

# *H*Health insurance schemes for people outside formal sector employment

GUIDELINES FOR GOVERNMENTS



Division of Analysis, Research and Assessment  
Health Systems Development Programme  
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87 These guidelines are a product of a global review undertaken by WHO in 1996 and 1997. The review process included the preparation of a database, a synthesis paper, and an international consultation with experts in health insurance for people outside formal sector employment, from international organizations, insurance schemes, and senior health policy makers from developing countries. Both the review paper and the accompanying database on over 80 health insurance schemes are available on request (see contact details at the end of this document). The schemes reviewed all involve some sharing of risks among the individuals, families or villages joining the scheme. One large sub-group of schemes is exclusively focused on covering the costs of hospital inpatient care, another group of schemes is designed to protect members against the costs of pharmaceuticals and primary care, and yet a third group is oriented to primary level care with limited referral services. The schemes examined involve more risk-sharing than personal pre-payment schemes, such as "medical savings accounts" or "abonnements", which prepay all or part of the costs of care only for a single individual or family. All the schemes reviewed involve spreading risk among a larger pool of families, and a few are national in scale, though membership in almost all cases is voluntary.

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**An acute and growing need exists for more widespread mechanisms to protect people against the costs of necessary health care. Most vulnerable are people outside formal sector employment.**  
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▶ Few developing countries presently provide protection against the costs of health care for the whole—or even for the majority—of their population. Recent and widespread trends in health policy, such as increased user charges, reduction of public expenditure and a greater role for private providers, have often put greater financial burdens on to people using health services. Yet large segments of the population in low income countries remain without effective financial or physical access to local health services of good quality. This is particularly true for people in subsistence agriculture, and the growing numbers of people in informal urban or rural employment or self-employment. People in formal employment are generally better off than the average, and are also easier to organize into insurance schemes as their income is easily identified and can often be taxed at source.

▶ Numerous initiatives have been taken in recent years, by governments, international agencies and particularly by non-government organizations, to extend protection against the costs of health care for people who are outside formal employment. These include community financing innovations, such as

those promoted in many countries under the Bamako Initiative, the establishment of community credit or revolving funds for the purchase of pharmaceuticals, and the development of several different types of prepayment systems to spread financial risks over time or between individuals. Many of these schemes have been designed specifically to improve access for rural populations, or for the growing number of urban people whose occupations are outside the formal employment sector.

► The World Health Organization has recently reviewed a number of initiatives focussed on improving access to care through health insurance schemes. Some clear lessons emerge from this review of experience. The purpose of this briefing note is to summarize these lessons, and to encourage governments to develop more explicit policy support towards such initiatives. It is also clear that we are far from fully understanding the factors which determine the success or failure of this type of insurance, and that a more continuous effort to evaluate and learn is required.

**Experience with innovative risk-sharing schemes reveals some general lessons for governments. These centre on ensuring *better linkages* with the rest of the health system and with overall health objectives. Specific lessons also emerge on *insurance scheme design*. These are summarized below.**

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↳ Most governments wish to improve the accessibility, quality and efficiency of health care services. Health insurance schemes for people outside formal sector employment may be a means to further these objectives—if appropriately designed and managed. By allowing communities to contribute to health care, and spreading their contribution over time between sick people and healthy people, extra resources for health care can be mobilized. These can be used to improve quality of care. In addition the accountability generated through community participation may enhance efficiency and further improve quality.

↳ But health insurance schemes for people outside formal employment are not just a financing mechanism. They can also have a broader positive impact—if well-designed—on the organization and delivery of health care. These schemes may help raise extra revenue for health in varying degrees, but they only succeed where this additional revenue is **supplementary to government resources** and not a substitute for them.

► Ensuring access to a basic package of health services by the poorest people and communities is not likely to be achieved through “self-financing” health insurance. There will continue to be a need for government subsidy to ensure that the poor have access. Subsidies can flow directly to health care providers or through insurance funds. Which route is more appropriate depends on the overall structure and objectives of the health system. If government subsidy flows via the insurance fund this may help to strengthen the purchasing role of the fund or the local health authority.



### **Governments can create an enabling environment for well-designed insurance schemes**

► Governments have an important role to play in promoting good design and practice of health insurance schemes for people outside formal employment. In particular, government should ensure that:

- schemes have the necessary legal status for them to function as official entities. At present schemes in some countries operate without legal recognition. Governments should review current legislation to ensure that approved schemes have the protection, security and accountability conferred by legal existence.



- existing schemes have the opportunity to share experiences and discuss strategies;
- technical support, advice and training is available to groups wishing to establish such schemes, and groups already operating schemes;
- schemes are adequately monitored and evaluated;
- there is scope for strategy development, so that schemes can evolve over time, for example by using their purchasing power more actively to contain costs and improve quality and accessibility.

► An umbrella body, including government and representatives of schemes, could provide a useful partnership forum in contexts where there are already several schemes functioning in a country.

**A clear policy framework is often needed to publicize "good practice" and guide the future development of insurance initiatives**

► Few, if any, governments appear to have explicit policy positions to guide and monitor health insurance initiatives for people outside formal sector employment. A **policy framework** would be a valuable tool to support the growth of schemes which complement and reinforce overall national health

policy objectives. A policy framework means a public statement of roles and responsibilities of major actors, such as communities, insurance organizations, government and health care providers. Such a framework is **not** a master-plan, but a flexible and consultative vehicle, allowing scope for innovation. The framework should be developed through a consultative process, bringing together the knowledge of policy makers and people within the country who have experience with operating such schemes. The development of such schemes has shown itself to be a continuously adaptive process, and a policy framework will itself need to be adapted in the light of accumulating national and international experience.

► Steps in the development of an initial draft framework would include:

- review and evaluation of the scale, scope and nature of existing insurance or prepayment schemes related to health care;
- identification of those groups currently not protected by insurance, who face financial risk when seeking health care;
- an assessment of whether and how existing and proposed schemes link with and support (or contradict) existing health policy objectives.

► Governments are already over-stretched with regulatory tasks and challenges, but need not themselves undertake all of these steps. However, governments should initiate the process, in partnership with relevant groups.

► Some of the difficulties which insurance schemes frequently encounter have little or nothing to do with the attitude and policy of government. Many schemes run into difficulties which could be avoided if they were planned and structured differently, and evolved flexibly. Getting the initial architecture right is part of the challenge, but adapting it as circumstances change is at least as important.

### Five key issues in the design of successful insurance schemes

■ Many schemes fail quickly because only sick people join them.

**Schemes should aim for the widest possible pool of risks.** Schemes with purely voluntary individual membership tend to attract people with pre-existing health problems, and to be unattractive to the healthier and often better off members of the community. A successful insurance scheme requires a broad risk pool, with both healthy and unhealthy members, and both better off and poorer people involved. Only by spreading costs over a large and diverse pool of risks can health care be made affordable for all. Compulsory membership of the whole population is the best way to maximize risk pooling, but is normally difficult to implement for those outside formal employment. To avoid "adverse selection" resulting from voluntary membership, steps should be taken to make schemes as **widely inclusive as possible**. This may be done by defining the unit of

membership to be a village or group of villages, or at the very least a whole household. Schemes which do not implement measures to avoid adverse risk selection rapidly get into financial difficulty as increasingly less healthy people join. Sometimes, in response to this problem, schemes amend membership rules to exclude more vulnerable groups such as the elderly, but this may be undesirable from a social perspective.

■ A second design factor is the need for an **enrolment or qualifying period**: the time which has to lapse between joining the scheme and qualifying for benefits under it. Schemes which allow enrolment at any time and offer immediate access to benefits fail financially very quickly, as people tend to join only when they are sick. Some schemes have limited enrolment periods, such as at harvest time (when rural people are most likely to have cash). In addition, a required waiting period of at least one month is recommended. The waiting or qualifying period is particularly important in schemes offering insurance cover for more expensive, hospital inpatient services.

■ A third key design issue relates to **referral services**. Some insurance schemes provide coverage for hospital care; others are primarily focused on primary care. The latter are usually more affordable. It is extremely important that all schemes should reinforce—and not undermine—the referral system. Hospital based schemes may encourage insured members



to bypass health centres unless a referral requirement is built into the design. Again, schemes which omit the "gatekeeping" and referral system rapidly become unsustainable, as people (and providers) are given no incentive to use the most cost-effective services first. The first point of contact between the beneficiary and the health system should be at the primary level. Consideration should be given to the exclusion of non-referred hospital outpatient consultations from the insured benefit package, where adequate first-level primary care facilities exist.

■ A fourth key design issue is the need to ensure that **preventive and promotive services are included** in the activities of all service providers. These both reduce morbidity and mortality and help to improve sustainability by containing overall costs.

■ Finally, scheme managers need to have an **investment strategy** for the funds under their control. Inflation has often eaten into the operating resources of insurance schemes, whereas those which have actively managed investment strategies have often succeeded in keeping ahead of inflation.

◊ Establishing sustainable risk-sharing mechanisms for the benefit of people outside formal sector employment is an enormous challenge. There are no "blueprint" solutions suitable for all situations. Yet there is an accumulating body of experience with such schemes from which a preliminary set of lessons is

briefly summarized here. Governments and NGOs, scheme designers and managers all have an important role to play in developing a better understanding of how social protection mechanisms of this kind can adapt, develop and grow. WHO hopes that this brochure, and the supporting reference materials, will serve to stimulate debate, enquiry and development in this important area.

**Contact details:**

► Further information, the review paper, and the database diskette are available from:

Mr Andrew Creese

Division of Analysis, Research and Assessment

Health Systems Development Programme

World Health Organization

1211 Geneva 27

Switzerland

Fax: (41) 22 791 07 46

E-mail [CREESEA@WHO.CH](mailto:CREESEA@WHO.CH)