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PRIMER FOR POLICYMAKERS

PSP-One

Insurance as a Way to Increase the Utilization of Reproductive Health Services

Increasing access to and utilization of reproductive health (RH) services in developing countries is critical to improve RH outcomes and reach the Millennium Development Goals, especially the reduction in maternal mortality. In most developing countries, there is inadequate public funding of health care services, due in part to the lack of financial resources resulting from limited tax revenues. Households are forced to compensate for the lack of public funding by paying for health care directly at the point of service. The cost of health care, particularly these out-of-pocket payments, constitutes a significant financial barrier to access to health services, especially for the poor. Households' reliance on out-of-pocket payments makes them financially vulnerable to catastrophic events. A serious illness that results in loss of employment and income coupled with the loss of savings or debt accumulated to pay for out-of-pocket health expenses can easily lead to impoverishment for financially fragile families. To increase health services utilization it is necessary – but not sufficient – to reduce or eliminate financial barriers to access by giving users financial protection against the cost of seeking care. Financial protection improves access.

Insurance mechanisms, which pool risks and eliminate or significantly reduce point-of-service user fees, can provide financial protection. Insurance can ease the burden on households of paying out of pocket for health services at the time when individuals are ill and most vulnerable. It can also reduce the financial barriers to seeking health services, especially seeking care early, regularly, and for preventive services. A recent study that compared health seeking behavior between insured and uninsured groups in Rwanda (Schneider and Hanson 2005) found that "financial and not need-related criteria seem to determine uninsured individuals' care-seeking behaviour, leading to large differences in service use between insured and uninsured groups."

Insurance mechanisms – such as private insurance, social health insurance, and community-based insurance – are increasingly being created and expanded in developing countries. These new and existing insurance mechanisms can be leveraged to add RH services to benefits packages. However, there are challenges to including RH services – especially family planning and deliveries – in health insurance. Since families are unlikely to purchase insurance just to cover RH risks, it will be necessary to incorporate RH benefits into insurance programs with broader benefit packages.

The purpose of this primer is to introduce decision makers to the basics of health insurance and outline some key issues related to leveraging insurance programs to include RH services. This primer explains what insurance is, different types of insurance, the challenges to developing viable insurance programs, what is an insurable risk and how that relates to covering RH; it then describes several country examples. These examples

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demonstrate that, under the right circumstances, insurance programs can cover RH services. Recent experiences show that adding RH services to covered benefits has had a positive impact on the use of some services in some countries, although not in all.

1. WHAT IS HEALTH INSURANCE?

Health insurance is a mechanism that pools funds from a group of individuals or families and pays for all or part of their health services according to a specified benefits package. That is, insurance funds, which can be paid by private and/or public sources, are used to purchase specific types of health services from providers, to which the insured have access when they need health care. When using the services, the insured pay less than the full amount of medical expenses, allowing them to obtain more health care than would be possible without insurance and protecting the insured against the risk of financial consequences of an uncertain illness or accident. The insured individual is protected because his/her risk of illness or accident is pooled with the risk of other scheme members. Because there is little probability that all members will fall sick within a given period of time, the group minimizes individual risk. Health insurance also facilitates early care seeking behavior and the use of preventive services – if such services are included in the benefits package – by decreasing the financial burden to households at the time of service.

Box 1. Risk Pooling

Insurance schemes work because they share the financial risk of illness and the financial burden of health care costs across a diverse population. People may be willing to pay a small amount to insure themselves against the risk of illness and the resulting financial consequences. Because different individuals face different health risks, it is likely that only a small proportion of people in a large and diverse group will fall ill at any given time. By using the collective resources of the group to pay for health services for the individuals, everyone in the group has access to health care when they need it. Insurance reduces financial risk of a catastrophic illness. Insurance can also reduce the likelihood of illnesses escalating into something serious by enabling beneficiaries to seek care sooner.

2. WHAT ARE THE TYPES OF HEALTH INSURANCE?

There are a number of variables that define different types of health insurance programs. Some of the most important are the source of financing, the provider of health services, and whether the insurance program is formal or informal. The source of financing defines whether a scheme is considered private or public (also called social) health insurance.

- Private health insurance: It is typically voluntary; it can be for-profit or non-profit. It differs from public insurance in that it has to compete with other insurers for customers, and plans have different prices and benefits packages. Private insurance is financed by household or employer contributions, which are paid directly to the risk-pooling entity.

- Public (social) health insurance: For this type of insurance, the government may be the insurer or it may choose to subsidize insurance through full or partial payment of premiums. It can be compulsory or not. Public insurance programs are financed from general revenue or with earmarked payroll taxes.

Health insurance takes a wide variety of forms and the boundaries between publicly and privately financed insurance are often blurred. Many insurance schemes combine public and private financing; the table below gives examples of such "mixed" schemes. It is important to recognize that the private or public nature of insurance funding is distinct from the private or public provision of health care services covered by insurers. Regardless of funding, either the public or private sector may provide health care services or, as is often the case, services may be provided by a combination of public and private providers; the table below also shows a selection of insurance schemes with service provision combinations that are prevalent in developing countries.

Formal insurance, which includes both privately and publicly organized insurance schemes, is typically defined by legislation and regulated. It is common in middle- and high-income countries,

TYPES OF INSURANCE

PROVIDERS	SOURCE OF FUNDING		
	PUBLIC	MIXED	PRIVATE
Public	*Indonesia:* Health Card Scheme	*Burundi:* Carte d'Assurance Maladie *Thailand:* Health Card Scheme *Ecuador:* Seguridad Social Campesina	*Guinea-Bissau:* Abota Village Insurance Scheme Indonesia: Dana Sehat Mali: Mutual Health Organizations (multiple schemes)
Mixed	*Colombia:* Social Insurance Scheme		*Rwanda:* Community-based Health Insurance (multiple schemes) India: Self-employed Women's Association
Private			*Democratic Republic of Congo:* Bwamanda Hospital Insurance Scheme *Senegal:* Mutual Health Organizations (multiple schemes) *Bangladesh:* Dhaka Community Hospital, Grameen Bank Health Program, Gonosasthya Kendra Health Care System

because it draws on groups of employees and, therefore, depends on a formal employment sector. The formal employment sector, including public sector employment, facilitates deducting employee contributions to premiums, consolidates employer or government premium contributions, and lowers premium costs by creating a large group in which risks can be pooled and diversified. In some developing countries, the lack of widespread formal employment coupled with problems related to information, contract enforcement, and contract management limit the feasibility and effectiveness of formal financial and insurance markets. This has caused communities, including the poor, to devise their own grassroots, informal pooling mechanisms, such as microinsurance.

Microinsurance is a "mechanism for pooling a whole community's risks and resources to protect all its participating members against the financial consequences of mutually determined health risks" (Dror and Preker 2002). Different terms are used interchangeably in the literature to designate this type of scheme, such as community-based health insurance, prepayment plans, community health funds, mutual health organizations (MHOs), and rural health insurance. There is no definitive typology and categories in which to classify the different microinsurance schemes. They can be for-profit or not-for-profit, provide services through public or private facilities, and may be organized by a variety of actors: community-based organizations, health service providers, associations, municipalities, districts, trade unions,

Box 2. Community-based Health Insurance

One type of microinsurance scheme that has emerged in the last decade, particularly in sub-Saharan African countries (Mali, Senegal, Rwanda), is community-based health insurance (CBHI). CBHI can be defined as "any program managed and operated by a community-based organization, other than government or a private for-profit company, that provides risk-pooling to cover the costs (or some part thereof) of health care services. Beneficiaries are associated with, or involved in the management of community-based schemes, at least in the choice of the health services it covers. It is voluntary in nature, formed on the basis of an ethic of mutual aid, and covers a variety of benefit packages. CBHIs can be initiated by health facilities, NGOs, trade unions, local communities, local governments or cooperatives and can be owned and run by any of these organizations" (Tabor 2005).

cooperatives, microfinance institutions, employer associations, women's groups, etc.

3. WHAT CHALLENGES DOES HEALTH INSURANCE FACE?

To be viable, insurance premiums must be set at a level that cover the expected payout for service delivery costs due to illnesses and injuries plus the administrative costs associated with running the plan. Adverse selection and moral hazard increase the cost of insurance programs and can threaten their viability.

Adverse selection (European Observatory 2005) refers to the fact that sick people are more likely to sign up for health insurance than healthier people. Because insured individuals have information about their health status and risks that insurers do not have, some individuals may be able to purchase insurance at rates that are below actuarially fair rates, i.e., rates that would cover their expected health services costs.

Moral hazard (European Observatory 2005) is the risk that individuals change their behavior once they have insurance and do not pay for services directly. They may seek health services more frequently or for minor ailments, or take risks that increase their demand for health services. This results in insured individuals exploiting a benefit system to the detriment of other consumers, providers, or the financing community as a whole, without bearing financial consequences of their behavior. Moral hazard can also affect providers' behavior. With fee-for-service reimbursement, knowledge that the patient is insured can lead providers to oversupply services and increase costs.

Adverse selection or moral hazard can lead to escalation of the insurance program's costs, because the increased claims on the insurance fund tend to push up costs. Insurers must control for adverse selection and moral hazard to control cost escalation. It is thus in the insurers' interest to create disincentives to such behavior, such as diversifying the risk of the group by requiring enrollment by all family members rather than individuals, or implementing co-payments[1] and deductibles[2]. These payments are intended to discourage unnecessary use or over-use of services, without creating a disincentive to use valid and necessary health services.

Other crucial issues for the financial stability of insurers in low-income countries are the high cost of insurance administration, weak administrative capacity, and difficulty collecting payments. Populations are informally employed, incomes are seasonal because of agriculture, and people are geographically scattered, all of which raise the cost of premium collection (Conn and Walford 1998).

4. WHAT IS AN 'INSURABLE' RISK?

Risk comprises both the probability and magnitude of potential health care expenditures. For example, high risk is associated with a high probability of expenditure (the event happens often) and/or a high level of expenditure (the event is costly). Typically, people want insurance against high-risk events. Individuals are less inclined to purchase insurance for potential expenses that are low cost or predictable, in other words, low-risk events. Family planning, for example, is low cost and predictable and, therefore, a low-risk expense. People would not purchase insurance only for family planning; instead they would use those resources to purchase family planning products directly. Routine deliveries are also a low-risk event.

Risks that can be efficiently insured are affordable, measurable, and random. The following types of risks are considered uninsurable:

- *Nonrandom health care risk:* Examples would be pregnancies, which can be planned, a war conflict, where the risk is predictable, or a community/region where there is an epidemic.
- *High-probability health care services:* These services are uninsurable because the price of

[1] A co-payment is a small fee that an insurance plan requires patients to pay each time they obtain a covered health care service (Schieber 1997).

[2] An insurance plan deductible requires the insured person to pay all charges for covered services out of pocket until the total cost reaches the deductible amount. After that, the insurance plan begins to pay (Schieber 1997).

an insurance plan that covers high-probability losses may equal or exceed the cost to consumers of remaining uninsured (and paying out of pocket for the services in question). Mental health care and other chronic illnesses fall in this category.

- *Very low-cost health care services:* For very small losses (i.e., services that cost very little), the administrative costs of insurance may exceed consumers' demand to be protected from a risk. The insurer would typically package coverage for these small expenditures with coverage for more costly and insurable services. This is the case for many preventive services, including family planning.

Although these types of services are defined as 'uninsurable,' this means they are unlikely to be insured as a stand-alone benefit. Many uninsurable risks, such as those that are nonrandom or low cost, can be efficiently covered if they are part of a broader benefits package.

5. CAN REPRODUCTIVE HEALTH SERVICES BE INSURED?

As explained in the preceding section, even though some RH services, such as family planning and routine deliveries, are considered 'uninsurable' because they are low-cost or nonrandom, they can still be included in an insurance benefits package. There are several challenges, however, to insuring RH services: From the perspective of beneficiaries, these services would not be the driving force behind a decision to purchase insurance. Insured populations may not demand RH services sufficiently to encourage or justify adding those services to the benefits package. Nonetheless, insurance coverage for such services will make household financing for health care more predictable, which is helpful, especially to poorer families. From the perspective of self-insured businesses and commercial insurance companies, improvements in health status that result from family planning and other preventive services occur in the future. These entities may have little incentive to pay for insuring such services if they are not assured of capturing the cost savings these services produce. However, some types of prevention interventions can have an impact in the short-term, for instance, promoting the use of condoms to prevent sexually transmitted infections. In that case, covering preventive services will benefit insurance companies who pay on a fee-for-service basis because stimulating prevention may avert accidents or illness and, hence, outlays associated with curative and rehabilitation activities. Employers will support adding prevention services if they believe those services will reduce absenteeism and improve productivity.

6. DOES THE TYPE OF INSURANCE HAVE IMPLICATIONS FOR COVERING REPRODUCTIVE HEALTH SERVICES?

Different types of insurance have implications for covering RH services. The source of funding affects the decision-making process for including RH services in a benefits package. For privately funded insurance, the payers – employers in the case of formal private insurance and communities for microinsurance – must demand benefits and be willing to pay and advocate for them. For publicly funded insurance, policymakers or members of the insurance program's governing body must be convinced of the value of adding RH services and motivated to take the necessary decisions. Availability of service provision also affects access to RH services: the closer service providers are to the covered population and the more service delivery points included in the insurance program, the greater the impact on access. Offering services through both public and private sectors will provide the most service delivery points and choice for clients.

The following section reviews country examples of insurance programs that include RH services. Columbia and Thailand are public insurance programs; Senegal and Mali are examples of private insurance. Each example discusses the type of insurance, benefits package, and impact on utilization.

7. COUNTRY EXAMPLES

Publicly funded programs

Colombia

Type of insurance: Colombia has a public universal health insurance program, which was established as part of the health sector reform in 1993. There are two payment options. The contributory plan, called the Compulsory Health Plan (POS), requires a monthly contribution proportionate to income for all individuals with means to pay, defined as earnings equal or greater to twice the minimum wage. For families with income below that level, there is a subsidized Basic Healthcare Plan (PAB), with a publicly funded allowance equal to the insurance premium. Municipal authorities receive tax revenue to subsidize the PAB and administer the program (United Nations 2000). Insured individuals choose an insurer and select providers within the insurer's network. Insurance companies pay public and private providers for their services. Between 1990 and 1996, public subsidies for health care more than doubled, with a portion earmarked for a solidarity fund to subsidize coverage for the poor (Bitrán y Asociados 1997).

Benefits package: Pregnant and nursing women and their children up to one year of age, even in the poorest sectors of the population, are entitled to prenatal services, delivery and puerperal care, nutritional assistance to mothers, and care for infants in the first year of life. The sexual and reproductive health contents in the general health and social security system are regulated and include the promotion of sexual and reproductive health (United Nations 2000).

Impact on utilization: In Colombia, the introduction of universal health insurance contributed to improving access to RH services. According to the Demographic and Health Surveys (DHS) (1986, 1990, 1995, and 2000), universal health insurance coverage has resulted in increases in physician-assisted deliveries (up 66 percent), deliveries in health facilities (up 18 percent), and use of prenatal care among rural women (up 49 percent). The DHS 2000 shows that there is a significant difference in infant mortality rates between children whose mothers used prenatal care and institutional delivery compared to those whose mothers did not use such services (Escobar 2005, Lopez and Perez 2003). A study on the impact of health insurance on the use of family planning and maternal health services showed that participation in the POS (contributory plan) increased the likelihood of delivering in a medical facility to 95 percent. The POS also increased women's probability of using prenatal care and modern methods[3] of family planning, although the subsidized plan did not demonstrate the same effect (Winfrey et al 2002).

Thailand

Type of insurance: Thailand has recently achieved universal coverage (UC) of health services through three schemes: Universal healthcare scheme (covers 78 percent of the population), Social Security Scheme (covers 13 percent of the population), and Civil Servant Medical Benefit Scheme (covers 9 percent of the population). Universal healthcare and Civil Servant Medical Benefit schemes are financed by general tax revenues. Payroll taxes fund the Social Security Scheme.

Benefits package: The schemes cover curative and preventive sexual and reproductive health services. Preventive services include family planning, antenatal care, sex education and promotion of condom use, screening for syphilis, HIV testing, prevention of mother-to-child transmission among pregnant women, pap smear, clinical breast examination, and general counseling services for sexual and gender-based violence. Curative services include abortion in cases of rape and risk to maternal health, treatment of abortion complications, essential obstetric care for the first two children, treatment of reproductive tract infections, definitive treatment and care for opportunistic infections for HIV/AIDS patients, and reproductive tract cancer treatment.

[3] Modern methods are those that require supplies or clinical services, including contraceptive sterilization, intrauterine devices, hormonal methods, oral pills, condoms, and vaginal barrier methods.

Impact on utilization: The case of Thailand shows that access to services is only one side of the utilization equation. Though RH services were covered by insurance and offered by providers, this did not necessarily translate into higher utilization due to lack of effective demand by the population. For example, patients did not express demand nor adequately utilize services such as screening for cervical and breast cancer, sex education, condom promotion, family planning and prevention of unplanned pregnancies, premarital counseling, and voluntary HIV testing (Teerawattananon and Tangcharoensathien 2004).

Privately funded programs

The following country examples are of community-based health insurance in Senegal and Mali. Premiums are paid exclusively by community members, with no subsidy from government or employers.

Senegal

In 1997, 19 MHOs were operating in Senegal. By 2000, the number of functioning MHOs increased to 28, by 2003 to 79. Also in 2003, another 48 schemes were being established throughout the country.

Box 3. Including RH Services in MHO Schemes

A qualitative study carried out by PHRplus in Thiès aimed to better understand the factors involved in decisions to include (or exclude) RH services in MHO schemes. The study showed that a lack of public education about family planning appeared to be a significant constraint to increasing inclusion of these services in MHO benefit packages. The lack of public education is translated into, for example, members not articulating a demand for FP services, people not being aware of the advantages of child spacing, women perceiving family planning narrowly, as a matter only of contraceptives, women confusing reproductive health with non-RH problems such as malaria, vaccinations, and chronic illnesses. Without further information, education, communication (IEC) and training, MHO beneficiaries are not likely to demand RH and FP services and products (PHR*plus* 2004).

Benefits package: Many of the existing MHOs cover some RH services, such as prenatal and postnatal care as well as deliveries. The historical evolution of the benefits packages show that MHOs have behaved prudently in the extension of their respective benefits packages. Several, but not all, MHOs in the Thiès region – the birthplace of rural MHOs in Senegal – have included prenatal care consultations, simple deliveries, cesarean, postnatal consultation, and family planning in their benefits packages.

Impact on utilization: A recent study of MHOs in Senegal looked at their impact on RH services, comparing utilization of members and non-members (Smith and Quijada 2006). Although the results show a positive relationship between MHO membership and service utilization, the small sample size means that the results should be considered indicative but not conclusive. [4] The study found that women belonging to MHOs were more likely to have four or more prenatal visits (63 percent of beneficiaries compared to 53 percent of non-beneficiaries) and to seek prenatal care sooner (39 percent in the first three months among beneficiaries versus 23 percent among non-beneficiaries) than women who were not MHO members. Eighty-seven percent of MHO members delivered in a health facility, compared to 68 percent of non-members.[5]

Mali

Benefits package: Although Mali was the first African country to establish a legal framework for MHOs, the number of schemes remains limited. One of the characteristics of MHOs in Mali is that they cover RH services, including family planning, prenatal and postnatal consultations, tetanus vaccination for pregnant women, and simple and complicated deliveries.

Impact on utilization: A recent study on the impact of MHOs on the utilization of priority health services showed that MHO beneficiaries

[4] Differences between members and non-members would have to be very large to be statistically significant.
[5] This finding is significant at the 5-percent level.

were more likely to consult for prenatal care and more likely seek the recommended number of visits. Fifty-seven percent of MHO beneficiaries had four or more prenatal visits compared to 36 percent for non-beneficiaries. MHO members were more likely to deliver in health facilities (89 percent for MHO members versus 64 percent for non-members) and be assisted with delivery by a skilled attendant (71 percent versus 43 percent)[6]. Overall the impact of MHO participation on health service utilization was positive (Franco et al. forthcoming).

8. CONCLUSIONS AND RECOMMENDATIONS

Health insurance – publicly and privately financed – is being introduced in many developing countries, providing a mechanism to reduce financial barriers to seeking health services. Existing health insurance programs, and especially new ones being designed, present an opportunity to expand access to RH services by including them in benefits packages. Given the nature of insurance, however, there are challenges to covering RH services. Because many RH services are preventive or address needs that are predictable, such as family planning, and prenatal and postnatal care, they would not generate sufficient demand for insurance by beneficiaries unless RH is bundled with other health services. The employers and communities that finance private insurance need to see both demand and benefit to decide to include RH services in their benefits packages. Advocacy efforts by sexual and reproductive health champions, supported by analysis that links access to RH services to reduction in the burden of disease, can often influence whether these services are covered by public insurance.

For insurance programs that have included RH services, the evidence on utilization is mixed. Data from Colombia, Senegal, and Mali show a higher proportion of deliveries in health facilities among women who belong to insurance programs than in women who are not members. Yet the impact on family planning and screening services in the Thailand program has been much more limited. This underscores the fact that improving access to services – by reducing the financial barriers – does not translate directly into increased utilization of health services. If clients have unfulfilled demand for services, reducing financial barriers to access is more likely to increase utilization of those services. Promotional activities can be an effective way to stimulate demand for services, particularly when an instrument such as insurance is in place to facilitate the conversion of the desire to use into effective demand. Information, education, and communication campaigns that inform the public about insurance programs as well as promote the use of covered RH services can help insurance programs reach their potential to improve utilization.

Although insurance can be part of the solution to expanding utilization of RH services, it also has its limits. CBHI schemes face problems related to low and sometimes falling enrollment rates, small scheme size (small risk pool), limited financial viability and sustainability, and weak administrative and management capacity (Atim 1998). Insurance is not a panacea but an effective mechanism that can be used as part of a broader RH strategy. Increasing access and utilization of RH services in developing countries has to be a multi-pronged approach.

[6] Due to the small sample size, the difference for delivery at modern facilities and with skilled attendants are not statistically significant.

ACRONYM LIST

CBHI	Community Based Health Insurance
DHS	Demographic and Health Survey
FP	Family Planning
GRET	Groupe de recherché d'echanges technologiques, Cambodia
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IEC	Information, education and communication
IUDs	Intra uterine devices
MFI	Microfinance institution
MH	Maternal health
MHO	Mutual Health Organization
NGOs	Non-governmental organizations
ORT	Organization for Educational Resources and Training, Philippines
PAB	Basic Healthcare Plan, Colombia
POS	Compulsory Health Plan, Colombia
RH	Reproductive health
SEWA	Self-Employed Women's Association, India
UMASIDA	Informal Sector Association for Health Care in Dar es Salaam, Tanzania

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