ACCELERATING UPTAKE OF HEALTH INSURANCE

INTRODUCTION

In a small village in rural Nigeria, Ada faces a difficult decision. Her son has been suffering from recurring fevers, and the health clinic in her village has recommended further tests that they cannot perform. The cost of these tests and potential treatments is far beyond what her family can afford out-of-pocket. Ada has heard about the National Health Insurance Scheme but is unsure how to enroll, and she doesn’t know whether it would cover all the necessary treatments.

Ada’s situation mirrors the experiences of many individuals in low- and middle-income countries (LMICs), where health financing reforms, aimed at accelerating progress toward universal health coverage (UHC), involve some form of health insurance. Despite these efforts, the uptake of health insurance programs in many LMICs remains relatively low, with coverage varying greatly by country and region. In several East Asian, Central Asian, and Latin American countries, health insurance coverage is nearly universal. Countries like India and some sub-Saharan African (SSA) nations such as Namibia, Rwanda, and Ghana have moderate coverage rates. In contrast, most SSA and South Asian countries still have very low coverage (1, p.4). For example, only 4 out of 36 SSA countries cover more than 20% of their population with any type of health insurance (2).

Governments in LMICs are implementing various measures to increase health insurance coverage. However, these efforts do not automatically translate into high uptake of health insurance or, among those enrolled, into increased utilization of services, as several barriers may still prevent individuals from enrolling or from utilizing the available services provided under insurance schemes. These barriers may include lack of awareness about benefits and entitlements, affordability issues, complex enrollment processes, or mistrust in the effectiveness of insurance systems, among others.

Drawing from international experience, several guiding principles can help ensure that health financing reforms drive progress toward UHC. Three of these principles are particularly relevant in the context of this brief: i) shifting away from reliance on out-of-pocket (OOP) payments ii) primarily relying on pre-paid and pooled systems of health financing and iii) reducing fragmentation in pooling to enhance the redistributional capacity (whereby the healthy support the unhealthy and the rich support the poor) (3).

As LMICs strive to reduce reliance on OOP spending and transition to pre-paid and pooled systems of health financing, they typically face two broad options. Countries may choose: i) to finance their health system primarily through general revenue (in which case the
pre-paid funds come mainly from general taxation), usually referred to as the non-contributory model, or ii) to introduce contributory health insurance, where pre-payment primarily takes the form of mandatory or voluntary insurance premiums (4). Increasingly, LMICs are adopting hybrid financing models that rely on both general revenue and earmarked contributions (5).

The relative value of different health financing models has been the subject of intense debate that continues to shape the literature and policy discussions on health financing reforms in LMICs, as illustrated in Box 1. The effectiveness of the different models with respect to key UHC indicators is mixed, which contributes to these debates. While some evidence suggests that health insurance schemes have improved healthcare utilization (1, 6-9), and financial protection for their members, this is not always the case, and evidence around improvement in health outcomes is limited (1). In many countries, having a health insurance card does not guarantee access to quality health services without financial hardship.

The relatively low coverage and uptake of health insurance programs in LMICs have been associated with a range of flaws in their design and their implementation that have hindered progress toward UHC. Efforts are being made in many countries to find ways to address these issues, often supported by different organizations as part of time-bound donor-funded projects.

Obvious design flaws are best addressed at the source by revisiting the country’s health financing strategy. However, these efforts take time, especially as reversing past health financing choices may require significant changes to legal frameworks and institutional setups. In the meantime, key challenges can be addressed on two fronts: (i) by mitigating the negative effects of suboptimal design choices and (ii) by tackling implementation challenges. Strengthening the underlying functions of key existing systems is particularly important even if health financing strategies are eventually revised.

This technical brief discusses the complexities of accelerating health insurance uptake in LMICs, highlighting the challenges and presenting potential pathways, initiatives, and key insights drawn from Population Services International (PSI) and other organizations supporting health financing reforms in LMICs.
NAVIGATING THE HEALTH FINANCING MODEL DEBATE

In their article, Yazbeck and colleagues (4) argue that the evidence supports the superiority of tax-based financing (non-contributory) to the contributory model (linking entitlement to pre-payment in the form of mandatory or voluntary insurance premiums) that prevails in many LMICs. This stance is primarily driven by the limitations of contributory health insurance schemes in terms of reaching those who are most in need of health insurance. Additionally, evidence highlights the fragmentation frequently associated with such schemes, and the fact that the implementation of contributory health insurance has not demonstrated an increase in revenues for the health sector or supported LMICs in their efforts towards UHC. However, Ashraf and Mor emphasize that in many LMICs, the available option is not choosing between tax-based or contributory financing, but in most cases, there is a continued reliance on out-of-pocket (OOP) expenditures. Therefore, exploring alternatives to OOP expenditures represents a more pragmatic approach (10).

Kutzin and colleagues stress the importance of understanding health financing policy and its reforms by examining specific functions and policies, rather than relying on historical labels tied to the primary source of funds (3). They further highlight the need for tailoring new reforms to each country’s unique context and existing institutional arrangements through an adaptable approach, rather than defining “a single, best model of health financing for UHC (p. 269).”

With health insurance schemes in many LMICs failing to improve affordable access to essential health services and products among those who need them the most, some authors argue that alternative approaches to improving access to these services and products should be explored (11). While these authors’ argument relates specifically to family planning services and products – in response to global calls for the integration of family planning into health insurance benefit packages – it could equally apply to other health areas. Their concern is legitimate: if health services and products are included in the benefit package of an ineffective health insurance scheme, their inclusion may make no difference to those who need these services and products the most. This raises a question of why LMICs are seeking to include FP services within these insurance schemes. Although there is no denying the importance of exploring alternatives, as the authors suggest, doing so should not imply abandoning efforts to support the national strategy. Considering that governments are unlikely to reverse course on their health financing strategy, it is essential to simultaneously pursue both approaches: seeking alternative solutions to address the immediate needs of marginalized populations while addressing the flaws of the health insurance scheme.

IMPACT OF FLAWS IN HEALTH INSURANCE DESIGN AND IMPLEMENTATION

DESIGN FLAWS

POLITICIZED AND UNDERFUNDED HEALTH FINANCING REFORMS

Political economy can often influence health financing reforms and their effectiveness. Political structures and interest groups, which bring together distinct interests, power dynamics, influences, and agendas, play a crucial role in developing health reforms, including health insurance initiatives. As a result, health financing reforms are shaped by negotiations and compromises, often leading to reforms that prioritize political rather than technical perspectives (12-14). Similarly, securing adequate and sustainable financing for any health reform competes with priorities from other sectors, resulting in compromises and underbudgeted ambitious reforms.
Understanding the different stakeholders, power dynamics, and incentives is crucial for successfully navigating the challenges inherent in health financing reforms.

Given the political and funding challenges inherent in health financing reforms, considering a component-based sequencing approach may be a pragmatic approach, as some authors suggest in response to the challenges associated with the commonly observed “Big Bang” approach to implementing national health insurance (NHI) in LMICs (i.e., covering the whole population and the whole country in one go). A component-based sequencing approach entails gradually constructing the necessary components for NHI over time, with an initial emphasis on improving the supply of quality health services and strategic purchasing through small-scale interventions. This approach is considered to be more manageable, cost-effective, and equitable, allowing countries to strengthen the quality of services and strategic purchasing before introducing explicit entitlements and collecting premiums from the population (15).

LOW COVERAGE OF THE INFORMAL SECTOR

Another common design flaw results from the challenges associated with extending health insurance coverage to individuals working in the informal sector. Mandatory contributions for health insurance can be collected most easily from those employed in the formal sector. In contrast, the informal sector lacks formal structures and mechanisms, as many businesses remain unregistered, making it challenging to enforce contributions to health insurance schemes. Accordingly, numerous LMICs have introduced social health insurance schemes focusing exclusively on the formal sector, especially where health insurance was primarily introduced for its revenue-generating potential. The formal sector in many LMICs, however, tends to be relatively small in comparison to the informal sector, meaning that the vast majority of the population is left without health insurance coverage.

In an attempt to overcome these challenges, some countries, such as Burkina Faso, India, Nepal, and Senegal, have introduced separate health insurance schemes targeting the informal sector or promoted the introduction of community-based health insurance (CBHI) schemes to increase coverage of different population groups (16). In either case, enrollment into the health insurance scheme tends to be voluntary. Voluntary health insurance suffers from the inherent challenge of adverse selection, in that people expecting to need healthcare are more likely to join the scheme, while people not expecting to need healthcare opt out. Health insurance is based on the principle that those who are healthy and rarely use healthcare services cross-subsidize those who have more intensive healthcare needs, so when there is a larger share of high-needs, high-cost healthcare users in a risk pool, it leads to a higher average cost of healthcare per member. This, in turn, leads to an increase in the amount that each individual needs to contribute, making the insurance unaffordable for a growing share of the population, and especially among those who need financial protection the most.

Making participation mandatory could in theory address the problem of adverse selection. Given the very nature of the informal sector, however, this solution is extremely hard to enforce. Instead, the government may decide to subsidize premiums to make the scheme more attractive and increase enrollment. If premiums are heavily subsidized, however, the revenue-generating potential of the scheme will diminish to the point where collecting premiums may not be worth the effort and the administrative cost involved. Advancing toward UHC in these contexts may therefore require abandoning attempts to collect contributions from the informal sector altogether (20), and instead, focusing on improving access to high-quality health services while ensuring financial protection for all, echoing some of the debates highlighted in Box 1.

1 The informal economy refers to economic activities carried out by workers and economic units that are not adequately covered by formal arrangements (17).

2 According to the International Labor Organization (ILO), more than 60% of the world’s employed population are in the informal economy (85.8% and 68.2% in Africa and Asia and the Pacific respectively) (18).

3 “CBHI is a type of health insurance scheme that is organized and managed by members of a specific community or group. It typically operates on a voluntary basis, where community members come together to collectively contribute funds to cover the expenses associated with healthcare (19).
CHALLENGES IN IDENTIFYING AND COVERING THE POOR AND VULNERABLE

A third design flaw relates to the coverage of the poor and vulnerable, who may not be able to afford to pay a contribution. Health insurance schemes in many LMICs fail to reach these population groups (21). One solution is for the government to pay the contribution on their behalf. Identifying the poor and vulnerable is complex and extremely costly. To increase efficiency, the strategy for identifying them should serve all social assistance programs and be developed collaboratively across sectors. According to a systematic review, the most equitable health insurance systems across 20 LMICs were characterized by successful identification of people living in poverty and lower administrative burdens to enrollment either through automatic enrollment or community outreach (22).

OPENING THE DOOR TO PRIVATE HEALTH INSURANCE: EXACERBATING DISPARITIES AND FRAGMENTING HEALTH SYSTEMS

Poor performance in terms of health insurance coverage leads many countries to open the doors to private insurance companies. Most of these companies are for-profit and offer health insurance on a voluntary basis to those who can afford it – mostly the rich and, in some cases, the middle class, excluding large segments of the population who cannot afford premiums. If private health insurance is poorly regulated, which tends to be the case in many LMICs, this can create a dual system where the quality and client-friendliness of healthcare services are significantly better for those with private insurance, exacerbating health disparities. An example is the two-tiered, highly inequitable healthcare system in South Africa (23). Underwriting practices, introduced to counter the adverse selection that arises as a result of the voluntary nature of private health insurance, can further exclude large segments of the population. Individuals with pre-existing conditions, older people, or those considered high-risk due to lifestyle factors or occupational hazards may find themselves unable to secure insurance or face prohibitively high premiums, undermining progress toward the goal of UHC. Moreover, the presence of multiple private insurance schemes can lead to a fragmented healthcare system, complicating efforts to provide comprehensive and coordinated care, and resulting in inefficiencies both at the system and individual level.

In conclusion, many LMICs end up with health financing arrangements that violate each of the three guiding principles mentioned earlier. A large share of the population, including the most vulnerable, remains without health insurance coverage and, as a result, continues to pay for health care out-of-pocket, which violates the first guiding principle – shifting away from reliance on OOP payments. Voluntary participation – whether in schemes targeting the informal sector or in schemes offered by private insurers – goes against the second guiding principle – primarily relying on pre-paid and pooled systems of health financing. Many LMICs have started implementing a mix of social, national, private, and CBHI schemes over the years, however, having separate risk pooling mechanisms for different population groups represents a departure from the third guiding principle – reducing fragmentation in pooling to enhance the redistributional capacity (whereby the healthy support the unhealthy and the rich support the poor).

In addition to design challenges, implementation flaws further limit the uptake of insurance and service utilization.

IMPLEMENTATION CHALLENGES

Implementation challenges can relate to both the supply side and the demand side. Below, we first discuss a number of common supply challenges before turning to the demand side.

CUMBERSOME ACCREDITATION PROCESSES

Integrating private sector providers into national health insurance schemes provides an opportunity to expand access to affordable health products and services. Typically, healthcare facilities, especially private ones, will first need to get accredited to be
contracted by a health insurance scheme. However, accreditation procedures can be cumbersome, time-consuming, and costly, deterring many providers from even applying for accreditation (24). When voluntary, only those with substantial resources and established quality standards may be able to achieve accredited status. This widens the quality gap between public and private sectors or primary and higher levels of care and limits members’ options for providers who accept their health insurance card (25).

UNVERIFIED QUALITY OF SERVICE PROVISION

Quality of care is an important factor influencing uptake of health insurance. Enrolled consumers are more likely to use health insurance schemes if they feel confident that they will be able to access quality care when needed and that healthcare providers will readily accept their health insurance card. A positive experience of care contributes to fostering trust in both the health system and insurance programs, ultimately increasing the likelihood of enrollment and retention (26).

Accreditation mostly focuses on structural aspects of quality (e.g., whether the facility meets the minimum standards required to deliver quality services). It rarely assesses the quality of service delivery. Consequently, seeking care at an accredited facility is not a guarantee that the services will be of high quality. In fact, health insurance does not systematically enhance the quality of existing healthcare providers and there is little evidence to suggest that health insurance enables patient access to higher quality providers (1, 27). Rather, health insurance primarily influences structural aspects rather than process and outcome measures.

DISINCENTIVIZED HEALTH PROVIDERS

In some cases, provider payment rates are perceived to be inadequate to cover the cost of service provision (more common with private providers), or providers may not fully understand how a particular payment mechanism works. Confusion about capitation payments⁴, for example, is not uncommon. Providers may also experience substantial delays in receiving payments, which affects their cash flow (again, this particularly applies to private providers who use payments to also cover their overhead costs). These challenges may deter providers from renewing their contracts with insurers, or they may result in providers giving differential treatment or denying care to cardholders, lowering the value of and trust in health insurance (1). In Ghana for example, interviews with clients and NHI staff revealed that delayed reimbursements have led to instances where providers resort to charging insured clients informal fees or treat them unfavorably (24).

Different solutions have been tested to mitigate some of these common supply-side challenges. A few examples are outlined below.

EXPANDING PROVIDER NETWORKS AND CONSIDERING INCENTIVES

Several LMICs, such as Ghana, India, Indonesia, Kenya, Nigeria, the Philippines, and Vietnam, have embarked on integrating private sector providers into national health insurance mechanisms (28). Successful integration requires effective management processes and adequate resources across all stages, from accreditation to contracting and quality assurance. Experience from the USAID-funded Health Policy Plus (HP+) offers important policy recommendations on managing and avoiding common barriers to private sector contracting. These include solutions to regulatory challenges, scheme management, quality assurance, facility operations, financial sustainability, and governance. For instance, implementing measures such as strengthening data systems to streamline national and state registration and licensing procedures can help avoid licensing delays. Incentives for private sector providers to obtain accreditation and remain engaged could include regularly adjusting reimbursement rates to keep pace with inflation and rising costs; accompanying the introduction of digital systems with comprehensive capacity-building efforts; ensuring adequate resources, support, and ongoing capacity-building for private sector providers to meet quality standards; and providing some flexibility for achieving accreditation requirements (28). Financial viability is also an important concern to be taken

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⁴ Healthcare providers are paid a fixed amount for each patient they serve, regardless of the actual services provided.
The experience of social franchising in Uganda and Kenya offers insights that can be useful in mixed health systems where there is an interest in leveraging private healthcare services through public (or other third party) financing to improve access to quality of care. Insights gained from social franchising initiatives and consultations with PSI personnel, indicate that a key factor for willingness of private providers to participate in public financing arrangements and remain in such initiatives is the extent to which the arrangement impacts (directly or indirectly) their sustainability and profitability, both in the short- and long-term (see Box 2).

**CONSIDERATIONS FOR ENGAGING PRIVATE HEALTHCARE PROVIDERS IN PUBLIC–PRIVATE INITIATIVES: LESSONS FROM SOCIAL FRANCHISING**

When private sector interests around sustainability and profitability are not taken into consideration in the design of a public financing initiative, private providers are unlikely to participate. For example, when such arrangements result in a net loss to private providers, it will hold little attraction to them, regardless of the intended benefits to population health outcomes. This explains a common concern among policy makers, who fear that contracting private for-profit providers will increase healthcare costs. Lessons from social franchising, however, suggest various ways in which contractual arrangements can enhance sustainability and profitability of private healthcare providers without necessarily increasing costs. These include:

1. Improved competitiveness and attractiveness of the private provider due to certification and recognition of quality standard
2. Lower operating costs by adopting more efficient business, administrative, and clinical protocols
3. Expansion of consumer base with inclusion of (or channeling of) publicly funded patients
4. Improved cashflow and more continuous revenue stream from third party payer

Other countries are establishing pathways to streamline the future contracting of private providers by health insurance programs and create the necessary conditions for this process. In India, for example, PSI helped the government of Uttar Pradesh contract private providers by developing a user-friendly digital platform, called Hausala Sajheedari, that streamlines the whole process of accreditation, contracting, and reimbursement of private providers. The model effectively decreased time to accreditation, unlocked domestic financing for private providers, and increased the speed with which private providers were reimbursed for the provision of family planning services. This, in turn, has increased equitable access to family planning services for clients across the state (see Box 3). Similarly, in the Philippines, the MOMENTUM Private Health Care Delivery (MPHD) project has started to create pathways for private sector integration into public purchasing to increase access to family planning products and services (see Box 4).
UNLOCKING DOMESTIC FUNDING FOR PRIVATE SECTOR FAMILY PLANNING PROVISION IN INDIA: THE CASE OF HAUSALA SAJHEEDARI

The Hausala Sajheedari platform optimizes various processes, including streamlining private sector facility accreditation, provider empanelment, claims submission, service validation, and reimbursement for sterilization and IUD services. The introduction of a digital platform eased the accreditation process for providers, offering an effortless procedure from application submission to the issuance of a government-approved digital certificate. This digital ecosystem enables quick verification of health services, audit calls to clients, and approval of reimbursements, marking a substantial leap forward. Around 95% of all private sector claims are now reimbursed within 50 working days, which has helped rebuild private providers’ trust in the government. Additionally, the transition from a year-long accreditation process to just 15 working days showcases a significant improvement in operational efficiency.

One important lesson learned was the importance of ensuring sustained leadership and securing earmarked domestic public funding for the program’s sustainability. In this regard, PSI advocated with Uttar Pradesh representatives to create a Private Sector Purchasing (PSP) Cell within the government. The PSP Cell enabled government personnel to take a leadership role in the Hausala Sajheedari platform and secured government budget to sustain project activities. The Hausala Sajheedari model facilitated a significant increase in public funding being channeled to private provision. Over the course of the project alone, the government of Uttar Pradesh purchased the equivalent of 15 million USD in sterilization and IUD services from the private sector.

The intent of the Hausala Sajheedari platform was focused on resolving supply-side challenges. PSI did not initially plan for demand creation activities but quickly realized women were not aware of the new opportunities for affordable family planning services in the private sector. At the same time, private providers were reluctant to invest in demand creation for family planning services, which are not that profitable. The realization that supply-side interventions alone may not suffice led to an adaptive approach. PSI, in collaboration with the government, pioneered a demand creation strategy by incentivizing accredited social health activists (ASHAs) to promote private sector family planning services.

The successful integration of private sector providers into public financing arrangements for the provision of family planning services has created opportunities for further expansion into other health areas. The initiative now aims to also engage private sector pharmacies and include maternal and child health services and other family planning products, thereby extending the reach and impact of Hausala Sajheedari.

A further example of how public funding can be used to purchase services from the private sector comes from a strategic purchasing pilot in Myanmar, implemented by PSI. This pilot demonstrated how governments can purchase services from private providers to incentivize the delivery of quality services and better align the behaviors of providers with the broader health system goals, while simultaneously reducing households’ impoverishing spending on health. In this pilot, PSI was “simulating” the role of a purchaser, which would then be taken over at some point by a national purchaser, as it was outlined in the National Health Plan (see Box 5).
STRENGTHENING PRIVATE SECTOR ENGAGEMENT IN PUBLIC PURCHASING FOR INCREASED ACCESS TO FAMILY PLANNING IN THE PHILIPPINES

Leveraging the enactment of the Universal Health Care Act of 2019 in the Philippines, which provided an opportunity for private family planning providers to join healthcare provider networks (HCPNs), the USAID-funded MPHD project collaborated with an intermediary, the Integrated Midwives Association of the Philippines (IMAP), to facilitate private sector engagement in healthcare provider networks. This initiative created pathways for the participation of private providers in the Philippine Health Insurance Corporation (PhilHealth) and other forms of public financing.

Focused on the provinces of Antique and Guimaras, identified by the Government as UHC integration sites, the project, using a human-centered design approach, closely supported IMAP in co-designing solutions, strengthening capacities, and localizing solutions that foster engagement between the public and the private sectors. This included establishing a community of practice for private sector engagement and implementing other strategic initiatives.

The MPHD project’s successful demonstration of the impact of strengthening an intermediary in facilitating private sector engagement for inclusion of private providers in health financing mechanisms strongly indicated the approach’s potential for scalability and broader implementation.

BOX 4

Despite private sector engagement being part of the National Health Plan, decision-makers were unsure of how to operationalize it. The pilot project served as a demonstrative example of the “how.”

- Implementation research played a significant role in fostering dialogue among diverse stakeholders, including those from the private sector. Different stakeholders were invited to help shape and, where necessary, redirect the project, transforming it into a joint learning experience, leading to the establishment of the Project Scale-Up Management Team. Stakeholders included representatives from the Ministry of Health and Sports, Yangon Regional Health Authorities, the General Practitioner (GP) society, as part of the Myanmar Medical Association, participating GPs, donors, and representatives from the Health Financing Group, which helped with the implementation of the research. During each meeting, the Project Scale-up Management Team reviewed the findings from the completed cycle of learning, discussed their implications, and defined priority questions for the next learning cycle.

Beyond its initial focus on implementation research, the Scale-Up Management Team played a crucial role:

- **Increasing understanding of health financing:** Stakeholders gradually broadened their perspectives, which facilitated more informed discussions, contributing not only to the pilot project but also to the country’s overall health financing strategy.

- **Enhancing trust:** Regular meetings provided a forum for open discussions and dialogue between different stakeholders who otherwise rarely interact (e.g., Ministry of Health and the General Practitioners Society). These conversations highlighted diverse perspectives on policy and implementation challenges, fostering mutual understanding, building trust, and cultivating relationships crucial for a successful pilot implementation and beyond.

- **Building a shared vision:** The Scale-Up Management Team’s regular meetings stimulated reflection on the country’s mixed health system. These discussions contributed to shaping a shared vision regarding the roles of government and non-state actors in progressing toward UHC. The collaborative approach promoted alignment and understanding among stakeholders, reinforcing their commitment to a common goal.

Further reading: **strategic purchasing pilot briefs series.**
ENSURING CARDHOLDERS RECEIVE HIGH-QUALITY HEALTHCARE

Numerous initiatives have been implemented across different countries to improve the quality of care. Thailand, for example, which is known for its rapid expansion of health insurance coverage, has undertaken various initiatives to enhance quality of care. These include the introduction of fee schedules for high-cost interventions to prevent under-provision of services due to the capitation payment mechanism; the establishment of a 24-hour call center to process complaints and problems from both providers and insured individuals; and the implementation of an improved healthcare accreditation system, in which providers receive incentives based on the level of accreditation they achieve (29). Evidence regarding the impact of these initiatives on the quality of care, however, remains limited.

In Cambodia, the implementation of the Health Equity Fund, designed to provide financial coverage for essential health services, was extended to all public sector health facilities in 2015. Despite this effort, the perceived quality of care at public facilities continues to be lower than that at private facilities, and less than 20% of the population seeks care from public sector health facilities as a result (30). The Health Equity and Quality Improvement Project phase II, supported by the World Bank, seeks to address quality issues in the country’s public sector health facilities. Its objectives include improving health service utilization, particularly among the poor and vulnerable, through enhanced efforts to improve service quality, expand service capacity and coverage, shift the service delivery model towards providing more comprehensive services, and strengthen community-based essential service provision, among other components.

Digital signposting solutions, which were the focus of our previous Health System Strengthening (HSS) insights series brief, could be an avenue to improve access to high-quality services and increase trust in the health system. By integrating additional layers of information, such as providers’ accreditation status and specific characteristics that reflect quality of care, these tools can help consumers make better-informed decisions. Greater information access and transparency influence people’s health-seeking journeys and could potentially also serve as a motivating factor for healthcare providers to improve the quality of their services.

Strategic purchasing can also serve as a lever to enhance the quality of care. However, in many health insurance schemes in LMICs, the full potential of strategic purchasing to incentivize quality improvements is yet to be harnessed. The impact of strategic purchasing on quality of care and other outcomes is influenced by different factors, including the design and implementation of purchasing functions, the economic and political environment, and the institutional capacity and maturity of a country’s health system and infrastructure (31).

DEMAND-SIDE CHALLENGES

On the demand side, a number of factors may deter people from joining a health insurance scheme even if eligible and interested to do so. These factors may include, for example, complex or time-consuming enrolment procedures or inconvenient payment modalities (e.g., not aligned with the household’s cash flow); perceived poor quality of care; lack of trust in the health insurance scheme; and inconvenient location of providers contracted within the health insurance scheme (32). Other factors may deter cardholders from seeking care when needed. People who are enrolled may not be fully aware of or understand their entitlements (22), or where to go for care, or they may feel disempowered to demand quality care (33).

To overcome demand-side barriers that hinder the uptake of health insurance, governments and other organizations in LMICs have implemented diverse initiatives. There is a growing emphasis on making health insurance programs more responsive to the needs of the population and on designing and evaluating health insurance schemes from a user’s perspective. Some of the initiatives, documented in a series in BMJ Global Health, aim at increasing awareness about health insurance entitlements and benefits, support users in navigating their healthcare journey, and engage citizens in the design of benefit
packages and insurance oversight (33). For example, the Self-Employed Women’s Association (SEWA) in India is an organization of women workers in the informal economy that implemented successful community engagement initiatives (doorstep services, center-based support, and health system navigation) that improved women’s utilization of health insurance. Expanding this model, as the authors state, would require strategic investments in partnerships with community-based organizations and strong local leadership and commitment (34).

There is also strong evidence of the positive impact of integrating social and behavior change (SBC) into HSS, including health insurance schemes, as highlighted by the USAID Practice Spotlights Social and Behavior Change series. The series explores how behaviorally informed shifts were employed to address enrollment concerns, simplifying the process through point-of-care registration by nurses in the Philippines. Additionally, it examines how a combination of behavioral science, community engagement, and SBC strategies is hypothesized to have driven increased enrollment and utilization of the SHI scheme in Karnataka state, India. These strategies included community outreach through health camps, facilitating easy enrollment, cashless treatment, and more (35, p.5). A review of initiatives aimed at increasing the uptake of health insurance also highlighted the need for exploring tools from behavioral economics proven effective in addressing diverse aspects of health behavior (36).

The The African Health Markets for Equity (AHME) Program implemented in Kenya from 2013 to 2020 provides an example of a coordinated package of clinic-level interventions, including social health insurance, social franchising, the SafeCare quality-of-care certification program, and business support, aimed at addressing not only the demand side, but also the supply side and policy environment, with the overall goal of improving access to high-quality primary health care for the poor, delivered by private clinics (see Box 6).

### BOX 6

**ADDRESSING DEMAND SIDE CHALLENGES: LESSONS FROM THE AFRICAN HEALTH MARKETS FOR EQUITY PROGRAM**

The AHME program was implemented in Kenya from 2013 to 2020, through a coordinated package of four clinic-level interventions. The program was designed and implemented through a consortium of four implementing partners: PSI, Marie Stopes International (MSI), PharmAccess Foundation, and the International Finance Corporation (IFC), and funded by the Bill and Melinda Gates Foundation and the UK’s Department for International Development, now replaced by the Foreign, Commonwealth & Development Office (FCDO). A cluster randomized controlled trial was carried out in Kenya from 2012 to 2020 at 199 private health clinics to assess the impact of AHME on demand- and supply-side outcomes, as well as whether AHME achieved its goal to expand access to affordable healthcare for the poor (37). “At endline, clinics that received AHME support were 14.5 percentage points more likely to be empaneled with the National Health Insurance Fund (NHIF). These clinics also served 51% more NHIF clients and attracted more clients from the middle three quintiles of the wealth distribution compared to the control clinics. When comparing individuals living in households near AHME treatment and control clinics (N = 8241), AHME resulted in a 6.7 percentage point increase in the likelihood of having any health insurance on average. However, the study found no additional benefit of AHME for individuals from poor households, who remained less likely to have health insurance than wealthier individuals in both the treatment and control groups.”

The increase in patient load and the finding that individuals in the AHME treatment group were more likely to have any health insurance at endline compared to control clinics are promising. According to the authors, there are various pathways by which expanded clinic NHIF empanelment could potentially boost demand-side insurance enrollment. Future studies are recommended to explore these pathways, including investigating whether clinics’ promotion of NHIF acceptance—such as through signage—contributed to increased insurance uptake in the AHME treatment group. Additionally, following clinics’ NHIF empanelment, clients may have had stronger motivations to enroll in NHIF and to seek care at NHIF-accepting clinics (37).
Implementation flaws occur both on the supply and demand sides, and it is important to address both sides concurrently. For instance, demand-side interventions alone are insufficient to drive increased member enrollment in insurance programs (36). Increasing enrollment when the supply side is not ready may be counterproductive, as it might negatively impact the user’s journey, thereby eroding trust in both the health system and the insurance program.

CONCLUSION

While many LMICs have opted for a pathway toward UHC that involves some form of health insurance, the feasibility and effectiveness of such approach, and the value of different health financing models, remain subjects of debate. Despite efforts to expand health insurance coverage in many LMICs, low uptake remains a persistent issue. In many LMICs, health insurance schemes fail to reach the poor and the most vulnerable, and evidence regarding their impact on key UHC indicators is mixed. In practice, health insurance arrangements in many LMICs often suffer from a combination of flawed design and weak implementation.

Even when health insurance coverage increases, barriers often prevent individuals from enrolling or utilizing the services available under these schemes. These barriers may include a lack of awareness about benefits and entitlements, affordability issues, complex enrollment processes, mistrust in the effectiveness of insurance systems, or limited access to accredited providers, discouraging people from enrolling in or using health insurance. At the same time, providers, especially private providers, might experience several barriers to joining or remaining engaged in health insurance schemes, including cumbersome accreditation processes, delays in reimbursements, limited support to meet quality standards, and more.

Efforts to address these issues are already underway in many countries. In many cases, these efforts are being supported by different organizations as part of time-bound donor-funded projects and they often lack coordination and, as a result, fall short of addressing all the main challenges simultaneously.

Addressing these challenges requires a more holistic and coordinated approach, involving the design and implementation of mutually reinforcing interventions that simultaneously address the main pain points related to the demand side and the supply side, while strengthening underlying functions. This can ultimately be beneficial irrespective of the chosen health financing pathway. This entails, for example, aligning demand-side interventions, such as raising awareness, community engagement, and facilitating enrollment with supply-side initiatives, such as expanding the network of healthcare providers, integrating private sector providers, and improving service readiness and quality. Moreover, it is important to consider the political economy surrounding health financing reforms. Each country has its unique set of stakeholders, power dynamics, and incentives that shape the reform landscape. Understanding these dynamics is crucial for navigating challenges and advancing reforms successfully.

Implementing a more holistic and coordinated approach will necessitate close collaboration among all key stakeholders, including relevant government bodies (such as the Ministry of Health and health insurance agencies), donors, partners, private sector representatives, and civil society organizations. It will also require the involvement of a range of implementing agencies and representatives from diverse sectors that bring the right mix of skills and solutions to the table. Establishing a dedicated coordination mechanism and piloting this approach in select countries could be a starting point, providing important insights for shaping more sustainable, equitable and effective health insurance programs.

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