either due to enrolment demand or capacity), or because the relatively large risks they cover among low-income populations represents a disproportionate impact on the portfolio as a whole (Dror et al. 2009).

One of the few well documented examples of micro health insurance comes from Uganda, where efforts to sell policies through microfinance institutions proved surprisingly challenging. Although the microfinance institution clients wanted insurance, Microcare's sales representatives failed to develop sufficient levels of trust. Sales representatives underestimated the amount of time needed to convince a group to buy health insurance and were discouraged by the small commissions that the small premiums generated. Microcare's sales staff were generally provided access to the microfinance institutions' clients but little support from their field staff, who were not trained to sell insurance. This lack of involvement by the microfinance institutions resulted in limited sales success among microfinance institution clients. Ultimately, Microcare suffered from the combined consequences of unrealistic service provider expectations, unreliable reinsurers, weak public sector institutions, a breakdown in its internal controls, and ineffective financial management (Greyling 2013).

### **3.4.4 Innovative ways of increasing the scale and efficiency of micro health insurance: mobile micro-insurance**

Prashad, Saunders and Dalal (2013) provides an overview of how insurers are making use of mobile phones and forming partnerships with mobile network operators to reach scale and increase efficiency of micro-insurance. This was based on a review of literature and selection of 13 schemes that are using mobile phones, some of which provide health insurance cover. They found that mobile phones have reduced turnaround times for enrolment, premium collection, claims processing; lowered costs; and bridged geographical distances.

More broadly, mobile microinsurance has potential to increase insurance coverage. In Africa, the 44.4 million lives and properties covered by any type of insurance pale in comparison to the more than 600 million mobile phone subscribers. In Ghana, with a population of just under 25 million, there are six mobile network operators with over 26 million mobile phone connections, compared to an insurance market of just over 1 million (McCord, Maskus, and Saggi 2012).

There are a few examples of the use of mobile microinsurance schemes with a health component. In Kenya, Linda Jamii, Swahili for “protect your family”, is a mobile health micro-insurance program implemented by Safaricom in partnership with Changamka Micro-Health and insurance provider Britam, as the underwriter. It provides health insurance to self-employed Kenyans. The benefit package covers in-patient and out-patient services, maternity services as well as dental and vision cover, income replacement and funeral expense payouts. The premium is US\$150 per family per year. Every component of the program, from registration to submitting claims, is done through a mobile phone (Lemaire 2013).

Changamka has already been working with Safaricom's m-Pesa service for their maternal health micro-savings program. For Linda Jamii, Changamka's contribution was to bring in a cloud-based application that manages the whole process from registration to the provider side. Kenya's Ministry of Public Health and Sanitation (MOPHS) is providing all public hospitals as part of the provider panel for Linda Jamii. The Minister of Health wants to integrate Linda Jamii as part of the KimMNCHip program which will be rolled out in all 8,000 health facilities. The Kenyan integrated mobile Maternal and Newborn Child Health (MNCH) information platform, or KimMNCHip, is a national-scale mHealth initiative for maternal and child health run by a cross-sector partnership between the Government of Kenya, Safaricom, World Vision, Care, AMREF, and NetHope (Sæbø and Sahay 2013).

One other example mobile microinsurance in Africa is from Tigo in Tanzania, which is described in detail in Box 1.1 below. Examples from Asia include HDFC ERGO General Insurance in India which works in collaboration with Palmyarah Workers Development Society (PWDS). They use a mobile application to enrol clients into their health insurance scheme and create an auditable trail for reconciliation of premium payments. The enrolment cards are provided to clients in 4 days instead of the 15 days that it took before the mobile-phone-supported process was implemented. In the Philippines, mobile phone operator Globe works with Oriental Insurance to provide a hospital benefit plan. It is an accident and hospital insurance provided to the recipients of remittances through GCASH (Prashad, Saunders, and Dalal 2013).

#### **Box 1.1 A case study of mobile microinsurance: Tigo in Tanzania**

**Products need to be adjusted to client needs, and success in one market does not guarantee success in another.** When Tigo moved from Ghana to Tanzania, it initially planned to replicate the life product that had been successful in Ghana. However, market research indicated that the target population was much more interested in health insurance. In an attempt to introduce simple yet relevant products, Tigo in Tanzania introduced a hospital cash product that paid clients a fixed amount for each day of hospitalization, up to a maximum stay of 30 days. The premium for the policy is paid through airtime or mobile money deductions via Tigo Tanzania's mobile wallet, Tigo Pesa. The premium starts at TZS 750 (US\$ 0.47) per month and the scheme requires face-to-face enrolment through dedicated agents. The policy lasts for 30 days and is renewed provided the client has purchased enough airtime during the previous month to be eligible. Clients' sum assured, based on their previous month's airtime usage, is communicated to them at the beginning of the month by SMS. Bima supports Tigo's delivery and management of this product and is responsible for sales, distribution, general administration, daily operations and the technical platform. The product is underwritten by Golden Crescent Assurance, and MicroEnsure, which developed the original hospital cash concept for Tigo, supports claims management. *Source: Prashad, Saunders, and Dalal (2013)*

## 4 Discussion

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Even from the experience of voluntary health insurance in high-income countries, it is difficult to draw generic, empirically based, policy lessons from the experience of voluntary health insurance. The system-wide impact of voluntary health insurance appears to be influenced by a variety of factors, including its functions, the nature and extent of mandated financing, and the extent to which there are binding (and relatively inelastic) constraints on key inputs (such as the number of doctors practicing in a country). What is more, there is a paucity of data on the experiences of developing countries.

The complexity of **risk-rated private health insurance** raises questions about their relevance and feasibility for large scale adaptation in low-income countries. They may be more plausible options in middle-income countries with large literate and mobile urban populations. Some of the challenges and market failures associated with these markets can be addressed through regulations that mandate certain insurer actions (on acceptance of applicants and premium calculations) and minimize or rectify market failures. Yet these regulations can be difficult to implement and enforce. And they presuppose regulatory resources, political backing, and well-functioning financial and insurance markets. It can also be challenging to strike the most appropriate balance between access and equity concerns and desires to promote an efficient and competitive marketplace (Gottret and Schieber 2006).

The regulatory tools Colombo and Tapay (2004) propose to improve access include issuance requirements, which require all insurers to issue at least one standard policy to all applicants, and market-wide restrictions on insurers' ability to consider health status; the objective of both these measures is to prevent risk-adverse behaviour on the part of the insurers - in essence prohibiting them from discounting those applicants likely to require costly or chronic care, and ensuring that financial risk is spread evenly across the entire privately insured population. To increase affordability, the authors advocate for risk equalisation schemes, which seek to compensate insurers covering a higher risk population, and the imposition of caps on the premiums that must be issued to high-risk persons, facilitated by a process of cross-subsidisation.

With **employer-based health insurance schemes**, the link between health insurance and the workplace may create inefficiencies by distorting the behaviour of workers and employers, including their decisions to participate in the labour force, to work full or part time, and whether to hire part-time and part-year workers. One distortion that has received considerable attention in the USA is a negative effect of employer-based health insurance on voluntary job mobility, or "job-lock." Surveys consistently indicate that a large percentage of workers have stayed in a job that they wanted to leave for fear of giving up their health benefits, though the evidence from academic studies is mixed (Gruber and Madrian 2002).

**For enterprise financing schemes**, a holistic approach to addressing the social and health needs for their employers, their dependants and the local communities would be useful. For example, sexual and reproductive health beyond a focus on HIV may better engage community members, mining companies and governments in healthcare delivery (Dawson and Homer 2013). Further, it is not clear yet how to better incentivize companies to dedicate financial resources to disease control when disease incidence declines, as seen in the case of agricultural plantations in Malaysia and malaria control efforts (Sanders et al. (2014)). In addition, further studies need to be done to assess the effectiveness and impact of involvement of (or partnerships with) private companies to control diseases in the areas they operate. This will require an analysis of epidemiology on company sites and in nearby communities.

For **CBHI**, studies have found that community-run CBHI schemes seem to be stronger in terms of reaching out to marginalized groups. On the other hand, top-down government-run CBHI schemes appear to be better in terms of ensuring health care access and reducing OOP expenditure as compared to community-run schemes (Mebratie et al. (2013)). Schemes that have access to external sources of financing, in addition to premiums, are more effective in providing financial protection and expanding access to healthcare services but not at reaching out to the ultra-poor. This pattern suggests that subsidies are more likely to flow to the relatively better-off. A clear pattern, regardless of scheme type is that schemes where the community plays a role in scheme design and implementation are better at ensuring access to health care and financial protection – in turn, rather ironically, suggesting a greater need to bring in the community into scheme design and implementation. More broadly, social capital is a major determinant of the willingness to pay for CBHI:

The greater the social capital in the community, the more people are willing to prepay for CBHI (Hsiao (2001)).

For **micro health insurance schemes**, designing valuable, sustainable products is inherently more complex for health microinsurance than for other types of microinsurance. Most health microinsurance products cover catastrophic risks which occur with low frequency, are often unpredictable, and result in a need for high-cost services. These catastrophic events are more easily insured than routine healthcare needs, so insurers have focused on them, often designing in-patient only coverage. However, health microinsurance programmes struggle to reach sustainable membership for these in-patient policies, partly because the poor perceive more value in coverage for high frequency, predictable and often low-cost services. An ideal solution would optimize both needs, simultaneously reducing clients' vulnerability to catastrophes and improving overall health outcomes (Leatherman, Christensen, and Holtz 2010).

Finally, although mobile phones have currently been used mainly by micro health insurance schemes, they have the potential of being used to increase the scope and population coverage of other health insurance mechanisms.

## 5 Policy recommendations

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### 5.1 Issues in increasing the role of private health financing schemes

For all of the private health financing schemes discussed, the following recommendations would be useful in increasing their scope, effectiveness and impact:

1. Mandating core benefits is important if the various forms of private health insurance are intended to be a primary source of coverage for large segments of the population. At a minimum, insurance coverage should provide financial protection against significant health expenses. Standardizing benefit packages or requiring minimum benefits restrains insurers from designing packages to attract only lower risk individuals. But it also limits innovation and the range of plans available in the market; a standard plan may be too costly for some and offer the wrong mix and level of services for others which can limit participation in voluntary markets.
2. If coverage restrictions exclude care for common high-cost conditions in developing countries, like AIDS and cancer, then the financial protection provided will be insufficient. Limited coverage of pre-existing conditions, contract exclusions and waiting periods are stipulated in most policies to discourage adverse selection and keep premiums affordable. Consequently, in many developing countries people may not be able to buy insurance for high cost diseases such as AIDS or cancer, which are often the very conditions for which insurance is most needed. Most developed countries should allow exclusions for certain conditions in primary insurance policies but set boundaries on what can be excluded and for what period.
3. It is important to strike a balance between providing effective financial protection and assuring affordable premiums. Patient cost sharing through mechanisms such as deductibles, co-payments, co-insurance and payment ceilings is generally introduced to discourage excessive service use and keep insurance premiums lower (Schieber 1997). However, co-payments may disproportionately reduce service utilisation among the poor and discourage people from seeking preventive services that would avoid the subsequent need for costly curative care. Also, insurance is only effective if it covers a substantial share of health service costs. Many countries have experimented with the appropriate use of these mechanisms to strike a balance between providing effective financial protection and assuring affordable premiums (Sekhri and Savedoff 2005).
4. Policy-makers need to remember that methods used to calculate premiums have an important effect on equity and affordability. Community rating which imposes a single average premium for all individuals in a region or group promotes solidarity by sharing risk across the healthy and the sick.
5. There is scope for donors and other non-state actors to promote and ensure that countries are openly vigilant regarding the potential for fraud, abuse and corruption. These vices are not specific to private insurance markets as corrupt practices occur in all kinds of health systems, whether public or private. However, for countries that are dealing with private insurance markets for the first time, provision needs to be made for stemming the emergence of new forms of fraud and abuse. Public transparency is an important tool to prevent capture by special interests and limit fraud. This involves making as much information public as possible through open hearings on regulations, special decisions, standards and performance, financial information on those who assume particularly sensitive responsibilities and publication of all licensing information.

At the same time, given the current difficulties and limited scope of private health financing schemes in developing countries, it is equally valid to question the extent to which such schemes can provide coverage for the poor. The alternative of investing more in larger-scale prepayment schemes (whether government schemes or social health insurance, or some combination of the two) may well be a more feasible way to provide financial protection for the poor, as well as hasten the transition to universal health coverage.

### 5.2 Specific recommendations to PSP4H

In view of the broader aims of the PSP4H programme to help identify pilot interventions that increase access to health care and provide better health and better poverty outcomes linked to health or the working poor (Cardno 2014), we make the following recommendations:

### **Private health insurance (risk-rated)**

PSP4H should advocate for current private health insurance (risk-rated) to have packages that, at the very least, cover broader outpatient services or particular benefits (like ambulance transport) whose unavailability is a barrier to access of healthcare in Kenya.

As risk-rated premiums may currently be too high for the working poor, it would be useful for PSP4H to assist insurance companies in market research to understand what levels of premiums, coverage and targeting they implement and that there is a focus on equity.

### **Employer-based health insurance**

Private sector employers should be encouraged to have health insurance schemes as part of their corporate practices, even if they are small companies. Whenever possible, as part of their incentives to retain workers, companies should subsidize the contributions their employees have to make into these health insurance schemes, if they are not free for the employees.

### **Enterprise financing schemes**

Enterprise financing schemes could be utilized to promote disease-specific interventions in specific geographical areas. It is imperative that PSP4H outline the regulatory benefits (i.e. adherence to occupational health laws) as well as the social and economic advantages (e.g corporate social responsibility) of such endeavours.

### **Community-Based Health Insurance (including micro health insurance)**

Fostering the development of CBHI schemes, particularly health microinsurance schemes, will also enable PSP4H reach the working poor. With recent innovations in mobile phone technology in Kenya (like M-Pesa), there is potential for the use of mobile phone-facilitated health microinsurance.

For any of the health financing schemes that will be chosen to be pilot initiatives, it would be prudent to have PSP4H support market analysis and, if need be, help in accessing funds. However, PSP4H should not engage in direct delivery of services or direct financing, since it is crucial that the pilot initiatives be sustainable, both from an operational and financing point of view.

In addition, technical assistance to the insurance providers would be needed to ensure that they have the right infrastructure and technology to operate dynamic, efficient and responsive insurance schemes. Engaging in policy may be beyond the scope of PSP4H mandates as this may require a longer-term engagement. However, future research/efforts should also focus on improving the regulatory environment for and improving awareness of all these forms of private healthcare financing schemes described in this study.

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