Each year, over 150 million people suffer financial catastrophe and another 100 million people are pushed into poverty as a result of health related expenses. Though governments are now making major strides towards universal health coverage through approaches such as health insurance, there is a long history of private sector involvement in addressing financial barriers for individuals through microinsurance.

Many communities began to develop their own microinsurance schemes—community based health insurance—in the late 1980s in Africa and the late 1990s in Asia. Often these schemes developed in the absence of options from the government, but over time, some have actually become the foundation for national level schemes. Though microinsurance struggles to achieve the scale necessary to reach universal health coverage, it plays an important role in filling gaps in government coverage. Many governments pursuing universal coverage have had an initial focus on hospital care for the formal sector and civil servants, leaving out the large informal sector population that microinsurance seeks to address. In addition, microinsurance has been able to complement the benefits offered by governments by providing outpatient coverage in cases where governments are focused on inpatient care, or even providing top-up benefits to existing government packages.

**Key Takeaways:**

- 23% of microinsurance programs in the CHMI database, are located in India, 14% in Uganda, 17% in Kenya, 8% in the Philippines, and 5% in Tanzania, Pakistan, and Bangladesh each.
- Several microinsurance schemes are developing innovative ways to collect payments via mobile phones.
- 91% of microinsurance programs have a population focus on the bottom quintile; the majority (63%) also include the lower-middle and middle-income groups.
CHMI, in partnership with the Microinsurance Network, has identified 146 different microinsurance programs in 54 different countries that offer standalone microinsurance products, or integrate services to a package of health delivery services.

What is microinsurance?

The definition of microinsurance is one that continues to evolve, but the International Labour Organization (ILO) defines it as “the protection of low-income people against specific perils in exchange for regular premium payments proportional to the likelihood and cost of the risk involved.” Various microfinance institutions, community organizations, cooperatives, non-governmental organizations, and commercial insurers provide microinsurance products. The products vary, depending on factors that include the scheme’s objective and resources, the disease burden of the target population, and the type of healthcare providers that it contracts.

Where is microinsurance used?

The visualization to the left depicts the geographic spread of microinsurance according to the CHMI database, with larger areas representing higher numbers of schemes. Of the 146 microinsurance programs that are profiled in the CHMI database, 23% are located in India, 14% in Uganda, 17% in Kenya, 8% in the Philippines, and 5% in Tanzania, Pakistan, and Bangladesh each. Typically, microinsurance programs provide access to a group of people that have limited access to healthcare through the government, thus it is logical that the majority of programs are located in countries where national health insurance systems are either weaker or non-existent.

Microinsurance characteristics

Microinsurance schemes typically target the low-income population in the informal sector—for instance, taxi drivers, market sellers, or other independent workers—since they are vulnerable, being excluded from formal social protection schemes. The schemes profiled in the CHMI database are consistent with this theme. Of those reporting a population focus, 91% include a focus on the bottom quintile; the majority (63%) also include the lower-middle and middle-income groups, but only 16% target high income groups. The vast majority of programs include a focus on rural populations.
(90% of those that report); only 6% of programs have a specific focus on urban populations.

Of the programs that reported profit status, the majority of programs (64.2%) are not-for-profit; 35% report as being for-profit entities. The vast majority of programs are post-pilot stage (84%) and though some receive donor funds—21%—most leverage revenues from individual contributions to support operations.

**Microinsurance and government partnerships**

Microinsurance and governments are also linking together to provide coverage. Twenty-six programs within the CHMI database describe some type of relationship with the government. For instance, the *Mukhyamantri Jibon Jyoti Bima Achoni Insurance* scheme in India is a partnership between the government of Assam and ICICI Lombard Insurance Company to provide health and personal accident insurance to employees in the state with an income under INR 200,000 (about $3,100 USD). The premium is shared between the Government of Assam and individual members.

The *Tarlac Health Maintenance Plan* in the Philippines is a partnership between the provincial government of Tarlac and the PhilHealth insurance scheme. The provincial level health insurance scheme attempts to fill the gaps left in the government’s PhilHealth insurance scheme by providing outpatient coverage, hospital treatment, and medicines.

**Microinsurance growth over time**

Most of the programs in the CHMI database launched in the 1990s. While two or three programs launched in the 1970s and 1980s, three to 12 programs launched each year from 1997 onwards. The last two years have seen a decline, but this could be due to a lag time in reporting new programs.

![Microinsurance Growth over Time](image)

*Year microinsurance programs in the CHMI database were founded*
Emerging practices of microinsurance organizations

Microinsurance schemes are developing innovative ways to address barriers clients face, including liquidity constraints and geographic access barriers. The ability to pay an annual premium all at once can be a barrier for many informal sector workers due to the seasonality of income, which is often tied to harvest times. Many microinsurance schemes are attempting to address this by avoiding a one-time annual payment and spreading smaller payments out over time.

Addressing liquidity constraints:

Microfinance institutions have developed innovative ways of integrating loan re-payment with health insurance premiums, allowing users to pay over time while the institution fronts the premium amount. For instance, the CARD Microinsurance scheme in the Philippines provides a $26 loan to clients so that clients can pay for their coverage in small, weekly installments. Clients add the weekly payment to regular business and savings loan repayments at CARD meetings. The scheme offers group hospitalization coverage under PhilHealth.

The Kenya Women Finance Trust (KWFT) is one of the largest microfinance institutions serving women in Kenya (67.2% of the market share). KWFT developed a microinsurance scheme for its members, using women as an entry point to provide inpatient coverage for the entire family at a cost of US$39 (KSH 3,600) per year, linking premium payments with loan repayments.

Using mobile-phones to collect premiums:

Schemes are also developing innovative ways to collect payments. The Afya Milele Halisi program in Kenya allows members to pay their premium either monthly or annually by mobile money transfer, cash or bank transfer, cutting out the need to physically connect with an agent to pay. The scheme requires members to be part of the National Hospital Insurance Fund in Kenya, complementing the state’s benefits, and offers a health insurance card that covers specialized care for chronic diseases, HIV/AIDS, and maternity care for low- and middle-income Kenyans.

Developing targeted benefits, such as for women and children:

Health microinsurance schemes are developing viable products that offer value to female clients. *Shilpakala Kamtekar, 48 with her Swasth Health Clinic card at the clinic in Goregaon.*
by covering maternal benefits and preventative care. One product offered by Zurich Bolivia and BancoSol—Sol Salud—provides full maternity coverage with a rare seven-month waiting period, giving pregnant women a valuable two-month window to purchase insurance to cover the birth of their child. Sixty-two percent of BancoSol’s clients are women, compared to just 4.5 percent of loan borrowers, underscoring the high value of gender-sensitive microinsurance programs for women.

In Bangladesh, the Dushtha Shasthya Kendra program focuses on women and children since they are more disadvantaged in Bangladeshi society. The program now offers both outpatient programs and secondary health provision.

The Future of Microinsurance

Though microinsurance struggles to attain scale due to limited ability to expand risk pools and cross-subsidize, it does play an important role in guaranteeing financial protection for individuals. A recent paper I and colleagues at Results for Development and the ILO authored describes this interplay between government-sponsored insurance and health microinsurance:

Before government health financing strategies are in place and operating effectively, microinsurance may be the only option available to informal workers for providing financial protection against health risks. Over time, microinsurance can grow to become a foundation for national level strategies, scaling up CBHI schemes across the country. Governments can also form partnerships with microinsurance schemes and other private actors in order to deliver key insurance functions, such as marketing, identification of enrollees, distribution of insurance, premium collection, and even claims processing and risk-carrying. This may be an attractive alternative to creating and providing the functions within government, and may enable faster, more efficient scale-up. Even as government initiatives expand benefits, microinsurance schemes can offer valuable products that supplement government benefits. Governments and microinsurance schemes should look to each other as partners, working towards the same goal of assuring high quality, affordable health care.

*Photo at top:Sangeeta Murlidhar Rahate, 53 shows her health card at Swasth Health Clinic in Goregaon