



## Can health insurance be the magic bullet? The case of Microcare Ltd in Uganda

Achieving the Millennium Development Goals (MDGs) remains an important global challenge. Better protection for the poor against health shocks is crucial in this endeavour and international organizations, such as the ILO and the WHO, have advanced micro or community-based health-insurance (CBHI) schemes as an appropriate instrument. It is argued that these schemes can improve access to health care, reduce the costs of medical treatment and lessen the need to use costly strategies to pay for medical expenditures. As such, health insurance or CBHI schemes should be an integral element in poverty-reduction strategies.

Can health insurance schemes live up to these expectations? Do insured households have lower expenditures on health? Do they use other means to cover their medical costs, such as loans or the sale of assets, less frequently? And if they use such strategies to meet expen-

ditures, do they sell less costly assets or do they take out smaller loans compared to non-insured households? The findings presented here are based on a survey conducted in Uganda in 2006 in collaboration with the health-insurance provider Microcare Ltd. The sample covered insured and uninsured households in five rural communities in Kisiizi District and two urban communities in Kampala, where Microcare operates.

*Micro-insurance is a term that is often used to describe the risk-pooling instruments designed for low-income people with a relatively low capacity to pay for insurance. In the last few decades, several types of micro-insurance have been designed, such as life insurance, crop insurance, health insurance, credit insurance, etc. There are four ways to deliver micro-insurance to the public. The Community-Based or Mutual Model is designed and managed by the clients themselves. In the Partner-Agent Model, an insurance company links up with an NGO to deliver and market the insurance policy, while in the Full Service Model, all the activities are in the hands of the micro-insurance company. In a Provider-Driven model a (health-care) provider runs the insurance scheme and is responsible for all operations. Microcare operates according to the Partner-Agent Model.*



### *Illness: consequences and protection*

Poor people in developing countries are frequently confronted with illness. Formal social protection, either through state social-security programmes or market-based insurance, is often lacking and many families are not protected against the consequences of illness. Apart from the need to care for a patient, illness is likely to reduce a household's income if people are not able to work. Illness may also involve extra expenditures to cover the costs of treatment. As it is common for patients and their families to lack the cash needed for medical fees, people may forego treatment, with potentially detrimental effects for their long-term health. Alternatively, some families use costly strategies to pay for medical care: they reduce spending on basic needs such as food, sell household or produc-

tive assets or borrow money. Such strategies may endanger the future economic status of the household as people become indebted, deplete their savings or reduce their future income-generating capacity by selling productive assets such as cattle or agricultural tools. This, in return, will increase their risk of ending up or being trapped in poverty.

In this context, protection against high medical costs through health insurance allows earlier medical treatment, which is likely to shorten the duration of an illness, reduce the number of workdays lost and improve productivity at work because of better health. More indirectly, when households are better protected against high medical costs, they are less likely to have to rely on other strategies to finance medical expenditures and are more likely to be able to accumulate savings and assets.

Policy debates have placed a great deal of emphasis on the development of health-insurance products for the poor. Following the micro-credit boom, micro-insurance is being advanced as a successful method of improving poor people's lives and in the past two decades, hundreds of small schemes have been implemented across the globe. However, empirical evidence on the effects of health insurance is still limited.



### Microcare in Uganda

Health insurance is thought to reduce out-of-pocket (OOP) expenditures on health. Out-of-pocket expenditures include the total costs of a consultation and treatment, including transport costs and insurance premiums (for those insured). In the communities where Microcare operates, insured households pay, on average, lower medical expenditures. Figure 1 shows that, on average, annual medical expenditures for insured households are Ush 103,220 (US\$ 55.79) lower compared to households without insurance. If the number of illnesses a household experiences in a year is taken into account,

*Microcare provides health insurance to groups of households in the so-called informal sector, such as self-employed farmers. These groups are usually well established, such as credit groups or farmers' associations, or are groups that have organized themselves specifically to access insurance. Participation rates in Microcare's informal-sector health-insurance scheme are approximately 15% of the population in Kisiizi but less than 1% in Kampala. The health-insurance package offered covers outpatient and inpatient services but excludes medication for chronic illnesses such as HIV/AIDS, hypertension and diabetes. Premiums have to be paid as an annual lump sum, are non-refundable and vary according to a household's size and location. At the time of this study, the annual premium in Kampala was USh 149,000 (US\$ 80.54) for a family of four, with additional premiums for extra members: USh 52,000 (US\$ 28.11) for each extra adult and USh 26,000 (US\$ 14.05) for an extra child. The Kisiizi scheme charged annual premiums starting at USh 24,000 (US\$ 12.97) for a family of four while a family of eight paid USh 32,000 (US\$17.29) per year and a family of up to twelve members USh 40,000 (US\$ 21.62). On average, this amounts to between 1% and 2% of a household's annual expenditure.*

the difference amounts to Ush 28,770 (US\$ 15.55) per illness. As these expenditures include insurance premiums, the results show that having access to Microcare's health-insurance scheme reduces total medical expenditures considerably.

Similar findings have been reported in studies on health-insurance schemes in Senegal, India and Vietnam. The innovative element in this Ugandan study is the inclusion of the relationship between health insurance and other strategies to finance medical expenditures, such as acquiring informal loans or selling assets.

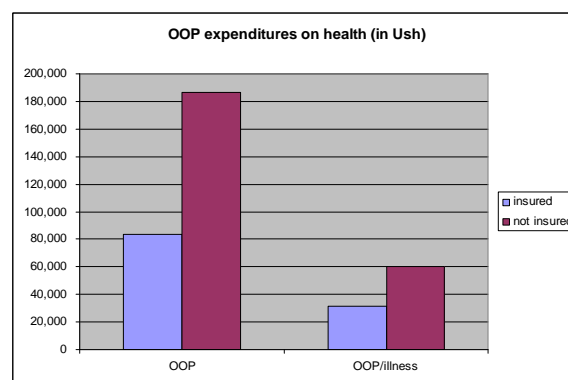


Figure 1

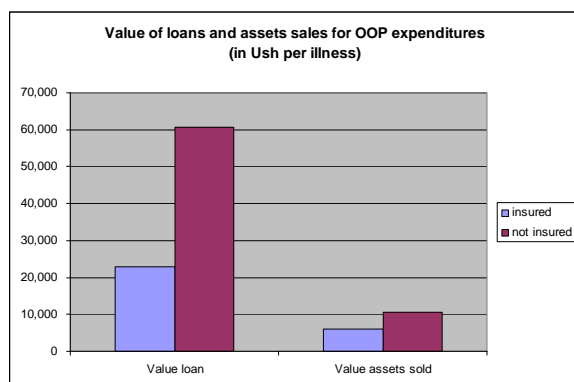


Figure 2

The Ugandan data show that insured and uninsured households acquire loans to the same extent to cover medical expenditures. However, insured households on average borrow smaller amounts per reported illness. Figure 2 shows that the difference is more than Ush 35,000 (US\$ 18.92), indicating that insured households are less heavily indebted than uninsured households. At the same time, insured households are less likely to sell assets and if they do, the value of the assets sold per illness is lower – some Ush 5,000 (US\$ 2.70) per illness. These findings suggest that insured households are better protected against health shocks and less often resort to coping strategies that could endanger their future well-being.

Although insured households use other strategies less often to finance medical expenditures, there are two reasons why health insurance is unlikely to make these other strategies completely redundant. First, Microcare's insurance policy covers a limited number of costs and excludes, for example, medication for chronic illnesses that may confront insured households with high recurring costs. This can



Microcare meeting in Kamoobwa

be especially taxing for households with patients suffering from AIDS, hypertension or diabetes. In addition, health-care providers ask user fees for outpatient visits and admissions from both insured and uninsured patients. And patients

may have to spend a considerable amount of money on transport to a medical facility and these costs are not covered by the policy either. Such expenditures may force households to borrow money or sell assets as many households are strapped for cash, especially in rural areas.

These additional costs are common in small-scale insurance schemes and are necessary to prevent insured members from behaving in a riskier manner because they are insured (moral hazard). Such costs are also related to the nature of the schemes: low costs insurance for a relatively small group. As the number of members is restricted, the associated pool to share the health risks is equally restricted, which limits the costs to be covered by the policy. This could in theory be solved by increasing the premium of the insurance, but that is not an option in schemes targeted at the poor.

*Insured households can still be confronted with substantial health-related costs, for example, for medicines for chronic illnesses. Insured households in the rural areas paid more than USh 54,000 (US\$ 29.19) per chronic illness, while insured households in urban areas reported twice this amount; USh 108,900 (US\$ 58.86). Additionally, health-care providers ask uninsured and insured patients to pay user fees for both outpatient (OPD) and inpatient (IPD) departments. An OPD visit to Kisiizi Hospital was USh 1,000 (US\$ 0.54) for the insured and USh 1,200 (US\$ 0.65) for the uninsured, while admission costs USh 5,000 (US\$ 2.70) for everyone. An OPD visit in Kampala varied from between USh 2,500 (US\$ 1.35) and USh 5,000 (US\$ 2.70). Transport costs can also be high in cases of severe or repeated illnesses or if it is a long way to the nearest health-care facility, as is often the case in rural areas. Transport costs in and around Kisiizi amounted to about 31% of total OOP expenditures for medical care, ranging from 53% in one community to close to zero in another. In urban neighbourhoods, households allocated on average 18% of their total OOP health-care expenditures to transport costs.*

A second reason why other strategies to finance medical expenditures are not being made redundant by health insurance is that numerous respondents reported difficulties in paying their premium and borrowed money or sold assets to be able to do so. Information from the survey shows that only 37% of insured household heads could pay their premiums from available cash sources. More than half of the insured

household heads (55%) borrowed money to pay their premiums, while the remaining 8% sold assets. Among the insured respondents who borrowed money, over 82% borrowed from members of their community. Others, especially those in urban areas, used a micro-credit loan from FINCA Uganda to pay the premium.

Although these examples demonstrate that health insurance cannot offer households full protection against the financial effects of health risks, the lower incidence of asset sales, the lower value of asset sales and the smaller sums borrowed by insured respondents are encouraging. Health insurance potentially has a contribution to make beyond reducing medical expenditures and improving access to health care. With lower levels of indebtedness and asset depletion, health insurance can improve households' well-being more generally.



*Kisiizi hospital*

### *Lessons learnt*

The study focused on the direct and indirect effects of Microcare's health-insurance scheme (i.e. its effect on medical expenditures and strategies to finance these expenditures), and found a positive association between the scheme and these indicators. Three practical recommendations can be offered as a result of this study. The limited availability of cash in households, especially in rural areas, may trigger informal loans and asset sales to finance the payment of premiums, transport costs or co-payments for consultations and treatment. To minimize informal loans and asset sales, it is therefore recommended that (1) micro-insurance schemes are restricted in charging co-payments beyond the level required to prevent moral hazard, (2) design tailor-made premium payment schedules that coincide with households' cash availability and (3) operate in conjunction with a micro-finance institution to facilitate the payment of premiums and/or encourage savings to cover future payments. The precise possibilities to implement these recommendations should be assessed in the context of the scheme(s) under consideration.



*Town around Kisiizi*

The results presented here are based on one case study and limited to Microcare's insurance schemes in Kampala and Kisiizi. These may not be representative of members across Uganda or of other schemes. To ascertain if the relationship between health insurance, medical expenditures and strategies to finance medical costs is to be found more generally, the African Studies Centre has started a research project that addresses similar questions in micro-health insurance schemes in other African countries. Currently, we are working for example in Togo to study the impact of CBHI on the welfare of households, and in particular their children's health.

### **Publications related to this project**

Dekker, M., & Wilms, A., Health Insurance and Other Risk-Coping Strategies in Uganda: The Case of Microcare Insurance Ltd., *World Development* (2009), doi:10.1016/j.worlddev.2009.09.004.

Wilms, A. (2006) *The Financial Impact of Formal Health Insurance Schemes: Evidence from Uganda*. Unpublished Master Thesis. Vrije Universiteit Amsterdam, Amsterdam.  
<http://www.microfinancegateway.org/p/site/m/teplate.rc/1.9.27012>.

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