

# Access to health insurance

A photograph of a hospital room. On the right, a patient is lying on a bed, partially covered by a white sheet with blue floral patterns. The room has a light-colored tiled floor and a wooden door on the left. A window with a brick wall outside is visible through the doorway. The image is overlaid with a blue and green curved banner at the top and a blue rectangular box containing text.

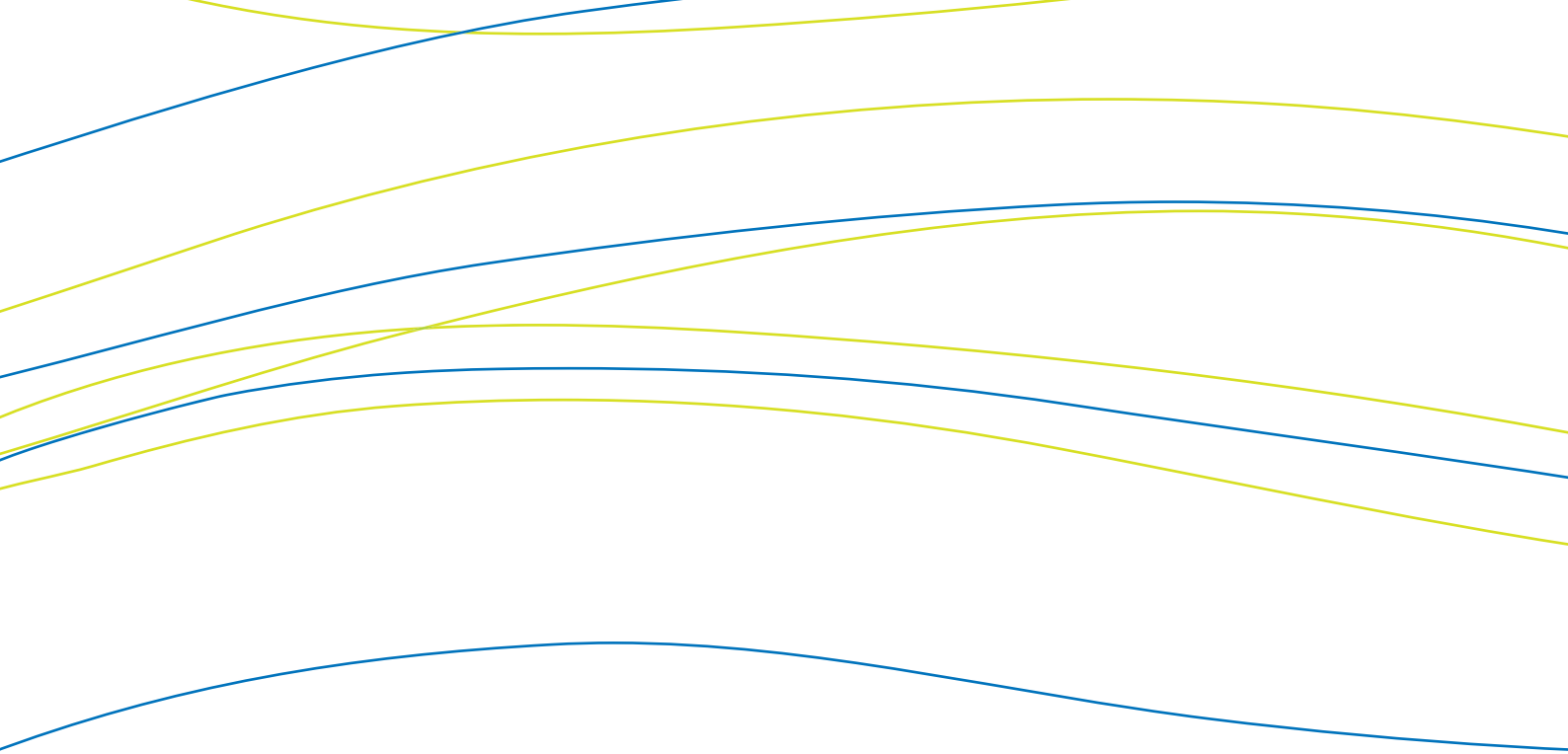
Voices from the field  
on lessons learned

Michael Grimm and Godelieve van Heteren (eds.)

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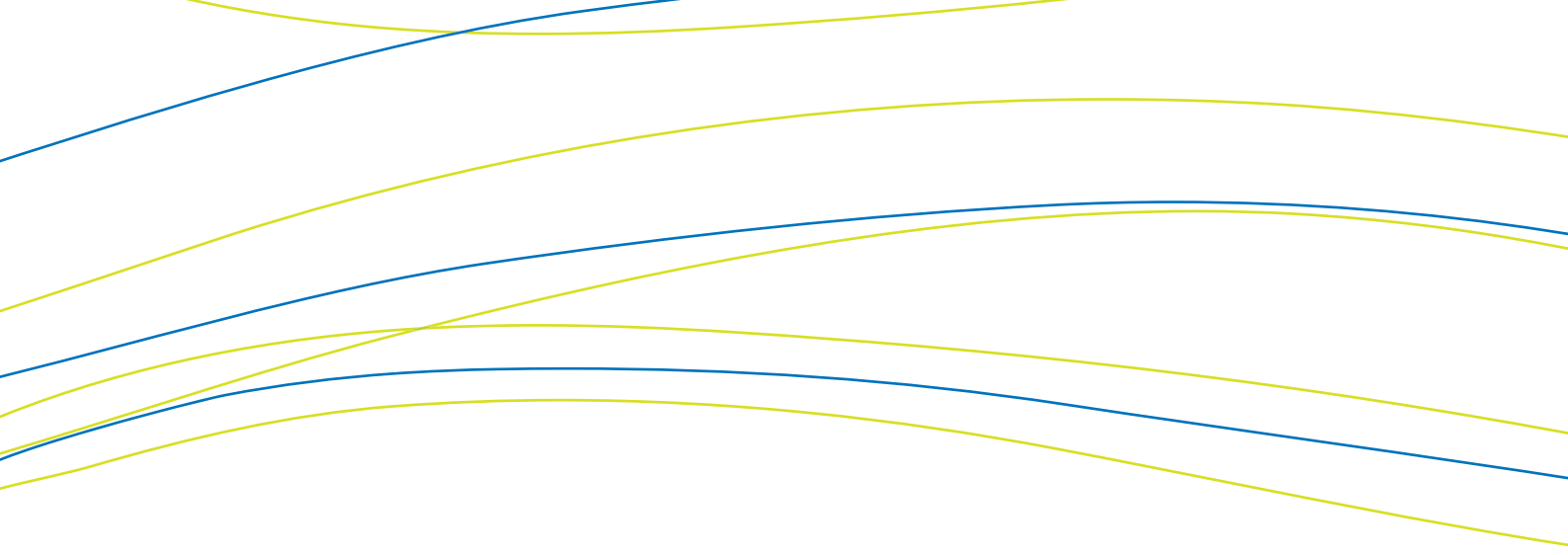
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# Preface

In this booklet, voices from the burgeoning field of health insurance, speak to the major challenges regarding access to health and health financing, especially in developing countries. The booklet presents several cutting-edge practices and policy recommendations which may help to foster better access to health insurance in such challenged environments.

Lively discussions on the subject took place during the international Access to Health Insurance conference, which was held on June 5, 2012 in Rotterdam, The Netherlands. The meeting was organized by the Curatorium of the Prince Claus Chair, the International Institute of Social Studies ISS (part of the Erasmus University Rotterdam), the Dutch Ministry of Foreign Affairs, the Office of the UNSGSA, the Rotterdam Global Health Initiative and the PharmAccess Foundation. Her Royal Highness Princess Máxima of the Netherlands, the UN Secretary-General's Special Advocate for Inclusive Finance for Development and Chair of the Prince Claus Curatorium, attended the event and addressed the many health practitioners, policy makers, financial experts, academics and consumer representatives from around the world.



H.R.H Princess Máxima of the Netherlands, the UN Secretary-General's Special Advocate for Inclusive Finance for Development and Chair of the Prince Claus Curatorium during her keynote speech at the AHl conference

Experts from the World Bank, ILO, IFC, large telecommunication companies, the Hygeia group, global health research groups, and health insurance initiatives from Europe, Asia, and Africa engaged in animated, multidisciplinary debates about the 'dos' and 'don'ts' of health-insurance schemes, the prerequisites in low and middle income countries, the knowledge gaps and political agendas necessary to promote access to health and health financing worldwide.

In this booklet, some of these experts – from the health policy world, the world of insurers and implementers, and the world of researchers – share their views and dilemmas.

# Statement by Her Royal Highness Princess Máxima Advocate for Inclusive Finance for Development and



# of the Netherlands (UN Secretary-General's Special Chair of the Prince Claus Curatorium)



From: Keynote speech at Access to Health Insurance Conference, Rotterdam June 5, 2012

As UN Special Advocate, I am accustomed to looking closely at the factors that influence development. Health is of course a very important one. Health affects all of us. Health is an especially pressing concern for poor families. This is even more so in developing countries, where healthcare and financial safety mechanisms may be limited. When poor people get sick, they commonly sell productive assets, pull children out of school or take expensive loans in order to get the care they need. Or they just simply do without. As a result, daily priorities such as food and shelter suffer. And there are long-term consequences. In fact, about 100 million people around the world fall into poverty every year due to health expenses.

So protecting poor people from these devastating financial impacts should be a concern for all of us. We need to explore the ways that health insurance can help. Health insurance is somewhat different than other financial products. For example, it involves a large element of public good. It is linked to broader, complex issues that require national leadership and diverse partnerships. So, this issue is about financial inclusion, but also about so much more. One of the responsibilities of government is to address the availability of healthcare for everybody needing it. Some countries do so through a totally government-run health system. Others do it through a combination of public and private health providers. Some finance health mostly through tax revenues, some through insurance schemes and some through diverse financing mechanisms. The Philippines, Thailand, Colombia and Mexico are among countries that have introduced nation-wide health insurance. The point I would like to stress is that there is no single approach. Whatever we do to do this successfully, it will entail a combination of coverage and quality care that is accessible and affordable.

In the best cases, health insurance works in combination with public health goals to reinforce or even change behavior. But this can present some challenges. Why? Typically, insurance generally covers infrequent events and large losses. Health insurance that covers regular clinic visits and medication is just the reverse – high frequency, low risk and small amounts. This can make it very expensive and complicated for an insurance provider. So, knowing that prevention is the most effective means of improving health outcomes and reducing costs, this issue needs to be addressed. Moreover, health insurance is no use if there are no good doctors, clinics and hospitals. We must also consider the availability of care.

For health insurance to contribute to public health goals, it must be used on an on-going basis, it must be trusted and it must be sustainable for providers. We can learn a lot from experiences in Brazil, India, Kenya and other countries where health insurance is increasingly available. There, we see that despite the availability, low-income families still do not often purchase



# Statement by Her Royal Highness Princess Máxima Special Advocate for Inclusive Finance for Development

or renew health insurance. How can we understand this? Maybe it is because there are no clinics nearby. Or because of the competing claims on available cash against other priorities like food or school fees. Or, perhaps the product is just not right.

So, we must understand client needs and local context very well. From that, we can design products that add real value. Value comes from the kind of benefits that are provided. Value also comes from convenient premium payments through mobile phones or flexible premiums that allow for uneven incomes. The claims process must also be very easy. It must pay benefits in a matter of days, not weeks, if it is going to prevent debts. These factors, and many more, may explain why health insurance products that work for higher income populations do not always succeed with lower-income groups.

I am especially encouraged by innovations that go beyond insurance to support client needs and social goals. For example, in Brazil, a company is designing a small savings scheme to go with its insurance. This can be used to pay premiums when money is tight. And in Indonesia, another company is piloting a savings account for education. This account comes with small life insurance and hospital cash coverage as a benefit, thus protecting the family's educational goal. I would be remiss in my duties as Special Advocate if I did not point out that we also need to make basic savings accounts much more widely available. After all, savings is the simplest form of insurance.

Now, knowledge is of course a factor. Low-income families are often not aware of health insurance or they do not understand precisely how it can help. But basic knowledge is not always sufficient. Trust matters. And trust results from experience as well as knowledge. The more a person understands the obligations, costs and benefits, the more his expectations will match the actual experience. For these reasons, financial education is very important and something everyone should help to provide.

This leads me to my final topic. What can each of us do to increase access to health?

National governments have the most important role. We see many examples of national commitment and leadership striving to expand national health systems, provide access and build medical and nursing capacity. I am thrilled that we have policymakers with us today to share their experiences and priorities. Donors and other partners are also key. I am proud of the support that the Netherlands, along with many other countries, has given in the past years to global health. This has brought tangible benefits and, importantly, fostered so many national initiatives. But to make sure that all the efforts have positive outcomes, it is all the more urgent that we together share what we know about what works and what does not.

What is certainly important is to ensure that healthcare reaches the poorest and most marginalized families. Subsidies of premiums and supplemental support conditional on regular visits to health clinics are all proving effective.

# of the Netherlands (UN Secretary-General's and Chair of the Prince Claus Curatorium)

It should go without saying that providers have a lead role in product design. Donors and academics can also help, for example with research to help us understand client needs. Or to evaluate the impact of specific products. There is so much more that we would like to understand. When it comes to sustainability, providers are also best placed. We have seen lots of good projects that have not succeeded due to costs. This and reaching the poor are two areas where public-private partnerships are essential to get the scale needed to be able to pool risks.

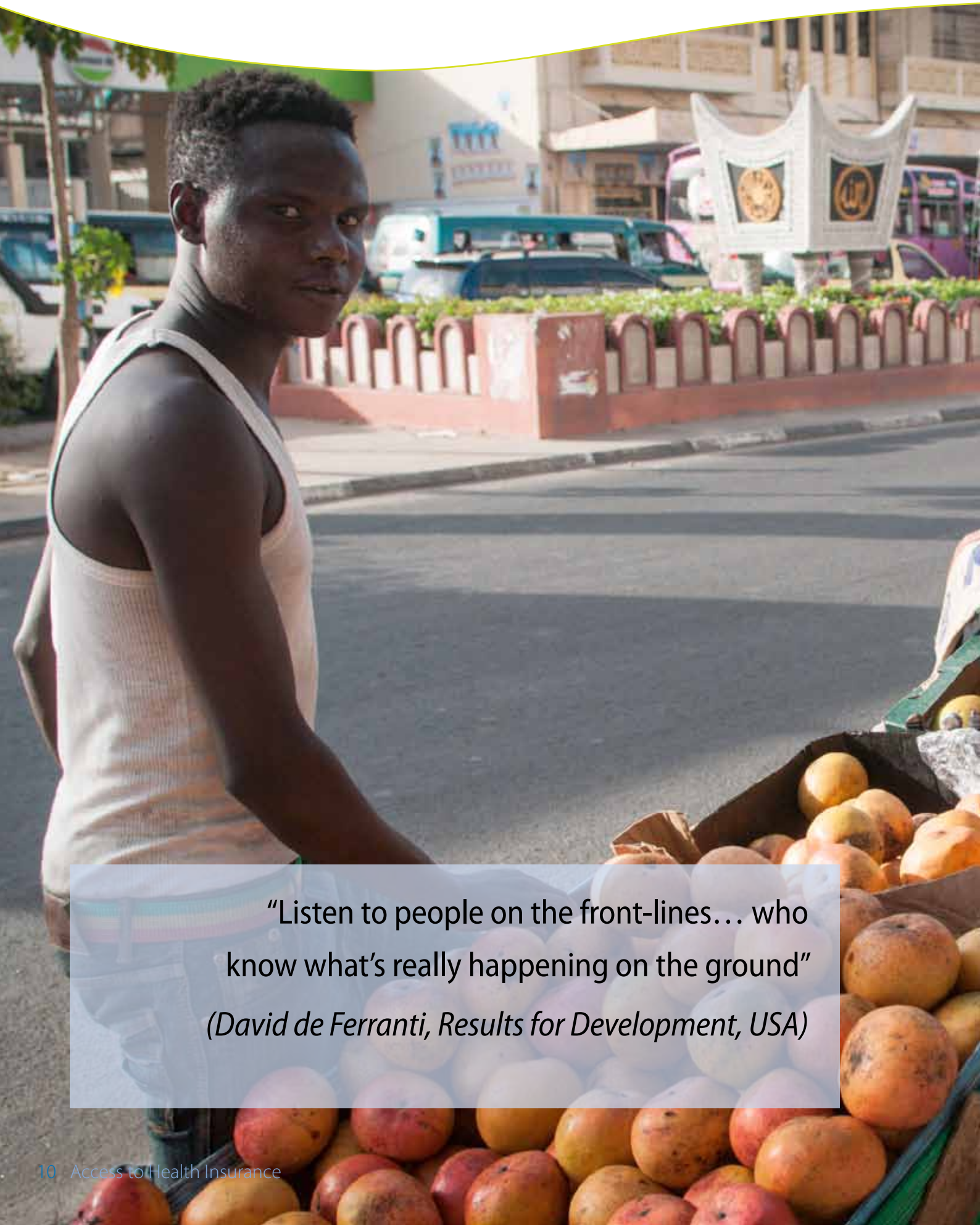
I think it is important that many diverse stakeholders join forces and continue to address the following four issues:

- Identify knowledge gaps. Where is there consensus and enough said? What needs to be studied more?
- Prioritize where we need more pilots and on what aspects.
- Agree, more or less, on some successes and also failures, so that we can communicate this clearly to policy makers and practitioners
- Call attention to the importance of this subject. Of course, not only today, but as you return home and in months to come.

Investments in health pay very high dividends. If through insurance we can help people to become more healthy and productive and prevent impoverishment when they get sick, then we really need to focus on what is stopping us from doing so.

See: <http://www.koninklijkhuis.nl/nieuws/toespraken/2012/juni/toespraak-van-prinses-maxima-bij-internationale-conferentie-access-to-health-insurance-te-rotterdam/>

# Introduction: Access to health insurance,



“Listen to people on the front-lines... who know what’s really happening on the ground”  
*(David de Ferranti, Results for Development, USA)*

# best practices and recommendations



Universal health coverage is on everybody's agenda. In December 2012, the United Nations General Assembly even adopted a resolution in its support. Numerous meetings, conferences and publications testify to a widely shared interest in the tough issue of access to health and health financing. At the same time, health systems everywhere are faced with fundamental challenges. Over a hundred million people fall into poverty each year due to health issues, many in developing countries.

Urgent action is needed. Business as usual is no longer good enough. Globally, we see a combination of high disease burden, limited and unequally distributed financial resources, a shortage of services and qualified personnel to provide for basic care, and thus a lack of affordable healthcare provision of good quality for many poor and low-income citizens.

Healthcare insurance – whether public or private – is not yet a very common phenomenon in developing countries. It only accounts for a low percentage of health expenditure (e.g. 4% in Sub-Saharan African countries). People struggle with high out-of-pocket expenditures and as a consequence, adverse effects on their food consumption and other basic necessities. Often people forgo care altogether, with detrimental effects on health that lead to reducing their general earning capacity. On the supply-side we see fragmented healthcare systems lacking standards of quality and a structural financial basis to develop and improve services and meet the needs of the population.









In such circumstances, how can development of inclusive and sustainable health systems and the access to services of good quality be stimulated? One of the means to face these challenges is the development of inclusive and sustainable health insurance financing and delivery systems that are accessible for low income groups. The development of such systems is urgently required. They need to be contextualized and adapted to local circumstances. More specifically, it is vital to look into the financial and administrative systems of each country or region and develop schemes that at least match these systems and at best enhance their functioning. This implies on the one hand that governments strengthen their institutional capacity to implement or support such complex services as health insurance. On the other hand, it is crucial to engage the private sector and set up partnerships with local organizations that encourage local ownership and foster the acceptance on the part of the communities involved, their trust in the system and willingness to pre-pay.

There is no 'one best way'. Many initiatives have been developed in different countries using different approaches. But all of these approaches are geared towards the same objective: improving access and quality of health (care) for low income groups. We need to learn from different experiences and initiatives in order to develop interventions that suit the specific characteristics of a country or region, their socio-political systems, traditions and the organization of the communities involved.



# Introduction: Access to health insurance,

What is, however, becoming increasingly clear is that ownership, political will, local leadership, motivation and trust are key success factors and that private sector involvement is vital. It will not be effective or sustainable just to direct more money into the existing – mostly public – healthcare systems and organizations. What is needed is systems that improve access and quality of services and provide for viable and inclusive health insurance, in which private sector and community initiatives can be important.






Examples of such innovative propositions were discussed during a unique, interdisciplinary international symposium on June 5, 2012. Researchers, policymakers and health financing experts of various backgrounds gathered to identify key issues, exchange best practices and formulate further recommendations to promote better access to health insurance. A large number of exciting practices were debated, including how to engage the private sector, how to improve the knowledge base, how to further smoothen implementation, how to assist the scaling up of proper health insurance practices and how to articulate the necessary policy requirements for such practices. Some examples of this are:

-  The 'QIDS Policy Navigators' (individuals who are engaged in helping to maximize the use of existing programs in the Philippines).
-  The Himaya and Riaya products of the Microfund for Women in Jordan.
-  Vodafone's mobile money transfer service, M-Pesa, which is being used to bring basic financial services to the rural poor in Kenya and Tanzania, and to improve access to health services.
-  The PharmAccess package of complementary health insurance (Health Insurance Fund), quality improvements (SafeCare) and financing of healthcare initiatives with loans to small private clinics and doctors (Medical Credit Fund)
-  Rashtriya Swasthya Bima Yojna scheme for people who live below the poverty line in India.
-  The Micro Insurance Academy (MIA)'s pioneering work in India providing technical assistance and training to grassroots communities that focus on collective structuring of solvent demand for health insurance (micro-insurance or Community-based Health Insurance).
-  FC's first-ever direct investment in the health insurance sector in Georgia and Kazakhstan through Archimedes Health Developments
-  The work of the Hygeia Group in Nigeria in community health care.

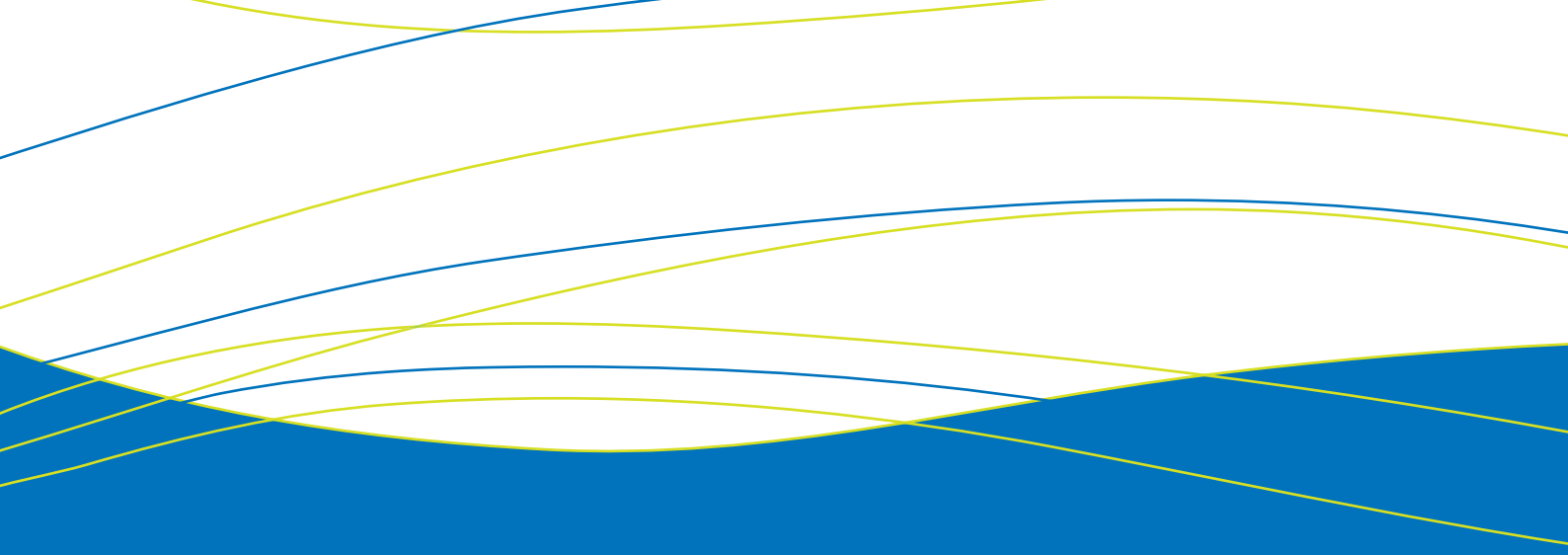
Seven key recommendations were widely shared:

-  Public-private cooperation may be the way forward in advancing the agenda of inclusive and sustainable health financing
-  There is no one-size-fits-all insurance scheme: contexts differ considerably, many stakeholders play a role. It is crucial, therefore, that practitioners, policy-makers and researchers should meet more regularly to exchange experiences in this dynamic field and address the pluriformity of solutions.

# best practices and recommendations

-  While it is good to look closely into the demand for insurance, supply-side improvements are just as vital.
-  Best practices in health insurance should be systematically communicated, failures should be sharply analyzed.
-  Intensive interdisciplinary research is needed concerning precisely how insurance can stimulate financial access to health.
-  Much more effort should go into sustainability: finding sustainable solutions for health financing.
-  Regulatory frameworks are urgently needed to make public-private partnerships in health insurance possible and focus attention on how micro- and macro-initiatives around health insurance can be firmly linked.

We hope the expert interviews in this booklet and on the DVD will give you a taste of these exciting examples, best practices, challenges and policy recommendations on the road to making accessible health insurance a reality for all.



# Voices from the Field I





# Stella Quimbo (Prince Claus Chair 2011- School of Economics, the Philippines)



“What stands out is how many of the issues we face in other financial services overlap with those in health financial services”  
*(Rodger Voorhies, Gates Foundation, USA)*



**Q What is the best practice in Access to Health Financing in which you and your organization have been involved?**

**A** There are two innovative practices which I consider among the best.

The first is the use of 'Policy Navigators', individuals who are engaged in helping to maximize the use of existing programs. This practice was piloted by the Quality Improvement Demonstration Study (QIDS) in partnership with the Department of Health and Philippine Health Insurance Corporation (PhilHealth). The QIDS Policy Navigators are medical doctors who performed enhanced social marketing for PhilHealth. They developed relationships with fund holders, particularly mayors of towns and provincial governors, who are all elected local officials. Policy navigators provided them with information on the benefits of health insurance as a whole and briefed them on the bureaucratic mechanics of the program. Their most important task was the regular follow-up on premium subsidies for indigent households. We found that the QIDS Policy Navigators were very cost-effective in getting poor families enrolled in PhilHealth's program.

The concept of Policy Navigators or variants of this idea have been adopted by both the Department of Health and PhilHealth, and directly target households or end users to help them effectively use the available health-infrastructure and resources. They reduce the transactional difficulties and the lack of awareness in many households and – to some extent – improve trust in publicly provided services.

The second practice is the use of clinical practice vignettes for measuring quality. Clinical practice vignettes are written case scenarios followed by questions for doctors to answer on how they would manage a specific case. QIDS has shown that the vignette scores, including a patient satisfaction index and measure of case load, can be an effective measure for quality despite its simplicity.

**Q What are the main obstacles and challenges regarding developing better access to health and health financing? What can we learn from failures?**

**A** In the Philippines, the biggest challenges concern extending social health-insurance coverage to the informal sector (about 35 percent of the population, and more than 50 percent of the working population) and providing sufficient financial-risk protection to the population (in terms of coverage, utilization, and currency support).

Enrollment for the informal sector is currently on a voluntary basis, only 4 percent of the population being enrolled in the voluntary PhilHealth program. Moreover, there appears to be evidence of adverse selection into this program, and thus, the urgent need to expand participation of the informal sector. We need to evaluate current initiatives, partnerships with cooperatives and NGOs. And we need to identify and test innovative methods such as premium subsidies.

# Stella Quimbo (Prince Claus Chair 2011- School of Economics, the Philippines)

A related and perhaps bigger problem is the limited value which the PhilHealth insurance-benefit package has to offer. Claims are not easy to file. And even those who are able to successfully file claims find that the peso support is not much. In addition, insurance payments are not fully utilized as a leverage for better quality of care. Getting PhilHealth reimbursements is not easy, they are not generous and do not automatically pay for high quality care. So while the country is fortunate in having a national infrastructure for health insurance, work still needs to be done to improve the program's operational efficiency and to maximize value for its clients.

**Q What is your advice to policy- and decision-makers in national and global health?**

**A** Social health insurance can be complicated. It requires solutions that are context-specific. At the same time, the search for solutions is a global task. Policymakers everywhere should experiment with local solutions, subject these to rigorous evaluation, and share their experience with the international community. It is from this shared pool of knowledge that individual nations will find what works best for them.

The importance of health insurance cannot be overemphasized. A single illness can wipe out all gains from employment, which an individual often only gets after many years of schooling. Falling ill can mean losing one's job and major disruptions in household consumption, unless protection is provided by health insurance. Policymakers should commit to providing effective health insurance, if only to prevent families from falling into poverty or children from dropping out of school because a family member has fallen ill.

# 2013, University of the Philippines



# Michael Joseph (Vodafone, UK)





**Q What is the best practice in Access to Health Financing in which you and your organization have been involved?**

**A** Vodafone Group Plc is one of the world's largest mobile communications companies by revenue. It has a significant presence in Europe, the Middle East, Africa, Asia Pacific and the US through the company's subsidiaries, joint ventures, associated undertakings and investments. Mobile services can transform healthcare in developed and emerging markets. Vodafone's mobile health (mHealth) business is bringing efficiencies for under-resourced providers, enabling better access to treatment for patients, improving quality of life for those with chronic conditions, and enabling the elderly to retain their independence through assisted learning.

With more than 50 services being trialled across the Vodafone Group, we have proven the benefits of mobile health services for patients and healthcare providers, specifically managing access to medicines, providing remote care services, and enabling smart working for healthcare workers. These include:

- Vodafone's mobile money transfer service, M-Pesa, is bringing basic financial services to the rural poor in Kenya and Tanzania, and is being used to improve access to health services. For example, the travel to treatment program enables money to be sent using M-Pesa from the hospital to the healthcare workers. The healthcare workers are able to book the treatment with hospital for their patients using SMS and can also pay for the bus ticket for the patient to travel to the hospital using M-Pesa. When the patient arrives at the hospital the healthcare worker also receives an additional incentive payment via M-Pesa. A simple and effective solution that has proven to be successful. In Tanzania, in partnership with the Comprehensive Community Rehabilitation, M-Pesa is being used to pay for treatment of patients with obstetric fistula.
- A mHealth solution to support the community care givers in South Africa via a smart phone solution. Our mHealth solution allows over 1,800 community care givers (CCGs) to spend more time with patients, reduce time allocated to administrative tasks and offers an opportunity to improve education for CCGs. Similar programs are being rolled out in Kenya and Tanzania.
- Our SMS for Life program in Tanzania, which has been developed with and initially financed by the Novartis Foundation. With over 5,000 facilities participating, it improves the supply of life saving anti-malaria drugs by tracking medicine stock levels via text message.

Our aim is to scale up these programs through partnerships with pharmaceutical companies, government health departments, NGOs, and healthcare providers.

# Michael Joseph (Vodafone, UK)

**Q What are the main obstacles and challenges regarding developing better access to health and health financing? What can we learn from failures?**

**A** Globally, telemedicine and mHealth policy is still in its infancy and converting pilots to sustainable programs will require partnerships between governments, mobile operators, pharmaceutical companies, NGOs and healthcare providers.

Key to this will be a joined-up approach to funding throughout the healthcare value chain to ensure right incentives are there to use mHealth services and ensure such services are financially sustainable.

In addition to the funding and cost of mHealth services, healthcare professionals and patients need to gain confidence in using such services. To achieve this a solution should be:

- Simple to use
- Interactive, responsive and improves efficiency
- Comprehensive in terms of information and interoperable with other systems
- Evidence based and proven
- Privacy and security risks managed
- Operationally reliable and maintained.

To date we have experienced that it is important to avoid stand-alone systems and use solutions that are already proven and successful, as Vodafone has done with SMS and M-Pesa services.

In addition to the technology required to adopt M-Health solutions, there are a number of additional factors which will assist a successful implementation. These include understanding local needs to ensure services meet these needs, work with Governments to change unnecessary regulatory and administrative barriers which may preclude healthcare needs being met, and regulations through building local relationships to ensure infrastructure and processes are understood, and the development of an outreach education program with healthcare professionals and patients on how to use the service.

**Q What is your advice to policy- and decision-makers in national and global health?**

**A** Mobile has already had a huge impact on society, so much so that Jeffrey Sachs, Director of the Earth Institute at Columbia University, has described the mobile phone as the 'single most transformative tool for development'. In part, this is because a mobile phone does not have the same barriers to access as other forms of technology and is simple, inexpensive and convenient to use. Access to mobile networks is now widely available, even in remote areas. This not only offers people the ability to stay in touch with friends and family but it also provides access to finance, improved healthcare solutions, supply chain efficiencies and increasingly automated mobility. As well as providing benefits to society, these services are commercially successful and therefore, we believe, more sustainable in the long term.

Payments are an essential part of the overall healthcare delivery continuum and as such a simple, secure, reliable, and cost-effective proposition can play an important part in enabling access to healthcare.

In developing policy to boost infrastructure for telecommunications, governments should take into account the potential needs of mHealth projects, for example, ensuring electronic access to appropriate healthcare services to people living in remote, rural and disadvantaged communities.

Additionally, regulation relating to branchless banking which could provide the fundamental 'backbone' to a number of mHealth propositions, should be proportionate and not overly burdensome. We are not advocating an exemption from the regulatory environment, but more of a risk assessed approach that would enable long term sustainable successful implementation.

Acknowledging that it is a challenge for mHealth implementers to get projects to scale is crucial when planning for long-term project sustainability, and mHealth solutions that balance scale and impact are the most likely to succeed.

It is also important to remember that in order for mHealth solutions to have scale and longevity, there is a need for sustainable business models. Currently, models tend to be donor funded pilots. Pilots such as these need to ensure that they can be sustainable in the absence of such funding – a challenge for all!

For all new incentive ideas to work though it is imperative to understand that all of the above actors need to be addressed and to be fully backed by all stakeholders including, most importantly, the recipients of such services.



# Ahmad Amoudi (Microfund for Women,

“Small is beautiful, Big is beautiful,  
but what about the interface”  
*(David Dror, MIA, India)*





**Q** What is the best practice in Access to Health Financing in which you and your organization have been involved?

**A** The Microfund for Women (MFW) is a private non-profit microfinance institution which was set up in Jordan in 1996. MFW is the largest and oldest Jordanian microfinance institution (MFI). It has disbursed more than 400,000 loans, mostly to small entrepreneurs. Its clients are 97% female. MFW is financially viable. It was not until 10 years after its foundation that MFW entered the micro-insurance market, as the very first institution to do so in Jordan. Its first insurance product – credit life insurance – was launched in 2006 after a thorough survey amongst MFW customers had revealed high demand for death coverage (especially for the breadwinners) and illness coverage, especially hospitalization. In contrast, health insurance scored low due to the availability of a publicly administered health program.

MFW found that providing micro-insurance through Microfinance Institutions is an efficient delivery channel because of the trust relationship that exists between the client and the institution.

We also found that starting micro-insurance programs in a *mandatory* fashion contributed to the success of the program in the sense that:

- The program quickly builds a larger pool in which the risk is initially minimal
- It helps to build the understanding of insurance and risk coverage concepts amongst the target sector of ‘under privileged people’
- Witnessing the benefit after going through the claim filing process helps in enriching the experience and builds trust in insurance products. This leads to higher take-up rates when voluntary products are offered.

Let me mention several examples of products and schemes which worked well.

**Example A: Leveled Credit Life (Mandatory)**

The micro-insurance program called ‘Himaya’ – which means protection – was the first product we created and marketed. In designing the product, we carefully considered that:

- It should be a basic and simple product: in its policy terms and conditions, enrolment process, and claim process
- It should be easy to access: with easy availability and purchase process and easy premium payment (affordability)
- It should have good client value: i.e. the cover should fulfill client needs and be fairly priced
- It should be efficient for both the insurer and the policy holder.

The program was designed to pay a fixed amount of death benefit. The benefit amount is a specific multiple of the microloan amount. In the event of the insured client’s death, the benefit pays off the outstanding loan balance and the remaining amount goes to a beneficiary designated by the client at the time of signing the contract. The policy premium is a onetime low amount paid with the first loan installment. The product is mandatory for microfinance clients.

# Ahmad Amoudi (Microfund for Women,

The evolution of the product has been rapid. The program lost money in the first two years (2006-2008) as the loss ratio exceeded 104%. In the third year, the premiums were slightly increased and the pool of insured grew to include more than 39,000 people. The result was a break even. Starting from the fourth year, 2009, the program became sustainable and was yielding profit. In the fourth year, the product was developed further to include a USD 300 life insurance coverage for the client's spouse with no additional premium. This decision was primarily philanthropically motivated. As the number of insured increased and the loss ratio stabilized, it became clear that the product would be generating profit. So rather than reducing the premium it was decided to increase the benefit to impact the household of the client. This goes along with MFW's mission. We decided to extend the coverage to the clients' spouses. The client goes through a period of hardship after the death of their spouse. The coverage amount helps in covering some of the financial expenses incurred after the death of a spouse. Almost 80% of clients' spouses are covered by this option. A year later – 2010 – the coverage amount was doubled to USD 600 with no additional premium. The program is still running successfully with a current loss ratio of around 58%. Looking at the program's over all benefit breakdown, 20% of the claims paid were used to pay off outstanding loan balances and 80% were paid to the beneficiaries.

### ***Example B: Hospital Cash Program (Mandatory)***

Riaya – which means care-giver – was created by the Microfund for Women in cooperation with the ILO (Micro-Insurance Facility) and WWB in 2010. It was a response to a specific demand previously identified through surveys and market research. Focus groups and data collected from local governmental agencies helped shape the product features. By April 2010, the product was ready to be piloted. Hospital cash is a simple insurance program that pays the insured a fixed amount for every night the insured stays in the hospital. Exclusions are limited to the common exclusions such as suicide, alcohol and drug treatment, natural disasters and acts of war. Admission into the hospital for any other reason than exclusions triggers the benefit. As an added value, this product also covers hospital stays both for regular and complicated maternal deliveries. The two critical factors that needed to be determined in this product were the monthly premium and the cover amount per night. The product was made compulsory for the procurement of a microloan from MFW. Making the product compulsory helped bring the premium down and reduced adverse selection risk. In addition, we established close relationships with the major hospitals in order to verify easily the authenticity of hospital discharge forms (the length of hospital stay should be consistent with the diagnosis). In the beginning, we did note a few incidents of fraud – and decided to take a tough stance: those who had made fraudulent claims lost their coverage and were excluded from the program. Once the word was out amongst clients (loss of coverage), fraud cases decreased to an insignificant number.

However, at the outset MFW also had to be very careful not to start losing loan clients due to such a possibly unwelcome mandatory insurance product. After all the product development phases and loan officers' training, a pilot protocol was drawn up and Riaya was piloted in one of the largest branches of the 39 MFW offices. The product acceptance and popularity grew as more claims came in and were paid. In the 13th month, the number of insured started to grow rapidly, and the loss ratio started to decrease sharply. MFW is currently working on extending the coverage so it could be offered to the clients' family members.

**Example C: Family Hospital Cash Program (voluntary)**

Two years after the successful rollout of the mandatory Hospital Cash Program, we introduced the voluntary Family Hospital Cash Program in the form of a microloan whereby the loan installments are the premiums for the insurance. MFW decided to exempt this loan from interest and loan fees. Basically the loan amount equals the premium due on the family policy. The policy premiums and terms are exactly the same as those for the mandatory program. The program is being piloted in two of MFW's branches for the past 4 months. Take up is as projected. Claims are beginning to come in.

**Q What are the main obstacles and challenges regarding developing better access to health and health financing? What can we learn from failures?**

**A** Some of the obstacles are related to product development. Others have to do with insurance providers. The product must be:

- Simple to understand with minimal exclusions
- Affordable and easy to purchase and keep
- Of value to the client, including fast claim processing; it is best if a Microfinance Institution (MFI) processes and pays the claims.

The insurer must design the micro-product in an efficient manner: efficient for the insurer, the delivery channels and the policy holders. One should pay attention to formulate the product in a 'win-win-win' fashion.

Our experience showed that because we started micro-insurance programs as mandatory participation (while the client is an active micro-loan client), the program had a very high success rate. The voluntary program which was subsequently introduced, enjoyed high success due to the high insurance literacy level plus the experience the clients had then gained. Clients had already learned about the risk coverage concept. Many filed claims and received their benefits, so the word spread about the value of insurance.

**Q What is your advice to policy- and decision-makers in national and global health?**

**A** In the context of public health programs and sky-rocketing, uncompensated care costs straining the budgets of governments, the responsibility of providing access to healthcare rests on everyone's shoulders. Both the private and the public sectors should be involved. Policymakers today are asking important questions: Where does the burden of coverage lie? Is health insurance a personal responsibility? Should employers be the main source of people's coverage? Or is access to healthcare a right of citizenship and the government's sole responsibility? Can the healthcare safety nets withstand the strain of the growing number of uninsured?

We are convinced that government subsidized programs offered and managed by insurance companies delivered through efficient channels (such as Micro Finance Institutions) are a successful formula. Good partnerships between the private and public sectors are key in the improvement and success of access to health.

# Matthias Adler (KFW, Germany)





**Q What is the best practice in Access to Health Financing in which you and your organization have been involved?**

**A** One successful path towards getting large numbers of clients is to have strong partner institutions, by which I mean financial institutions. This is the case in the Jordanian Microfund for Women (see description V4-Amoudi). As Ahmed Amoudi's examples show, clearly the potential for scaling up is there.

**Q What are the main obstacles and challenges regarding developing better access to health and health financing? What can we learn from failures?**

**A** My main messages would be that for health insurance to succeed, as in other forms of insurance, the biggest enemy to success is the adage of 'small is beautiful'. Scaling up rapidly is essential for success. I still hear a lot about pilots, and much less about mainstreaming. I feel any pilot should encompass the question of scaling up right from the outset.

In addition: health insurance requires a lot of financial literacy. You have the moral hazard problem. You have to deal with well educated health service providers. This makes health insurance much more complex than simple financial transactions.

**Q What is your advice to policy- and decision-makers in national and global health?**

**A** First of all: listen better to micro-finance institutions' clients about their needs.

Secondly, with respect to insurance schemes: if you use the term 'bad health' differentiate more between frequency, predictability and severity of ill-health conditions. I would say to policymakers that the case for insurance becomes more viable, the more you look at severe sickness, with relatively low predictability and frequency. When it comes to frequently occurring low intensity sicknesses or health services, savings products might be the better option.

# Onno Schellekens (PharmAccess Group,



# The Netherlands)



**Q What is the best practice in Access to Health Financing in which you and your organization have been involved?**

**A** The PharmAccess Group is dedicated to improving access to quality health care in Africa for low-income groups, by strengthening the private sector. PharmAccess and partners are stimulating both demand and supply of health care through complementary initiatives, namely health insurance (Health Insurance Fund), quality improvements (SafeCare) and financing of healthcare - lending to small private clinics and doctors (Medical Credit Fund). Parallel to the publicly-funded Health Insurance Fund, there is the private equity fund and the Investment Fund for Health in Africa. There is collaboration with the Amsterdam Institute for Global Health and Development (AIGHD), which conducts rigorous impact assessments into the health insurance programs. At this moment, the Health Insurance Fund and PharmAccess are supporting local companies and organizations to develop and implement health insurance programs for low income groups and people in the informal sector in Nigeria, Tanzania, Kenya, Namibia and Mozambique. Thanks to excellent cooperation with local partners - communities, national and state governments, companies, clinics and hospitals - we have achieved a record enrollment of 117,000 people.

The community health insurance program in Kwara State, Nigeria, has grown into a successful public-private partnership with more than 65,000 people enrolled. The program is developing into a State-wide health insurance scheme. In February 2013, the Health Insurance Fund, Kwara State Government and Hygeia Community Health Care (the local counterpart of PharmAccess) signed a memorandum of understanding to expand the program to cover 600,000 people within the next 5 years. During a visit to Nigeria in May 2011, the UN Secretary-General, Ban Ki-moon, spoke about the unique character and importance of the community health insurance program of Kwara State in providing access to poor people. The Kwara program demonstrates the importance of public-private partnerships in providing access to quality health care. The introduction of standards has led to a reduction in risks and increased trust among healthcare providers, communities and the State government. An impact evaluation by the AIGHD showed that the health insurance has contributed to improved financial protection for low-income people. The Kwara State Government has been increasingly contributing to the payment of premium subsidy for low-income people and investing in healthcare infrastructure. It is perhaps the first time that a State government has collaborated with a development organization to provide health care for its citizens. Providers are earning a steady stream of income, which encourages them to invest and deliver quality health care. The Kwara program focuses on investing in the healthcare system and creating consumer demand for health insurance. AIGHD's impact evaluation showed that the health insurance led to about a 70% increase in utilization of health care and improved health outcomes (notably the management of chronic diseases).



# Onno Schellekens (PharmAccess Group,

**Q What are the main obstacles and challenges regarding developing better access to health and health financing? What can we learn from failures?**

**A** In Kwara State (Nigeria), elements such as ownership, political will, local leadership, motivation and trust are key success factors for the program. Some of the main lessons learned are:

- Knowledge of the target population: knowledge about the group/customer behavior and the emphasis on mobilization and marketing are important for the insurance program.
- Subsidies: incentives in the form of subsidies can make coverage affordable and motivate people to participate in the health insurance. Higher enrollment reduces adverse selection.
- Business case for health insurance: insurance providers, administrators and health-care providers require considerable technical assistance to expand health coverage to lower income groups. Clear understanding is needed between the partners about mutual benefits, sharing of responsibilities and obligations as well as clarity on a partner's starting level of capacity (technical and managerial skills, information systems etc.).
- Availability of data: medical data on the target population and actuarial data on healthcare utilization and costs are vital in order to accurately determine size and cost of health care package and calculate premiums.
- The introduction and monitoring of standards is required for efficiency, transparency and the quality of services. The in-depth research being implemented parallel to the implementation has proven to be extremely valuable.
- Design and management of marketing and administrative systems: health insurance for low-income groups is a high-volume low-cost business, which makes it imperative for the local partner to have efficient distribution and administration systems.
- Flexibility in contracts is important because circumstances can change at the time of implementation or unforeseen elements in design of the program can make it difficult for the local partner to sustain the program.
- Leveraging and risks reduction: initiatives that use and leverage the capacity of the private sector and aim to lower the threshold for investment in private health infrastructure, are critical.
- Public-private partnerships promote sharing of risks, stimulate additional private resources, avoid crowding out and foster innovation that can help reduce costs and improve efficiency.

**Q What is your advice to policy- and decision-makers in national and global health?**

**A** Health care is a public good and it is the primary responsibility of governments to ensure that proper care is provided to their citizens. However, in many developing countries, the limited functioning of the State and its institutions hampers the development of health care. In addition, Africa has a chronic lack of resources for health care. Sub-Saharan Africa suffers

# The Netherlands)

from about 44% of the global burden of communicable diseases but only 1% of the global health expenditure is spent in the continent. Most of the donor spending has been channeled through governments in order to improve the ailing public health systems, while 50% of total care is provided through the private sector. Although progress has been made, these efforts have not led to well-functioning health systems. Since rights and laws are not consistently enforced, the public health services are largely consumed by the richer part of the population. Most of the poor people (e.g. 64% of lowest income people in Nigeria) obtain their health care services from the private sector.

Donor funding can be used to leverage private capital for the development of both supply (loans to and investments in health care providers and suppliers) of and demand (insurance) for quality health care. The multiplier effects could attract additional resources to foster healthcare as well as economic development. Such investments will ensure that providers are able to meet quality standards and demand for higher volume of services. Investments in public-private and private health initiatives should be stimulated, particularly in areas where a financial commitment can mobilize some larger multiple of private capital for investment. For example, donors could offer guarantees which extend the reach of private financing by mitigating political and regulatory risks and encouraging private sector involvement.

With the financial support of the Dutch Ministry of Foreign Affairs, the PharmAccess Group and the Investment Fund for Health in Africa have been able to mobilize additional resources of 290 million euros from third-party donors, local governments, investors, local banks, private clients and member contributions for the premium to support healthcare delivery. This is almost eight times the amount that has been invested until now by Health Insurance Fund. The funding enables us to intensify and expand the programs. The multi-lateral institutions such as the World Bank and IFC could also support governments to develop effective policies to stimulate private sector development and public-private partnerships in health insurance and health care. An important example is the Health in Africa Initiative based in Nairobi.

Good and rigorous monitoring and evaluation and research are crucial in order to assess the outcomes of interventions in financial inclusion and access to health insurance and facilitate effective implementation.

# Jacques van der Gaag (AID & Brookings)



“There is still a lot to be learned,  
for instance about sustainability”  
*(Jacques van der Gaag – USA)*

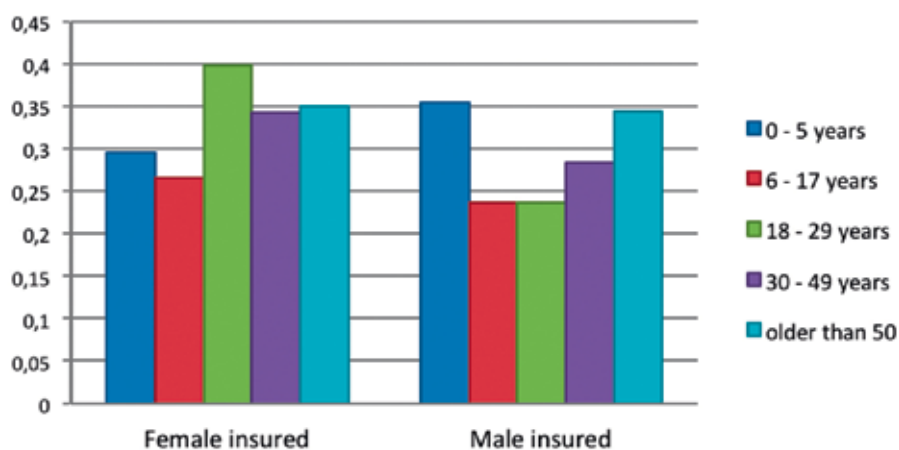
# Institution, USA)

**Q** What is the best practice in Access to Health Financing in which you and your organization have been involved?

**A** For me the Hygeia Community Healthcare program is an interesting case. It is a subsidized community-based health-insurance program which provides access to affordable and quality healthcare services to selected low-income communities in Lagos & Kwara State in Nigeria. What is noteworthy is that the program addresses both demand for care and the supply of services. It upgrades hospitals and clinics. The premium offers healthcare providers a guaranteed income over a longer period which allows them to invest in capacity and quality. The program was started to increase utilization of care provisions and reduce the gaps in coverage. It also aims to reduce out-of-pocket health expenditures and unexpected costs, and wants to improve health indicators. In 2009, the program was launched in the Afon district in Central Kwara State, Nigeria, targeting a rural farming community of 7,500 farmers and their families, 71,000 individuals in total. Currently, in Central Kwara, 23,064 individuals are enrolled. We evaluated this program by carrying out a quasi-experimental design, with two population-based household surveys in panels. We did a baseline study in 2009 and a follow-up panel in 2011, to see what was happening. We had good data from 4315 respondents, 2748 in the intervention area, 1567 in the control areas.

Our panel demonstrated that between 2009 and 2011 about 45% of the households and 30% of the individuals *enrolled in the program*.

## Insurance uptake by age and gender



We saw the lowest enrollment among children of 6-17 years and men of 18-29 years, the highest among women between 18-29 years. We wondered whether this was a case of adverse selection.

We did notice significant shifts in *utilization*: an increase in the utilization of 'any healthcare provider' in the treatment area as a whole, and a shift towards higher quality healthcare provision. We noted an increase in utilization of 'any healthcare provider' which was larger among

# Jacques van der Gaag (AID & Brookings)

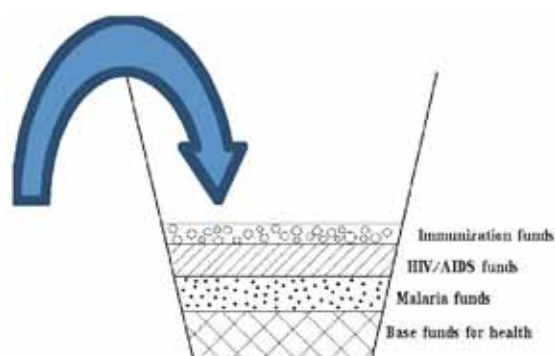
individuals younger than 18 years. In addition, we observed a shift towards modern health-care, again larger among people younger than 18 years of age. Men were using the services of 'any healthcare provider' slightly more than women. But the shift towards modern healthcare providers was similar for men and women.

As to *financial protection*, we noted a significant reduction in expenditure for health per head of the population in the treatment area as a whole. In fact, this amounted to about 40% decrease for people in health expenditures. Out-of-pocket health expenditures can be a real burden for people. We did see a larger decrease in per capita expenditure for adults. The effect was the same for men and women, but the decrease in expenditures was larger for the richest half of the population, an equity effect that needs further attention.

**Q What are the main obstacles and challenges regarding developing better access to health and health financing? What can we learn from failures?**

**A** Generally, in healthcare development, I see a number of major issues:

- **Substitution and crowding out:** As the Institute for Health Metrics and Evaluation already stated in its 2011 Financing Global Health report, governments tend to take \$0.56 out of the health sector for every \$1 of health aid they receive. An increase in donor funding for health in low-income countries often leads to a strong substitution effect, with a proportionate decrease in government spending on health. That money then gets spent on deficit reduction, debt service, or perhaps also on own-source revenue reduction instead. In other words: funds freed by the injection of donor money leak away to non-development activities, leaving in the end central government's general health expenditure choices unaffected by all the external assistance.
- **Vertical versus horizontal approaches to health financing.** There are many big programs which focus on one issue: HIV/AIDS, malaria etc. It may be smarter to pool funds into a general health financing basket.



We feel there are still many lessons to learn about the question if and if so, how community-based health insurance (CBHI) can help address these issues. We see a large latent demand for

# Institution, USA)

such insurance. Evaluations show that there may be increased access, use, financial protection and improved health. But many dimensions of such schemes still need to be further researched.

**Q What is your advice to policy- and decision-makers in national and global health?**

**A** The evidence from the Kwara State program in Nigeria shows that subsidized CBHI can stimulate increased utilization of healthcare, a shift to modern care, especially among the poorest half of the population and a decrease in out-of-pocket health expenditures.

However, there is still a lot to be learned, for instance about sustainability. Governments should support experimentation and evaluation of innovative insurance schemes. But in general: we also need to be patient!

# Berber Kramer (AIID, The Netherlands)



“Governments and private sector should have more dialogue, since they are all in the same boat”  
*(Maria Elena Bidino, CNSEG, Brazil)*



**Q What is the best practice in Access to Health Financing in which you and your organization have been involved?**

**A** As researcher at the Amsterdam Institute for International Development, I am involved in the impact evaluation of the Health Insurance Fund (HIF). Impact evaluation is an important tool for policymakers to decide what interventions are most effective. Such research enables them to use facts and figures in their allocation of future resources. It is important to do this research in a rigorous way. We need independent evaluations that are carried out by expert researchers. Too often I observe that organizations prefer to keep their impact evaluations in-house. This creates conflicting interests and will harm the quality of the findings presented.

**Q What are the main obstacles and challenges regarding developing better access to health and health financing? What can we learn from failures?**

**A** Let me highlight just one topic that I am currently studying: In one of the health-insurance schemes, I found that the ability to pay the insurance premium on credit substantially increased the proportion of household members enrolled. This reduced adverse selection. The credit resulted in a more healthy and sustainable risk pool. Not only women of childbearing age and old men with hypertension joined the insurance scheme, but also their household members who needed less insurance coverage – healthy young men and children of more than 5 years old. This finding stresses an important obstacle: the poor are liquidity-constrained and often unable to pay the health insurance premium for their entire family in one go. This is not only because their incomes are low, but also – or even more so – because they have very limited access to other insurance products, credit and savings. As a result, competing expenditures and risks make it difficult to earmark part of their budget for health.

It is important to take this into consideration when using *voluntary* health insurance as a tool to finance the health system. The ability to pay for health insurance will depend on the flexibility of the premium payment, subsidies, and on whether households have access to alternative financial products. Households need a general, broad portfolio of risk-management strategies. This portfolio does not only include health insurance, but also sound savings and credit products.

**Q What is your advice to policy- and decision-makers in national and global health?**

**A** We should start thinking about how new interventions or ideas will be evaluated at an early stage. For a proper impact evaluation, you need to do a baseline study before the intervention starts. Designing, piloting and rolling out these baseline studies takes time. Policy- and decision-makers should be aware of this and plan for such impact evaluation at an early stage. This is the only way to obtain sound and reliable impact figures. It is the only way to generate a benchmark that can inform practitioners about best practices in access to health finance.



# Muhammad Bello Waziri Dogo-Muhamm



# ad (NHIS, Nigeria)



**Q What is the best practice in Access to Health Financing in which you and your organization have been involved?**

**A** Since the year 2008, the Government of Nigeria has been working with a program named the NHIS-MDG Maternal and Child Health (MCH) Project. This project aimed at giving 100% free access to healthcare to all pregnant women and all children below the age of 5 years in selected States and Local Government Areas. The financing came from the Debt Relief Gains (DRG) that Nigeria got from the Paris Club which is being managed by the Millennium Development Goals (MDG) Office in the presidency. The intent was to cover all the thirty-six States in Nigeria plus the Federal Capital Territory (FCT) before 2015. The exit strategy was for each State to scale up its contribution within 3 years while the MDG Office was to gradually disengage from contribution within the same period. So far twelve States have benefitted from the project. This project won a Certificate of Merit from the International Social Security Association (ISSA) and was presented to the NHIS (Nigeria) in Arusha, Tanzania during its regional meeting on the 6th of December, 2011. The project was recognized as a 'Good Practice' worthy of emulation by other African countries and was posted on the ISSA website ([www.issa.int](http://www.issa.int)).

**Q What are the main obstacles and challenges regarding developing better access to health and health financing? What can we learn from failures?**

**A** Main obstacle is the lack of political will to drive the process. In a country like Nigeria, the 3 tiers of government are a serious obstacle as they are all independent of each other. As such, there is no synergy, harmony and coordination of activities. We are faced with a weak health system; poor budgeting for health; very high poverty level in the informal sector; a lopsided distribution of health facilities, personnel and other infrastructure in favor of urban areas; very low literacy levels amongst the rural populace with a high burden of disease; a lack of adequate information to the population; a lack of trust in the government and its policies and a general resistance to change.

In the face of these major challenges in Nigeria, currently our take on the failures is to properly position Health in the Constitution so that the 3 tiers of government could be assigned their responsibilities. It should be mandatory for every citizen to have cover under one form of health-insurance program or the other.

**Q What is your advice to policy- and decision-makers in national and global health?**

**A** Decision-makers should realize that health involves multiple sectors and requires collaboration inside and between ministries. There is a great need for integration, harmonization, coordination and consistency of policies and activities in order to achieve success and sustainability. They must also understand that 'top-down' and 'bottom-up' approaches should go hand-in-hand, as policies must percolate to the end-users in good time in order to get their buy-in and thus guarantee ownership and strengthen sustainability.

# Sanjay Datta (ICICI Lombard, India)





**Q What is the best practice in Access to Health Financing in which you and your organization have been involved?**

**A** To assess the contribution of health insurance, it is good to know the background of health financing in my country. Although total health spending in India at around 5% of GDP per-capita is comparable to countries at similar levels of development, **government** health spending in India which increased by 2-3% in 2012 is comparatively low. Low public health spending is being compensated by high private health spending, over 90% of which comes from out-of-pocket payments by households. The high share of out-of-pocket payments for healthcare imposes a large financial burden on households. Household expenditure on health goes to the fee-levying and largely unregulated private providers. The share of household consumption expenditure devoted to healthcare has also been increasing over time, especially in rural areas where it now accounts for nearly 7% of the household budget. The government health financing landscape is changing fast in India. The central government has increased its health spending substantially in the last three fiscal years, mainly on the national flagship program, the National Rural Health Mission (NRHM), that provides increased finances to states for existing programs as well as funding for several new initiatives. There have been initiatives to augment public spending on healthcare, though they have met with only limited success. The National Rural Health Mission (NRHM), established in 2005, and the introduction of the Rashtriya Swasthya Bima Yojana (RSBY) national health-insurance scheme for people below the poverty line are the two most important initiatives of the central government.

As active health insurers in this sector of society, we have contributed to nearly 20% of the market. Health Insurance has been provided to various strata of society which include the below poverty line population under the Rashtriya Swasthya Bima Yojna scheme and health-insurance scheme for weavers, artisans and sericulturists, over the period of last 4 years. These schemes have been largely beneficial to rural India, which forms nearly 70% of India's population, in the following:

- **Insurance allows for risk pooling:** This helps in making available additional sources of financing, thus reducing vulnerability and smoothing expenditure shocks. Pricing of the product becomes optimal owing to competition among insurers and optimum pricing allows the government to fund for the scheme across larger geographic areas.
- **Unique identification of the beneficiary:** The smart card technology intended in RSBY required technically equipped teams to reach out to the villages. Since this business model was based on revenue on the basis of conversion (premium per family basis), we have put our best foot forward in terms of technology and operational processes to cover the maximum possible population. Also by ensuring the right person is benefiting from such schemes and ensuring no leakages, we have been successful in saving costs and providing the best services.
- **Increased utilization of health services:** Our cashless model empowers the poor to opt for treatment with the health provider of their choice, in public as well as private set-ups, so as to get the best possible treatment without any effect on their pocket.

# Sanjay Datta (ICICI Lombard, India)

- **Standardization and cost effective quality healthcare:** We have standardized procedures and negotiated rates with hospitals so as to bring down costs considerably. This brings about standardization in the often unregulated cost patterns in the health sector especially with private health providers. Moreover, expenditure on treatment is found to be lower in the case of members as compared to non-members as most of the time the poor, due to illiteracy, are unaware of their health status and the actual financial worth of the treatment being rendered.
- **Administration and grievance redressal of large scale policy:** The scheme being technology driven demands a robust grievance redressal mechanism consisting of a toll-free helpline, district kiosks, help desks at the empanelled hospitals etc. Centralized call-center executives help address the concerns of the beneficiaries.
- **Stronger relationship with health providers and efficiency in health system in terms of value for money:** The parameters for selection of providers during empanelment, robust monitoring and standardization of the rates serve to create a sense of competition among the providers.

**Q What are the main obstacles and challenges regarding developing better access to health and health financing? What can we learn from failures?**

**A** We face a few major challenges:

- **Rural population spread:** Reaching down to the rural population is a major challenge considering the tough terrains and remote access, and the unavailability of sufficient data on the population to be touched at regular intervals.
- **Network of Efficient Healthcare Providers:** In some geographical areas, there is the dire issue of non-availability of an adequate number of healthcare providers who fulfill the empanelment criteria and provide quality health treatment.
- The schemes are implemented in rural areas where the hospitals usually **lack proper healthcare infrastructure** and do not meet the defined service delivery standards. Many healthcare providers lack the required infrastructure for the implementation of the technology.
- **Technology Infrastructure:** The cost of infrastructure like computers, Point of Sale (POS) systems and the connectivity in the remote areas is a bottleneck in implementing any scheme enabled by technology. Many healthcare providers are not willing to invest in infrastructure.
- **Leakages & Monitoring and Control:** Factors such as a large number of beneficiaries, illiteracy among the underprivileged, lack of knowledge of the technology among healthcare providers, pose a challenge to effective monitoring and control over the scheme.

**Q What is your advice to policy- and decision-makers in national and global health?**

**A** Governments must address several prevailing challenges at once, such as healthcare regulation, quality benchmarking and classification of providers and healthcare finance. They

should help create healthcare infrastructure. They should develop human resources. They should focus on reduction of the burden of infectious diseases on health, on reproductive and child health and nutrition, and on prevention and management of chronic diseases. They should promote systematic implementation of universal access to care and health equity, and develop policies/ a policy framework for health research. And they should instigate health-care-investment and health-insurance friendly policies and taxation structures.



# David Dror (Micro Insurance Academy, India)



“In developing countries there are now opportunities to achieve things much quicker than the time things took in the past in developed countries”,  
*(Sagie Pillay, South-Africa)*

**Q What is the best practice in Access to Health Financing in which you and your organization have been involved?**

**A** The Micro Insurance Academy (MIA) is a pioneer in providing technical assistance and training to grassroots communities that focus on collective structuring of solvent demand for health insurance, known as micro insurance or Community-based Health Insurance (CBHI). This is the only known successful practice of voluntary and contributory health insurance among poor people that survived without any premium subsidies. MIA's model is novel in that we recognize that the motivation to insure (and the main vector to scaling and replication of this access to health insurance) is anchored in a **collective rather than individual perception of welfare gains**. Therefore, in our implementation model we assist the target communities to develop a consensus to mutualize risks and pool resources, leveraging the communities' non-financial resources already within their reach (i.e. strong social networks, etc.) to design, implement and manage the micro insurance schemes, and MIA provides the technical assistance and knowledge needed in the insurance domain.

The second novelty is that **operational success of the scheme consists not merely of financial balance but of larger affiliation, high claims ratio and high renewal rate**. These results can be achieved when the scheme is perceived as relevant and affordable, claims processing is viewed as fair, operating overhead much lower (schemes are non-profit as well) and the insured gain a higher level of insurance literacy. MIA achieves an increasingly higher level of self-governance by involving the group in package design, premium setting, claim settlement and stewardship. This feature of MIA's model demystifies for the target groups a process that typically lacks transparency: the design of insurance products and the management of a financial scheme.

The third novel feature of MIA's model is that it **is unique in delivering results at any level of willingness to pay and with zero dependence on premium subsidies**. The initial willingness-to-pay may be lower than actuarial premiums, reflecting some doubts about the value of the new financial arrangement. We do not walk away from this challenge, but work with groups to adjust the coverage accordingly, reinforcing the notion that **benefits are linked to payments**. Positive experience with the scheme leads to voluntary increase in premiums subsequently. For example, among MIA's 7 health micro-insurance schemes in operation, one scheme (in Odisha) started with premiums of less than \$2 per person per year; it ended the year with a claim ratio of 82%, which led members to understand and trust the process, increase premiums voluntarily by 20%, and increase membership resulting in a 67% increase in overall premium income from one year to the next!

**Q What are the main obstacles and challenges regarding developing better access to health and health financing? What can we learn from failures?**

**A** (Micro) health insurance is an intangible 'product', difficult to explain, which in addition to the financial dimension, also involves social acceptance and durability. Social acceptance is ignored by health-insurance companies, but not by prospective clients. This creates an unbal-



# David Dror (Micro Insurance Academy, Ind

anced dialogue, aggravated by the relative power-disparity between poor people (who are required to pay) and for-profit insurers, perceived as richer (who collect premiums). Authorities could ease this difficulty if the law would require that health insurance be operated as non-profit and with guaranteed continuity, at least for basic cover. And supervision of insurers should be much more client-sensitive.

Another major obstacle is 'insurance illiteracy' among most prospective premium payers. Insurance education is essential to clarify e.g. when insurance solutions deliver more than savings.

Thirdly, voluntary and contributory health-financing schemes are discouraged from developing in low-income countries, in part due to short-term premium subsidy schemes that dampen willingness-to-pay, and partly by 'managed competition' arrangements in settings where cost-containment is not the main obstacle to affordable healthcare. Mimicking western solutions for western problems in low-income settings is a huge complication for the development of locally-relevant solutions.

## **Q What is your advice to policy- and decision-makers in national and global health?**

**A** Policy- and decision-makers can and should act on the following five recommendations:

- ***Develop insurance literacy at the base of the pyramid.*** Insurance education is as important for acceptance of insurance as primary education is for general knowledge; when children, teachers, women and men understand that they can make a real difference to their lives through collective action like insurance, they are more likely to purchase it. Today, this essential issue is ignored, relegated to 'sales and advertising', which of course it is not. Insurance education is a public good that decision-makers can and should help fund (e.g. through tax deductions by corporates, direct investments etc.).
- ***Create inclusive access to health financing.*** The main limiting factor in access to health financing is the exclusive/restrictive nature of health-related operations, on the part of both health insurance and healthcare providers (be it through pricing, risk-selection, or right to refuse services). Decision-makers can promote inclusive access by ensuring through licensing and supervision of underwriters/insurers that groups, without exception, can access affordable, relevant, sustainable insurance, with zero-tolerance of any form of exclusion. Such inclusive access should allow CBHI to underwrite risks or cede them, as CBHI holds huge promise for 'semi-automatic' affiliation of grassroots groups.
- ***Encourage mass customization to operate diverse insurance plans.*** One size does not fit all in health insurance. Today's health systems are based on archaic concepts of standard 'mass production' when we need customized solutions for many differ-

ent situations which share only one common trait: severe rationing of resources. Decision-makers should invest in developing fast-track methods for customization ('mass customization').

- **Enhance top-down support for bottom-up acceptance of insurance.** Most human systems function better in small numbers. CBHI is the small version of large-scale health insurance. It has many advantages over large systems, notably because of much better and cheaper links between flow of information and flow of funds. However, scaling CBHI requires an enabling regulatory environment and suitable reinsurance. Policy and decision-makers can provide this top-down support, so the end result will be 'small is beautiful *and* big is beautiful'.
- **Ensure predictability to build trust.** Incentives must be put in place to enhance a predictable system which can be trusted. Two types of trust are essential: **Relational trust** (respect for other individuals) and **Institutional trust** (trust in government and in businesses). If one or the other is weak, the system will be unpredictable and not survive, as previously seen in subsidy based schemes and in managed competition. As predictability means rule-based dealings, the responsibility to enhance trust lies with decision-makers.

# Pradeep Panda (Micro Insurance Academy,



“Don’t automatically assume that poor people don’t have anything. There is a lot of innovation in communities, there are resources, also among the poor”,  
*Sagie Pillay – South Africa*



**Q What is the best practice in Access to Health Financing in which you and your organization have been involved?**

**A** With our organization MIA we stimulate the provision of context-specific insurance packages that are relevant and affordable to the community. We offer insurance-package designs that are based on actual experience of the community in terms of the prevalence of illness and financing for such illness. We focus attention on groups rather than individuals and involve communities in the design, implementation and management of community-based health-insurance schemes. We attempt to enhance enrolment rate and renewal rate in CBHI schemes that are managed efficiently and effectively (no subsidy, trust in the scheme, just and fair operations etc.). We make insurance and health education an integral part of the CBHI schemes.

**Q What are the main obstacles and challenges regarding developing better access to health and health financing? What can we learn from failures?**

**A** A major obstacle to developing better access to health and health financing is the shortage of quality-healthcare supply, i.e. insufficient health services and lack of medical professionals. This is the main challenge.

We also suffer from a lack of knowledge among the community of insurance as well as among the community of preventive health.

In addition, some cultural practices inhibit insurance take-up, such as views that 'illness is not a risk', 'God will take care of me if I fall ill', or 'It is not good to think about illness'.

And finally, we have to deal with the sustainability of community-based health-insurance schemes.

**Q What is your advice to policy- and decision-makers in national and global health?**

**A** We would like policies to:

- Strengthen the healthcare-delivery system
- Provide awareness about insurance education and preventive health
- Motivate the community to save money
- Improve regulation and supervision mechanisms
- Find re-insurers to protect community-based health-insurance schemes.

# Peer Stein (International Finance Coopera



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**Q What is the best practice in Access to Health Financing in which you and your organization have been involved?**

**A** International Finance Cooperation (IFC) is the world's largest multilateral investor in the private healthcare sector in emerging markets. To date, IFC has provided financing of \$1.9 billion to 149 private healthcare and life-sciences projects in more than 53 countries. Currently, IFC has 73 active healthcare and life-sciences projects across all regions. IFC-supported health projects treat about 7.9 million patients annually. IFC's involvement in the health sector aims to introduce innovative means of financing and delivering services; improve standards of quality and efficiency; and expand access to quality healthcare to low- and middle-income groups.

IFC's recent first-ever direct investment in the health insurance sector in Georgia and Kazakhstan is an example of a best practice that will help promote international standards. In June 2011 IFC invested \$3 million in equity in Archimedes Health Developments to help expand access to health insurance and health services in Georgia and other emerging markets in Eastern Europe and Central Asia. IFC's investment will also support Archimedes Global's health insurance and health services business in Kazakhstan, and the company's entry into new markets in Eastern Europe and Central Asia. IFC's investment will help increase financial protection for people needing healthcare and promote transparency of payments in the local health sector.

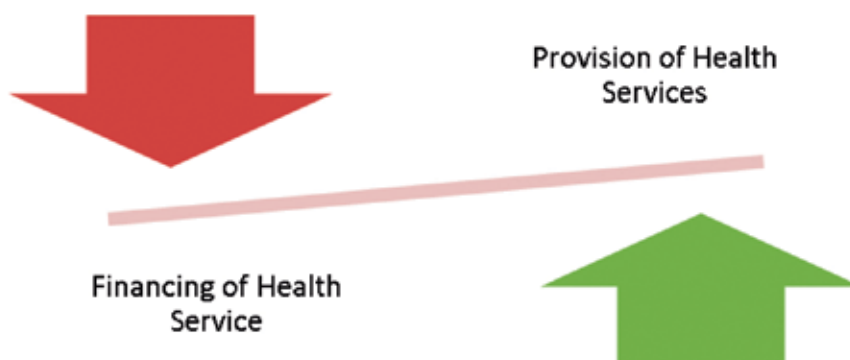
Another project in India's Meghalaya State will help implement a universal health insurance plan to benefit the state's population of over three million, including those from low- and middle-income households currently without health coverage. This project started in spring 2012, together with the World Bank. It will assist the state in designing and implementing the insurance plan, including promoting private-sector participation. It will broaden coverage for local families, allowing them to obtain quality healthcare and specialized treatment close to home. The project is also supported by the UK's Department for International Development.

**Q What are the main obstacles and challenges regarding developing better access to health and health financing? What can we learn from failures?**

**A** Improving access to healthcare has two major challenges

- provision of health services
- financing of health services

There are ongoing debates as to the sequencing of the two i.e., which comes first.



# Peer Stein (International Finance Coopera

Surveys in various countries and discussions with a number of IFC clients have highlighted the following obstacles:

## *From the perspective of the households (or insured):*

- There can be huge variation in terms of health risks and financing needs and hence the need for appropriate combination of financial products. For example, low-income households are exposed to a range of health shocks including ambulatory care resulting in huge expenditure on physician consultation and medicines, hospitalization following stints of malaria/tuberculosis/ diarrhoea. These are typically 'uninsurable' risks. Whereas, long stints of hospitalization and surgical procedures – which can push even the non-poor into poverty – can be better managed by insuring the risks. Combining the needs of different people, offering different products and explaining the products to poorly-informed households is a major challenge.
- A lack of qualified health providers in the vicinity, resulting in the need to travel long distances (10 – 25 km) to get access to a physician and over 100 km for any hospitalization, particularly for surgical procedures.
- The huge opportunity costs incurred by households – the cost of transportation, lost income/wages, incidental expenses, the cost of attendants accompanying the sick person, food, lodging etc.
- The value added of health insurance – if the insured person has to pay for various expenses (opportunity costs) in addition to paying the insurance premium itself.
- The complexity of the health insurance product in itself. This can also be a major obstacle. Conditions such as the exclusion of people with pre-existing diseases, deductibles and co-insurance amongst a plethora of conditions can dissuade people from buying health insurance and increase dependence on the public health system.

## *From the perspective of providers:*

- Due to the limited number of paying patients – notably insured patients – beyond the major cities and towns, providers tend to stay within the cities and towns and not go to the rural areas.
- In addition, given the low population density beyond the major cities/towns in many countries, particularly in Sub-Saharan Africa, the business of setting-up clinics and hospitals in smaller towns is economically unviable, resulting in people having to travel long distances to access any health services.

## *From the perspective of insurers:*

- Insurance is based on 'the law of large numbers', i.e. the larger the pool of insured people the better the risk spread is (sick vs. healthy, young vs. old, women vs. men...). If the pool is large, the premium tends to be on the lower end of the scale, thus leading to an affordable health-insurance premium.

- Reaching people in the informal sector and people living in rural areas. This is a major stumbling block in many developing countries where people working in the informal sector account for more than 90% of the working population. Reaching them is a major challenge. Similarly, a large pool of people live in rural areas and reaching them is often difficult. In these conditions the distribution cost of delivering insurance services becomes prohibitive.

There are some interesting lessons from which one can learn such as:

- ***Bundling of insurance along with other financial services, particularly microfinance:*** Currently an estimated 5 to 10 % of microfinance clients have insurance, predominantly credit life insurance which primarily protects the lender in case of death of the borrower. A closer look at the borrowings (or use of funds) of microfinance clients highlights the fact that health needs are one of the major causes of borrowing. Various microfinance institutions have developed innovative products and solutions like SEWA in India which offers a range of savings, credit and insurance products through various of its subsidiaries. Another interesting example is that of BancoSol: Bolivia's top performing MFI has nearly 200,000 clients and offers a uniquely comprehensive health micro-insurance program to women. In conjunction with Zurich Insurance, BancoSol quickly demonstrated the viability of the health-insurance program through a pilot test. In the two years since the pilot, BancoSol's health micro-insurance program has reached over 14,000 clients. Of these clients, 62% are women, and 45% are loan borrowers, underscoring the high value of bundled financial service.
- ***Leveraging Public Private Partnership (PPP):*** One of the critical success factors for developing a 'financially viable' micro-insurance program will depend on volumes, i.e. large numbers of insured people. In the case of micro-insurance this is all the more critical since the premiums are small and the margins are very thin. The World Bank Group is uniquely positioned to leverage the PPP model to improve access to health services, whereby the IFC's A2F Advisory Services will work closely with the World Bank or World Bank funded projects to deliver insurance to low-income households. The PPP could take many forms:
  - ***Publicly funded and privately managed health-insurance schemes***, such as the Rashtriya Swasthya Bima Yojana (RSBY) and a couple of other state-government sponsored health-insurance programs in India. The role of IFC will be to support:
    - Insurance companies in a) developing better systems to track the health insurance portfolio; and b) managing the insurance risk as well as providing assistance on the reinsurance front
    - Third party administrators (TPAs), who provide the administrative backbone in managing the health insurance
  - ***Public funds are used to build market infrastructure*** (such as the IT System/ Transaction Platform to manage health-insurance scheme/programs): i.e. common public good and IFC focuses on the supply-side, working with insurance and reinsurance companies to improve and increase the risk appetite of insurers to underwrite health insurance risks.

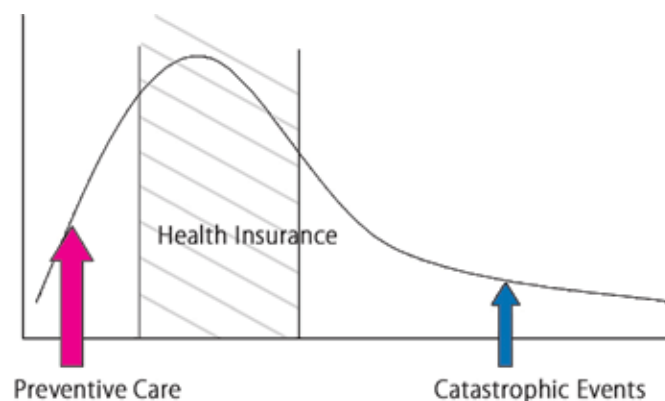


# Peer Stein (International Finance Coopera

## **Q What is your advice to policy- and decision-makers in national and global health?**

**A** One of the major challenges in many developing countries is the question of people being able to afford access to quality health services. One of the critical factors in insurance pricing is the pool of insured: the larger the pool of insured the lower the premium and vice versa. Also, a larger pool of insured gives the insurer an opportunity to negotiate a better price and delivery of quality health services with the providers. In many developing countries, given the lack of affordability, the insurance pool tends to be small, which leads to premiums being on the higher side, resulting in fewer and fewer people being insured. In the absence of insurance, people cannot appreciate the value of insurance and hence demand continues to be low. The lack of a health-insurance market or paying patients also negatively impacts the expansion of health provision beyond major cities and towns.

Following on the example of India, and a couple of other countries like Ghana and the Philippines, policymakers need to rethink the role which government can play as a catalyst in the development of health insurance. Historically, government and international organizations have tended to support or fund the supply-side: building clinics and hospitals, funding drugs and medicines, paying or subsidizing public health providers. Maybe it is time to rethink and support 'demand-side' financing, like paying for health insurance and leave the choice of accessing health services to the individuals and households. If results from India are any indication, health insurance can go a long way toward improving access to health services and fostering proliferation of health-service providers in smaller towns where there is a greater number of patients capable of paying for private health services.



tion, USA)







**Q What is the best practice in Access to Health Financing in which you and your organization have been involved?**

**A** The Center for Health Market Innovations (CHMI) is an extremely useful resource for helping countries make progress (<http://healthmarketinnovations.org>).

**Q What are the main obstacles and challenges regarding developing better access to health and health financing? What can we learn from failures?**

**A** Too many policymakers have too little of the right information they need. It is crucial that local leaders and stakeholders feel real ownership of whatever policies are being proposed.

**Q What is your advice to policy- and decision-makers in national and global health?**

**A** Listen to people on the frontlines... who know what's really happening on the ground.

# Karlijn Morsink (University of Twente, The



“Stimulating self-reliance,  
is something that excites me”  
*(Kwasi Boahene, HIFund, Kenya)*



**Q What is the best practice in Access to Health Financing in which you and your organization have been involved?**

**A** As a researcher I see an increasing interest in investigating the demand for insurance, which is a positive development. I have studied demand and its effect on consumption-smoothing activities used by low-income households in countries such as India, Kenya, the Philippines and Ethiopia. Despite the fact that research indicates that low-income households are constantly exposed to a variety of shocks, and informal risk-sharing and informal insurance are insufficient to cope with these shocks, the demand for insurance by low-income households is low. Even though several studies have attempted to explain this, there are many questions that are relevant for policy which remain unanswered.

**Q What are the main obstacles and challenges regarding developing better access to health and health financing? What can we learn from failures?**

**A** One main issue is the role that trust plays in the decision to take up or reject insurance. Lack of (enactment of) legal and regulatory frameworks, little experience with insurance or stories of fraud by or bankruptcy of insurers make trust-building especially important. In order to build trust low-income households rely extensively on informal mechanisms such as repeated interactions or encouragement by peers. The phrase 'seeing is believing', as expressed by many low-income people I have interviewed, always resonates in the back of my mind when I talk about this. One best practice, which I directly derive from my empirical research, is the reliance on trust built through payout experiences of peers in local networks. This can significantly increase the demand for insurance, especially for the poorest, most risk-averse households.

**Q What is your advice to policy- and decision-makers in national and global health?**

**A** I think it is very relevant for policymakers to find out more about the manner in which insurance can be combined with other financial mechanisms, informal risk-sharing or other risk-management activities. Even though it is generally recognized that insurance alone is insufficient to reduce vulnerability to shocks, there are still many unexplored linkages. How can we address a combination of savings and insurance to facilitate consumption in case of more frequent shocks? How can we design insurance policies which crowd-in informal risk-sharing? How can insurance incentivize households to take preventive measures? The most successful combinations of insurance with other mechanisms appear to be those where the insurance is combined with existing local structures or institutions, which are already working on reducing the impact of the shock. Identification of a pertinent value proposition for such a local institution can make the number of insurance policies grow relatively quickly.

# Michael Grimm (Passau University, Germany)





**Q What is the best practice in Access to Health Financing in which you and your organization have been involved?**

**A** At our institute we are involved in a few projects that explore the roll-out of health insurance, mostly community based, in very poor Sub-Saharan African countries. Much seems to suggest that trust building through an early involvement of the target population is key. We agreed with the implementing agencies that a process of experimentation is the best way forward. Hence, we are currently designing a set of randomized controlled trials to fill the relevant knowledge gaps. The 'communal dimension' is definitely seen as temporary, the medium term objective is to merge local initiatives into country-covering schemes. This in turn requires involving the government from the start.

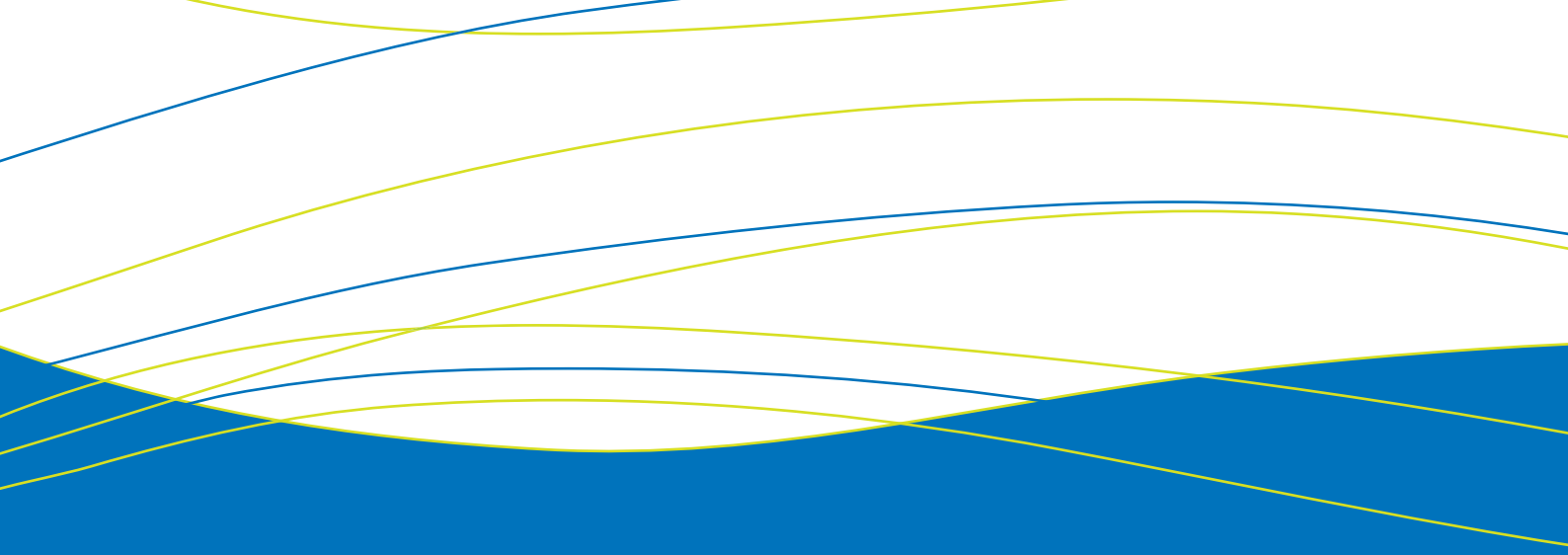
**Q What are the main obstacles and challenges regarding developing better access to health and health financing? What can we learn from failures?**

**A** In the context in which we are working problems arise from both the supply-side and the demand-side. On the supply-side the quality of healthcare is a serious problem. On the demand-side two aspects stand out. First, low trust in insurance products, and, secondly, the limited household capacity to pay the premium. Trust building implies, for instance, involving local associations and other reference groups. The budget constraints can be relaxed by subsidizing part of the premium.

**Q What is your advice to policy- and decision-makers in national and global health?**

**A** Definitely more research is needed and should be supported. We need research which can help us find out under which conditions health insurance works as opposed to research that addresses the rather general question whether health insurance per se is an adequate product. The latter is only of limited help.





# Voices from the field II

# Voices from the field DVD: Access to Health In

## List of interviews and film fragments

1. Interview with H.R.H. **Princess Máxima** of the Netherlands in her roles as the UN Secretary-General's Special Advocate for Inclusive Finance for Development and Chair of the Prince Claus Curatorium (5 June, 2012)
2. Interview with **Stella QUIMBO** (Prince Claus Chair 2011-13, University of the Philippines) (5 June, 2012)
3. Interview with **Rodger VOORHIES** (Bill & Melinda Gates Foundation) (5 June, 2012)
4. Interview with **Khama ROGO** (IFC Health in Africa Initiative) (5 June, 2012)
5. Interview with **Maria Elena BIDINO** (Brazilian Insurance Confederation – CNSEG) (5 June, 2012)
6. Interview with **Sanjay DATTA** (ICICI Lombard) (5 June, 2012)
7. Interview with **Jeanna HOLTZ** (Microinsurance Innovation Facility ILO) (5 June, 2012)
8. Interview with **Kwasi BOAHENE** (Health Insurance Fund) (5 June, 2012)
9. Interview with **David DROR** (Micro Insurance Academy) (5 June, 2012)
10. Interview with **Muhammad DOGO-MUHAMMAD** (NHIS Nigeria) (5 June, 2012)
11. Interview with **Ahmad AMOUDI** (Microfund for Women) (5 June, 2012)
12. Interview with **Fola LAOYE** (Hygeia Group) (5 June, 2012)
13. Interview with **Sagie PILLAY** (National Health Lab Service, South Africa) (5 June, 2012)

Two discussion panels, held at the Access to Health Insurance Conference on June 5, 2012 items are not included in this DVD but can be accessed on line in the original version at:

- a) Panel 'Access to Health Insurance in Resource Poor and Weak States', with **Christoph Kurowski** (World Bank), **Fola Laoye** (Hygeia Group), **Willem van Duin** (CEO Achmea), **Khama Rogo** (IFC-Health in Africa Initiative) and **Alex Preker** (moderator, World Bank). Rotterdam AHI Conference (5 June, 2012) [www.youtube.com/watch?v=yWangRuuqwl](http://www.youtube.com/watch?v=yWangRuuqwl)
- b) Panel 'Future of Access to Health Insurance Efforts', with **Peer Stein** (IFC), **Susanne Dorasil** (German Federal Ministry for Economic Cooperation and Development), **Muhammad Dogo-Muhammad** (former executive secretary NHIS Nigeria), **Stella Quimbo** (University of the Philippines) and **Godelieve van Heteren** (moderator, Rotterdam Global Health Initiative) and audience. Rotterdam AHI conference (5 June, 2012) [www.youtube.com/watch?v=IhWYv59SFiw](http://www.youtube.com/watch?v=IhWYv59SFiw)

# Useful web links

**UNSGSA.org**

United Nations Secretary-General's Special Advocate for Inclusive Finance for Development

**CGAP.org**

CGAP is an independent policy and research center dedicated to advancing financial access for the world's poor

**fas.imf.org**

IMF Financial Access Survey

**[econ.worldbank.org/WBSITE/EXTERNAL/EXTDEC/EXTRESEARCH/EXTPROGRAMS/EXTFINRES/EXTGLOBALFIN/0,,contentMDK:23147627~pagePK:64168176~piPK:64168140~theSitePK:8519639,00.html](http://econ.worldbank.org/WBSITE/EXTERNAL/EXTDEC/EXTRESEARCH/EXTPROGRAMS/EXTFINRES/EXTGLOBALFIN/0,,contentMDK:23147627~pagePK:64168176~piPK:64168140~theSitePK:8519639,00.html)**

World Bank Global Findex, global financial inclusion database

**[thinkprogress.org/health/2012/12/12/1324131/un-vote-to-endorse-universal-health-care-access-underscores-need-for-insurance/?mobile=nc](http://thinkprogress.org/health/2012/12/12/1324131/un-vote-to-endorse-universal-health-care-access-underscores-need-for-insurance/?mobile=nc)**

UN and universal health coverage resolution

**[microinsurancenetwork.org](http://microinsurancenetwork.org)**

Microinsurance Network

**[microfund.org/jo/public/main\\_english.aspx?M=3&page\\_id=1](http://microfund.org/jo/public/main_english.aspx?M=3&page_id=1)**

Microfund for Women, Jordan

**[microinsuranceacademy.org](http://microinsuranceacademy.org)**

Micro Insurance Academy, India

**[pharmaccess.org/RunScript.asp?Page=213&p=ASP\Pg213.asp](http://pharmaccess.org/RunScript.asp?Page=213&p=ASP\Pg213.asp)**

Health Insurance Fund / PharmAccess

**[kfw-entwicklungsbank.de/EN\\_Home/Sectors/Health/Action\\_by\\_KfW\\_Entwicklungsbank/index.jsp](http://kfw-entwicklungsbank.de/EN_Home/Sectors/Health/Action_by_KfW_Entwicklungsbank/index.jsp)**

KfW Entwicklungsbank

**[rsby.gov.in/about\\_rsby.html](http://rsby.gov.in/about_rsby.html)**

Rashtriya Swasthya Bima Yojana insurance scheme, India

**[issa.int](http://issa.int)**

International Social Security Association

**[www1.ifc.org](http://www1.ifc.org)**

International Finance Cooperation, World Bank Group

**[healthmarketinnovations.org](http://healthmarketinnovations.org)**

Center for Health Market Innovations

**[ilo.org/public/english/employment/mifacility](http://ilo.org/public/english/employment/mifacility) and [microinsurancefacility.org](http://microinsurancefacility.org) and [ilo.org/microinsurance](http://ilo.org/microinsurance)**

ILO Microinsurance Innovation facility

**[publications.worldbank.org/index.php?main\\_page=product\\_info&cPath=1&products\\_id=23732](http://publications.worldbank.org/index.php?main_page=product_info&cPath=1&products_id=23732)**

Publication World Bank Scaling Up Affordable Health Insurance: Staying the Course, 2013

**[who.int/health\\_financing/documents/tmi-community\\_insurance.pdf](http://who.int/health_financing/documents/tmi-community_insurance.pdf)**

Community-based health insurance in developing countries: a study of its contribution to the performance of health financing systems

**[portfoliosofthepoor.com](http://portfoliosofthepoor.com)**

Portfolios of the Poor: How the World's Poor Live on \$2 a Day (Princeton University Press, 2009) tackles the fundamental question of how the poor make ends meet.

**[media.swissre.com/documents/sigma6\\_2010\\_en.pdf](http://media.swissre.com/documents/sigma6_2010_en.pdf)**

Microinsurance – risk protection for 4 billion people (2010)

**[ilo.org/employment/Whatwedo/Publications/WCMS\\_124365/lang--en/index.htm](http://ilo.org/employment/Whatwedo/Publications/WCMS_124365/lang--en/index.htm)**

Landscape Study of Microinsurance in Africa

**[munichre-foundation.org/home/Projects/Microinsurance/2006Microinsurance\\_Compndium.html](http://munichre-foundation.org/home/Projects/Microinsurance/2006Microinsurance_Compndium.html)**

Microinsurance Compendium, 2012

**[munichre-foundation.org/dms/MRS/Documents/Microinsurance/2012\\_IMC/20121010\\_Landscape\\_Microinsurance\\_LAC.pdf](http://munichre-foundation.org/dms/MRS/Documents/Microinsurance/2012_IMC/20121010_Landscape_Microinsurance_LAC.pdf)**

Landscape Study of Microinsurance in Latin America, 2012

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