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This study seeks to address the role of microinsurance within social protection systems.

Microinsurance typically refers to insurance services and policies that are designed specifically for low-income clients who have no or very little access to mainstream insurance services. Microinsurance policies provide protection to low-income households against specific risks in exchange for a regular payment of premiums that are calculated proportional to the likelihood and cost of the relevant risk1. While the basic features of a microinsurance policy are not fundamentally different from other types of insurance policies, the design and operations of a microinsurance policy and scheme are adapted to the specific needs of the target group.

Social protection aims at “preventing, reducing and eliminating economic and social vulnerabilities to poverty and deprivation.” These vulnerabilities are caused by a lack of protection against the financial and in-kind consequences of income loss due to sickness, disability, maternity, etc. Social protection systems include public, community-based, and private/for-profit programmes, which are usually funded by contributory or non-contributory arrangements.

Overall, this study concludes that very few countries have formally discussed or even defined the role of microinsurance within a social protection system. Microinsurance and, in particular, community-based insurance, are mainly seen as a mechanism to extend coverage of the existing social protection system and are, thus, often tightly regulated in order to ensure compatibility and compliance with the current schemes. Usually, governments aim for a social protection system that achieves universal coverage by a single, public scheme, e.g. government-run social health insurance. Microinsurance is thus seen as a “transitory” instrument towards such a unitary scheme. Rwanda, Cambodia and Brazil are used in this report as case studies, exemplifying where microinsurance has been considered as an element of a social protection framework.

Further research is needed on the cost-benefit ratio of extending coverage through microinsurance mechanisms, the quality improvement of services provided to the beneficiaries with microinsurance, and partnering with commercial microinsurance schemes on extending coverage and quality of public social protection schemes.

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Illness, unemployment, old age, and similar events can lead to an unforeseen loss of income or financial expenditure. This affects every member of society in developing countries, but is particularly difficult to manage for the poor. Social protection systems usually cushion the impact of such events. However, the systems in most developing countries are insufficiently developed and inaccessible to the majority of their populations.

Microinsurance is a relatively new concept and instrument in social protection. Conceptually, it combines social protection and microfinance: Microinsurance is a financial service offered by different types of providers while also having an element of a social protection approach for protecting people against risks. Thus it is an element of a social protection system that comprises public social protection programmes, like social insurance, community-based insurance (often in health insurance), and private/commercial insurers. These systems aim at providing coverage against risks to the entire population, but especially to the poor.

Currently, the role that microinsurance plays within a social protection system, in particular with regards to improving and ensuring risk coverage of low-income groups and others, has not been documented and analysed comprehensively. This study, commissioned by the Social Protection Working Group of the Microinsurance Network, seeks to address this issue. The objective of this study is to identify the potential and current roles of microinsurance within a broader social protection framework in a country and to identify, describe and analyse the linkages between microinsurance and social protection.

The study is comprised of two main parts: In the first part we introduce and discuss a typology of roles of microinsurance within social protection. This typology serves as the conceptual background for the analysis of countries in the following chapter. In the analysis chapter the role of microinsurance in the social protection systems of Rwanda, Cambodia, and Brazil is described and we draw conclusions with regards to their role and their efficacy in improving the social protection system. The study concludes with and recommendations for further analytical work.

**BOX 1: THE SOCIAL PROTECTION WORKING GROUP OF THE MICROINSURANCE NETWORK**

The Microinsurance Network is a member-based network of donor organisations, multilateral agencies, insurance and social protection providers, policymakers, and academics. It promotes the development and delivery of effective insurance services for low-income people by encouraging shared learning, facilitating knowledge generation and dissemination, and providing a multi-stakeholder platform.

The Social Protection Working Group aims to increase the knowledge about the different roles of microinsurance within social protection frameworks, and its potential and possible contribution to an enhanced access to social protection. Firstly, this requires obtaining an overview of the possible conceptual approaches towards microinsurance within social protection frameworks. Secondly, it requires compiling the evidence of integration of microinsurance and social protection at the country level.
A. THE CONCEPT OF SOCIAL PROTECTION

Social protection aims at "preventing, reducing and eliminating economic and social vulnerabilities to poverty and deprivation."2 Vulnerability is caused by lack of protection against adverse events reducing income (e.g. unemployment), increasing expenditure (e.g. unforeseen need for healthcare services), or both. Furthermore, vulnerability can have indirect effects such as discouraging investment in income-generating activities or in education.

The Universal Declaration on Human Rights recognises the right to income security in case of illness, disability, and old age, as well as access to healthcare3. The declaration also includes other social rights, such as food security, basic housing, and essential items, such as clothing.

Social protection programmes provide cash or in-kind benefits that protect against the consequences of income loss due to sickness, disability, maternity, etc. The programmes also support and enable physical and affordable access to health care and provide mechanisms to avoid or reduce social exclusion4.

The International Labour Organization estimates that only 20% of the working age population and their families worldwide have access to comprehensive social protection and that only 60% have access to basic social protection that provides a minimum level of income protection and access to social services5.

Social protection is increasingly acknowledged as an important factor in the social and economic development of low-income countries and communities, because it breaks the “vicious cycle of poverty and vulnerability.”6 In this cycle, the lack of adequate protection against risks leads to risk-averse behaviour, especially among low-income groups. Without protection, many poor people decide against investing in income-generating business or human capital development, like education. Thus, the establishment of reliable mechanisms for the poor (and non-poor) to manage and cope with risks encourages investments and human development and gives the poor a means to escape poverty. Additionally, social protection supports and maintains macroeconomic development and performance by providing benefits during shocks that affect entire countries or communities, as is the case with climate events, macroeconomic crises and the like7. Social protection supports social development by organising the redistribution of economic gains within societies and making social services such as health and education accessible and affordable to everyone. This support also improves the social contract between a state and its people by demonstrating that governments act on behalf and for the benefit of the entire society. Furthermore, social protection is an important instrument for improving social cohesion, because it fosters solidarity and redistributes wealth among different socioeconomic groups.

Public, community-based, and private programmes are all integral parts of comprehensive social protection. Often, and particularly for population groups that can afford contributions to their risk protection private providers of protection, such as for-profit insurance companies or not-for-profit community-based insurance organisations, play an important role. On the other hand, public programmes are important for promoting, extending and implementing social protection for the entire society, especially for poor and marginalised groups. Furthermore, it is also the responsibility of the government to supervise as well as to support private commercial or not-for-profit provision of social protection8. Supervision includes monitoring and correcting market failures or insurance business practices that may lead to the exclusion of clients with certain socioeconomic characteristics, as well as taking action to protect clients against harmful business practices.

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5 International Labour Organization. World Social Security Report 2010/2011. 2010. The concepts of “comprehensive” and “basic” social protection are discussed in detail in this report. They are based on internationally recognised standards, such as the Social Security (Minimum Standards) Convention (No. 102) of the International Labour Organization and the United National Social Protection Floor concept.
6 Deblon, Yvonne; Loewe, Markus. The potential of microinsurance for social protection. 2012. p. 43.
Contributory Instruments

Generally in the form of private (incl. microinsurance) or social insurance policies, providing protection against potential hardship as a result of illness, old age, unemployment, etc. The beneficiaries and, in the case of social insurance, their employers contribute financially to risk protection. Social insurance and, to a limited extent, private insurance redistribute risk and income.

Non-contributory Instruments

Example of social assistance transfers, which provide protection against current hardship, in particular for people who are already poor and vulnerable. Social assistance is usually funded from government budgets or donors and provides cash or in-kind benefits. Examples include conditional or unconditional cash transfers, school feeding programmes, and others.

Other

Other public programmes and instruments that aim at correcting social imbalances and exclusion resulting from poverty. Often the poor or otherwise marginalised groups for example the disabled, children, migrants, etc. are excluded from social services and income-generating activities. This can either be a result of deliberate adverse selection by private risk management mechanisms such as the exclusion of disabled from private insurance or unintended market failures such as insufficient information of insurers or service providers about risk profiles. Governments can take corrective action through regulatory adjustments or establishing rights-based entitlements, e.g. free healthcare services or free schooling.

B. THE CONCEPT OF MICROINSURANCE

The term “microinsurance” typically refers to insurance services that are adapted to clients with low income and no access to mainstream insurance services. Microinsurance is a means of protecting low-income households against specific risks in exchange for a regular payment of premiums that are calculated proportional to the likelihood and cost of the relevant risk. In essence, the objectives of microinsurance are not different from the objectives of typical insurance, but the target group may be different. As a result, the design and operations of a microinsurance policy and scheme are adapted to the specific needs of the target group.

Microinsurance typically targets low-income groups, but not necessarily the extremely poor. One industry approach for segmenting

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9 This list is based on European Communities. Social Protection for Inclusive Development. A New Perspective in EU Cooperation with Africa. 2010. p. 33.
12 This paragraph is based on: Swiss Re. Microinsurance – risk protection for 4 billion people. 2010. p. 9.
and identifying the microinsurance target group is to include people above the international poverty line of US$ 1.25/day (2005 international dollars, at purchasing power parity) and up to US$ 4.0/day. Microinsurance is considered as “commercially viable” for this group, whereas the lower-income group must rely on governments operating “large-scale social [protection] measures on its own or subsidise microinsurance premiums.” The global market size is thus estimated at 2.6 billion people for the commercially viable microinsurance segment and 1.4 billion people for the segment of microinsurance with aid/government support.

The rising interest of insurance companies to operate in the microinsurance segment is, among other factors, based on the proliferation of microfinance programmes and products. This has shown that commercial financial services providers can work successfully among the poor if they employ innovative product design and client relationship management. As part of this trend, the number of microinsurance providers has risen significantly in recent years and worldwide microinsurance coverage has quintupled from 78 million covered in 2006 to approximately 500 million in 2011. Nevertheless, insurance markets in developing countries remain small, as shown by insurance penetration rates of 3.62% in Africa and 6.12% in Asia (compared to 7.43% in Europe and 7.94% in America).

Community-based insurance (CBI) in developing countries is a specific form of microinsurance that is “managed and operated by a community-based organisation, other than government or a private for-profit company, that provides risk-pooling to cover the costs associated with a risk event. Membership in many CBI schemes is voluntary.” CBI is often established in response to a lack of formal social protection mechanisms provided by the state or the private sector and is often based on the principles of self-help and mutuality. CBI has several distinct advantages, especially in the early stages of microinsurance market development: low transaction costs, good knowledge, and high levels of trust of the target group and clients in the organisation. There is significant prevalence of CBI in many developing countries with early microinsurance markets.

This is especially true for community-based health insurance, as health microinsurance is a very difficult product. Nevertheless, evidence suggests that the success and reliability of CBI is questionable, in particular in the long term, because schemes can easily be exposed to economic stress, especially if many members claim benefits at the same time or if the members-based management lacks the required competencies. Community-based insurance (CBI) in developing countries is a specific form of microinsurance that is “managed and operated by a community-based organisation, other than government or a private for-profit company, that provides risk-pooling to cover the costs associated with a risk event. Membership in many CBI schemes is voluntary.” CBI is often established in response to a lack of formal social protection mechanisms provided by the state or the private sector and is often based on the principles of self-help and mutuality. CBI has several distinct advantages, especially in the early stages of microinsurance market development: low transaction costs, good knowledge, and high levels of trust of the target group and clients in the organisation. There is significant prevalence of CBI in many developing countries with early microinsurance markets.

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C. POSSIBLE ROLES OF MICROINSURANCE IN SOCIAL PROTECTION

Microinsurance belongs to the contribution-based social protection mechanisms, alongside social insurance and other insurance mechanisms. A conceptual analysis of potential linkages between social protection and microinsurance has concluded five possible arrangements between microinsurance and social protection. These arrangements are presented in the following paragraphs.

• Substitute: Microinsurance can be a substitute for social insurance in contexts where the state does not have the capacity or the political will to extend social insurance to those not covered. Existing social insurance programmes are often only targeted at the formally employed because they rely on shared contributions between employers and providers. Many such programmes have a formal mandate to cover the “self-employed” or informal workers, but make it virtually impossible for these groups to become members, by for example setting high contribution rates or requiring detailed employment or income documentation.

15 Swiss Re. Microinsurance – risk protection for 4 billion people. 2010.
20 Deblon, Yvonne; Loewe, Markus. The potential of microinsurance for social protection. 2012.
• **Alternative:** This leads to the second potential role, namely microinsurance as an alternative to social insurance in situations where microinsurance is more attractive than other social protection programmes because of its adjustment to the specific needs and abilities of the low-income group.

• **Linkage:** Thirdly, social insurance may be attractive to informal sector workers, but the inability to reach out to certain geographic areas or socioeconomic strata makes effective communication and trust difficult. In such a situation, cooperation between private microinsurance schemes often community-based insurance established as an informal risk management mechanism and a social insurance programme may be possible and mutually beneficial. In such a linkage model, the microinsurance scheme takes over key operational tasks such as enrolment, contribution collection, benefit payments, claims management and the social insurance programme underwrites risk, thus growing and broadening its risk pool and also fulfilling its social mandate to extend coverage.

• **Complement:** Microinsurance can provide a complement to social insurance in settings where social insurance only covers part of the costs incurred due to risk events\(^\text{21}\). Complementarity is achieved because microinsurance and social insurance mutually reinforce their protection. One example is microinsurance covering drug costs associated with services provided by social health insurance.

• **Supplementary:** Microinsurance has a supplementary role if it adds to the benefits provided under social insurance, e.g. by increasing benefits or covering health conditions that are excluded by social health insurance. However, such microinsurance policies are independent from social insurance and provide benefits even in absence of coverage by social insurance. Microinsurance can thus be regarded as a "second pillar of insurance" for the same risk, such as illness or old age.

FIGURE 1: Possible roles of microinsurance as social protection instrument\(^\text{22}\)


\(^\text{22}\) Adapted from: Deblon, Yvonne; Loewe, Markus. The potential of microinsurance for social protection. 2012.
Microinsurance and social insurance can be coordinated at two levels:

At the **policy level**, coordination means that relevant social protection policies assign certain roles to microinsurance schemes, like covering specific socioeconomic groups or people in specific locations. In a further step, policy can impose rules for scope and operations of microinsurance, such as making membership in microinsurance schemes compulsory for specific groups or by regulating key microinsurance policy terms (e.g., premium levels, benefit package, etc.) Policy can also support the development of microinsurance through market development activities. These activities could include the establishment of identification systems, market information systems, and others.

At the **operational level**, microinsurance and social protection schemes or institutions can coordinate by providing (either free or against a charge) services, information, and resources (such as offices or staff) to each other. This coordination aims at improving the performance of at least one scheme, but often they are mutually beneficially, for example when increased outreach of social insurance through use of a microinsurance scheme’s offices provides additional revenue to a small microinsurance scheme.
The following chapters present three exemplary country cases of linkages between microinsurance and social protection. We selected the cases after performing research aimed at identifying countries that formally define and operationalise microinsurance as an integral part of their social protection framework. We chose Rwanda, Cambodia, and Brazil as the country cases based on the analysis and conceptual outline described previously.

**FIGURE 2: Overview of country case studies**

<table>
<thead>
<tr>
<th>Country</th>
<th>Key issues</th>
<th>Role of microinsurance in the social protection framework</th>
</tr>
</thead>
</table>
| Rwanda  | • CBHI schemes are fully managed by the community  
• Government regards CBHI as temporary, transitory health insurance provider while moving forward to universal nationwide social health insurance coverage | Substitutive |
| Cambodia| • CBHI is an element of a pluralistic approach towards universal social health protection coverage  
• CBHI schemes are supported and managed by local and international NGOs | Substitutive |
| Brazil  | • Detailed policy and strategy development process on microinsurance’s role in social protection | Alternative & supplement (depending on socioeconomic group) |

### A. RWANDA

Poverty is a major challenge in Rwanda, where 37% of the population were classified as poor in 2006 and where poverty actually increased in the last decade, mainly as a result of steep population growth.\(^{23}\)

The Economic Development and Poverty Reduction Strategy (EDPRS) 2007-2012 of Rwanda prioritises social protection and the government has taken major steps towards increasing coverage and expenditure of social protection programmes.

A particular success is the almost universal coverage of social health protection, even among the poor, rural, and vulnerable population. Coverage of health insurance was 97% in 2010, with 91% of the population being enrolled in the “Mutuelles des Santé”. The near-universal coverage has led to positive health system outcomes as a result of increased utilisation of health services and reduction of catastrophic out-of-pocket expenditure.

Shortly after independence Rwanda abandoned its free healthcare system and no other prepayment or health protection scheme was established. Later, this was partially corrected by the establishment of mandatory health insurance for civil servants and military personnel. Community-based health insurance (CBHI) was introduced as a pilot project in the late 1990s by the Ministry of Health and developed successfully in the following years. In 2004, the government formally adopted a CBHI development strategy and extended

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CBHI to all districts of Rwanda in 2005. Since 2008, every Rwandan is legally required to have health insurance.

i. Community-based health insurance

The Mutuelles de Santé are autonomous organisations, administered and governed freely by their members. The members determine the organisational structure, by-laws, management organs, as well as the benefit packages, contributions and similar aspects. The members are also responsible for information and sensitisation of prospective as well as current members, for validating membership and collecting membership contributions, and for coordination with providers. Therefore, the Mutuelles can be classified as a specific form of community-based health insurance (CBHI).

Health insurance coverage in Rwanda comprises different schemes. Each scheme focuses on a different target group, thus achieving complementarity in coverage:

- **La Rwandaise d’Assurance Maladie (RAMA)** protects against risks from illness, accidents and maternity. Benefits include services at all levels of the health system as well as pharmacy services. The scheme was established in 2001 and covers all civil servants and their families, who contribute 15% of base salary, equally shared by the employer and the employee. In addition, there is a co-payment of 15% at every healthcare level.

- **Military Medical Insurance (MMI)** covers military personnel and their families. The contribution rate is 22.5% of base salary and entitles to services at all healthcare levels.

- **Community-based health insurance (CBHI)** targets the “general population, including those in rural areas and working in the informal sector.” It is estimated that the informal sector comprises 95% of the population.

- **Employer-based health insurance** is mainly operated by private insurance companies, although employers could theoretically associate with RAMA. The insurance regulation authority regulates private health insurance.

Despite CBHI schemes being managed by their members, the government has introduced some standardisation for the structure and organisation of CBHI as well as for features of insurance policies (e.g., premium level). The organisational structure follows the structure of general government and public administration in the country: at the lowest level, each “sector” has a management committee for the mutual insurance scheme, above that are management committees at the village, district, and national level. There is a notable presence of state civil servants in the management committees, especially at higher levels. In addition, the government sets guidelines, in particular regarding contributions and benefit packages, and also provides subsidies for extending benefits to particularly vulnerable groups.

Government matches contributions to CBHI in order to provide for services at higher levels of care. At the same time, CBHI funding at the primary pool level is almost exclusively from relatively poor individuals. This is a challenge for constant and universal membership, but also for the financial sustainability of the mutuals since many individuals do not renew their membership or refrain from becoming members in the first place.

The regressive nature of the flat-fee contribution from households is one of the major obstacles for CBHI to further increase coverage. The current membership is on a per-household basis and the contribution is RwF 1000 per household member, plus a 10% co-payment at hospitals or US$ 0.4 per visit to a healthcare centre. Co-payments are still mandatory and sometimes make it difficult for the poor to access and afford services, especially for the relatively costly district and

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25 Although a framework regulation (specifying a minimum benefit package) for this was established in 2007.
referral hospitals. So far, the government has not enforced the legal requirement for health insurance membership because many of the very poor are not able to afford the CBHI contributions. Therefore, the government has decided to establish a sliding scale fee payment structure.

### Integration of CBHI into the social protection framework

The EDPRS identifies “sector targets” for 2012 in order to provide health insurance for all Rwandans and prioritise CBHI as a method for achieving this objective. The strategy stipulates that only 15% of the population, mainly those in the formal economy and civil service, should obtain health insurance through other schemes. This strategy aims at a comprehensive social health protection framework that better realises the objectives of “universal access as well as equity, solidarity and risk-sharing.”

The government is committed to a three-pillar approach to social health protection, including social health insurance, community-based health insurance, and private health insurance. Under this approach, different types of health insurance schemes target different groups but coordinate to achieve the overall objective of sustainable social health protection.

**FIGURE 3: Three-pillar structure of health insurance in Rwanda**

<table>
<thead>
<tr>
<th>Civil Service / Military</th>
<th>Formal Sector</th>
<th>General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Health Insurance</td>
<td>Private Health Insurance</td>
<td>Community-Based Health Insurance</td>
</tr>
</tbody>
</table>

The government acknowledges that private health insurance’s cost structure makes it affordable only to the richest segments of the population. In the short term, the government recognises private insurance as an option “for complementary coverage in addition to basic coverage provided under the CBHI regime and the social health insurance regime.” This is currently necessary as universal coverage can only be achieved through a system that links private insurance and social insurance with government-supported CBHI.

In the long term, however, the government is committed to integrate all health insurance schemes (except for private insurance schemes) under one umbrella organisation, the Rwanda Social Security Board (RSSB).

In order to further develop the health insurance system towards this objective of a unified system under the RSSB, the government established the Rwanda Health Insurance Council in 2010. The council’s responsibilities include the regulation and the oversight of schemes as well as ensuring the schemes’ sustainability, while also preserving the strengths of the current system, notably the “state-community partnership nature and decentralized arrangement and ownership of the CBHI schemes by the population.” The council is mandated to prescribe and enforce

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a minimum benefit package (specifying price, services availability and quality) that all health insurance schemes must provide, thus establishing a common basis on which private and mutual health insurance compete.

Until recently, many small, local risk pools existed, with little risk equalisation or even reinsurance beyond the government’s subsidies for contributions and grants or cost sharing for certain administrative expenses. The risk pools at district level are larger but still exposed to financial instability. As a result, poorer sections and districts are at high risk of bankruptcy. In 2008, the government enacted a legal framework for formal cross-subsidisation between existing health insurance schemes. Furthermore, the national health insurance policy states that private insurance and social health insurance will be required to make contributions to the national and district pooling mechanisms of CBHI, based on actuarial analysis of the funding requirements of all levels of the CBHI system.

For this reason, the government established a National Solidarity Fund that has four major roles:

• Guarantee a minimum benefit package for all CBHI schemes
• Pay for CBHI coverage of the poorest segments of society
• Provide assistance to CBHI and district CBHI that have defaulted
• Provide technical assistance services

Subsidies for the contributions of the poorest will come from a third party, such as the government, an NGO or the development partners. A precedent is the subsidisation of the contributions for over two million poor and indigents from the Global Fund to fight AIDS, Tuberculosis and Malaria in 2010. This was an innovative approach to injecting additional resources into the health system while also strengthening prepayment and risk protection. In the future, the Government aims at fully subsidising the premiums for the bottom two poverty categories identified through the community-led targeting mechanism used for other social protection programmes (e.g. cash transfers). The latest targeting exercise [2007] identified 28.6% of the population as belonging into these categories.

The financial stability of the CBHI pools is supported by two arrangements that resemble reinsurance: At the first level, the district-level pools accumulate the contributions from the schemes in the district and the financial support from the local government. At the second level, the National Solidarity Fund provides reinsurance with a focus on sharing the cost burden of tertiary care. Funding for the national pool is from national revenues (mainly from the health budget), grants from international donors, and contributions from district pools as well as cross-subsidies from RAMA, MMI, and private insurers.

iii. Conclusions

A distinct feature of the general CBHI model is that the community controls the design and management of the scheme and is the ultimate risk carrier. CBHI in Rwanda does not fulfil these features because the government has imposed legal requirements and definitions of the institutional setup as well as the policy design and has forced schemes to share risk between them. Furthermore, CBHI premiums are subsidised for the vast majority of the schemes’ members, in particular those from the informal and rural sector. Hence, it can be concluded that CBHI in Rwanda is a hybrid model that combines subsidised, mandatory “public” health insurance with a community-based institutional setup and management. Therefore, CBHI represents an institutional or management approach for extending coverage of the Rwandan social protection system and not a distinct additional approach that competes with or complements other approaches within the system.

The policy framework for social health protection in Rwanda confirms this view: The objective is universal access to healthcare as well as equity, solidarity, and risk sharing. CBHI is mainly intended by the government as a mechanism to extend health insurance to the poor over the medium term. It is not regarded as a long-term solution to health insurance coverage because the government

41 Ministry of Health (Rwanda). Rwanda National Health Insurance Policy. 2010. p. 16.
is committed to bringing all health insurance schemes under one umbrella organisation. This is despite the government’s stated aim to establish CBHI as the main provider of health insurance, at least for the foreseeable future.

Despite the policy objectives and commitments, and despite covering almost all population under the health insurance scheme, current social health protection in Rwanda faces significant equity challenges: Patients are still required to pay for services at the point of care (co-payments) and contribution to CBHI is a flat fee, thus posing a higher burden on poor and low-income groups. Furthermore, CBHI still relies on third party subsidies for funding healthcare for the poor, thus showing that CBHI cannot fully serve its role of financing mechanism for the poor.

In essence, the system in Rwanda demonstrates the limits of microinsurance, and especially of community-based health insurance, as this arrangement is clearly not able to cover all costs related to the risk.

It is also important to note that the only form of micro health insurance in Rwanda is CBHI, because commercial insurance companies currently do not offer micro health insurance products to the informal sector. Some CBHI schemes are facing financial difficulties and require government subsidies for their long-term survival. This is further evidence of the limited financial sustainability of micro health insurance in Rwanda and confirms the reluctance of commercial insurers to enter the market.

Currently, CBHI has a substitutive role in relation to social health insurance, because, for the time being, the government has decided against investing in extending the social health insurance (RAMA, MMI) to the informal sector by way of subsidisation of contributions to SHI or similar interventions. Instead, it is supporting and regulating CBHI and regards CBHI as the main health insurance scheme for the “general population.”

In the future, however, CBHI will become a supplementary insurance that will provide additional benefits outside the SHI system. This will happen when CBHI is integrated with SHI into the RSSB umbrella organisation. The transformation of the social health protection framework from a mostly CBHI-based arrangement into a social health insurance will require careful strategic planning.

**B. CAMBODIA**

Cambodia has significantly improved its standard of living over the past decade. Nevertheless, 30% of the population remains poor, mostly in rural areas.

Health sector spending amounts to 10% of GDP, which is higher than in most comparable countries in the region. Private spending, however, comprises 78% of all health spending and most of this is out-of-pocket spending. A typical healthcare episode costs US $30 for services, drugs, and associated cost. A significant number of people can only fund such costs by taking out loans or selling assets.

The “Health Strategic Plan 2008-2015” of Cambodia’s Ministry of Health formulates the following objective: “By 2015 the different elements and institutions of the current health financing system will be combined under a single strategy guided by national health priorities; social health insurance mechanisms will be in place; the poor will be protected by suitable social transfer mechanisms; ...”

The guiding concept is a sustainable system. The system is based on contributory and non-contributory schemes. It requires that those who can afford it pay for social/health protection and provides support from the state to those who cannot afford such contributions. In this system, complementarities exist between the different schemes, notably with regards to using contributions for subsidising the development and extension of the non-contributory system to the poor and to the informal sector, thus relieving the non-contributory schemes of financial burden and allowing them to focus on the poorest.

The Health Strategic Plan follows up on the “Social Health Insurance Master Plan,” which

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was published in 2003 and charts the way towards universal health insurance coverage. It recommends a pluralistic approach that incorporates and further strengthens the various health insurance schemes operating in the country:

- Compulsory social health insurance for formal sector workers in salaried employment and their families; i.e. for civil service employees as well as private sector employees
- Voluntary health insurance through community-based health insurance for those informal sector workers and their families who live above the poverty line and thus can afford relatively small contributions. The schemes are run and supported by local and international NGOs and development partners.
- Social assistance to the poorest through Health Equity Funds (HEF) that refund healthcare providers for user fee exemptions given to the poor.
- Tax-funded public healthcare (often with user fees payable at the point of service), private commercial insurance, and private healthcare providers for those who can afford full payment of premiums and fees

**FIGURE 4: Coverage for different population segments**

### i. Community-based health insurance

Community-based health insurance in Cambodia was first established at one health centre in 1999 and expanded to 13 schemes by 2010. A total of 170,000 individuals are members of CBHI schemes, paying premiums of between US $1 and US $3. The premiums are usually subsidised by NGOs that have agreed to support CBHI.

“Guidelines for the Implementation of Community-based Health Insurance” were passed in 2006 as part of the implementation of the SHI Master Plan. The aim of the guidelines is to establish a network of CBHI along common principles, allowing for the eventual merger of the schemes into a single risk-pool and scheme. Key provisions of the guidelines are:

- Training of CBHI management is coordinated by the Ministry of Health.
- Premiums must be affordable to the majority of the population and must not require co-payments at the point of service.

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• The benefit package must comprise outpatient and inpatient care.

• Beneficiaries must not be excluded from membership in CBHI because of pre-existing or chronic diseases.

• CBHI must adopt a nationwide standard for a waiting period after which new members are eligible for entitlements.

• Minimum standards for contracting of local health care providers and provider payment are established.

CBHI in Cambodia, like in other countries, is managed by local community organisations, usually with financial and managerial support from local or international NGOs. The management ensures that the scheme and its operations are relevant to the local conditions and needs. The CBHI schemes are voluntary, private, and not-for-profit. Nevertheless, the CBHI guidelines provide for some standardisation across the range of CBHI schemes. This standardisation shifts CBHI from a pure community-control model towards a government-supervised and -guided model. This is a logical reflection of the government’s commitment to integrating the CBHI schemes into a unified health insurance mechanism.

ii. Performance of CBHI in the social health protection system

The relatively small number of CBHI members contrasts with the share of population classified as “urban and rural near poor”, which is the target group of CBHI. This points to the big challenge of extending CBHI to the 50% of the population that live in the informal sector and can barely afford the contribution to CBHI. While the SHI master plan was optimistic that CBHI could be extended to the informal sector, the reality in the years after showed that establishing and operating Health Equity Funds was much easier and scaled up very rapidly. This has made the Health Equity Funds the most widespread and most effective form of social health protection in Cambodia, providing essentially free [i.e. tax-funded] healthcare to the poor in more than half of the country’s districts. Furthermore, most of the CBHI schemes are not self-sustainable and rely on donor support. It is estimated that the contributions of 135,000 of the total of 170,000 members of CBHI schemes are paid for by the NGOs supporting the CBHI schemes. The donors have indicated that alternative financing solutions must be found rather sooner than later.

Cambodia shows the limitations of using CBHI as a substitute for social insurance, in particular when the government is committed to building universal coverage of social health insurance. The major obstacles encountered concern the large number of poor people and the affordability of insurance premiums.

iii. Conclusion

The government’s multi-pillar approach for extending social health protection coverage is based on the intention to eventually merge all pillars into a single social health insurance scheme. In this approach, the Health Equity Funds have a transitory role and the government’s plan is [or was] to phase out the HEF within a few years after the passing of the SHI Master Plan in 2003. The intention is to then replace the HEF with membership in CBHI and SHI for most of the population. However, the current indicators point in the opposite direction: HEF coverage rates have soared in recent years, while CBHI membership has remained steady.

A key reason for the “success” of the HEFs is that they are much easier to scale up because they are, essentially, a tax-funded social assistance programme that is straightforward to execute. The original, and currently unrealised, intention of the government was to restrict coverage of the HEFs to the near-poor and to phase out the funds within a few years, as CBHI and SHI develop and assume coverage of the majority of the population.

The relative failure of CBHI also points to difficulties in convincing the near-poor of the relevance of health insurance and in motivating them to pay for CBHI. Additionally, CBHI is still not a self-sustainable approach to microinsurance and requires significant financial as well as operational support from local and international donors.

A possible strategy for moving from the HEFs to a more insurance-based health protection model could be to abolish the HEFs and use the funding for (further) subsidy of CBHI membership of the poor (and possibly also the near-poor). This would also enlarge the risk pool of the CBHI schemes, thus making them more financially viable.

C. BRAZIL

Social protection policy in Brazil during most of the 20th century focused on contributory approaches for the formal sector and on enabling non-profit and charity organisations to provide assistance to the poor53. A new constitution was enacted in 1988 and included a social protection system based on three pillars: social insurance, social assistance, and free health services.

Microinsurance has seen tremendous growth in Brazil in recent years and it is estimated that 23-33 million Brazilians are microinsurance clients. However, this number may be inflated as it includes such diverse policies as, for example, appliance “warranties,” motor insurance, and life insurance, etc. Over the next 20 years, microinsurance is projected to grow to 100 million clients54.

The case of Brazil differs from the cases of Rwanda and Cambodia in so far as Brazil has gone through a consultation process that defined the scope and role of microinsurance within social protection, but without setting limitations or standards to microinsurance provision and products.

i. The Consultative Commission and the Working Group on Microinsurance

The CNSP (National Private Insurance Council) is the regulator of the private insurance industry and, as such, responsible for minimum standards of insurance contracts, supervision of insurance companies, and general standards and guidelines for insurance in Brazil. The CNSP is chaired by the Ministry of Finance and SUSEP, but also counts the Ministries of Social Security and of Justice, as well as the Central Bank and the Securities Commission among its board members. In order to fulfil its responsibilities, notably with respect to supervision, CNSP established the Superintendence of Private Insurance [SUSEP] as its executive body.

In 2008 the CNSP established a Consultative Commission on Microinsurance with two objectives: to promote research into microinsurance, and to advise CNSP on technical and operational aspects of microinsurance.

SUSEP established a Microinsurance Working Group in 2008 in order to provide technical, legal and operational inputs to the CNSP Consultative Commission and also to act as the Secretariat for the Commission. The Working Group embarked on a research process in order to ascertain the optimal regulation of microinsurance in Brazil.

The Commission included other government bodies in order to broaden awareness of authorities and to ensure microinsurance regulation and development strategy is aligned with the priorities and interests of other sectors. This included: the Ministry of Finance, which has the overall responsibility for financial sector regulation and also chairs the CNSP; the Ministry of Social Security, because microinsurance may become a complementary instrument for social security in the future; the Ministry of Social Development which implements social assistance programmes and is interested in linking social assistance to financial inclusion; and the Central Bank of Brazil (BACEN). Outside the government and public administration sphere, the following organisations are members of the Working Group: the National School of Insurance; CNSeg, which represents the insurance industry; and FENACOR, the trade union for the insurance and investment brokers industry.

ii. Findings of the Working Group

The main impetus for establishing a government-wide process for developing microinsurance regulation and defining future support to the sector was the potential size of the market, as well as the growing market activity. A secondary impetus is the government’s commitment to financial inclusion. SUSEP emphasises its contribution to financial inclusion through insurance56.

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The Ministry of Social Development, which is responsible for the social assistance schemes, is committed to extending its activities towards linking social assistance with the financial system. The Ministry plans to pay participants of the Bolsa Familia social cash transfer scheme through a simplified bank-based transfer system, thus promoting financial inclusion and social inclusion. Furthermore, integrating recipients into the financial system would allow for additional, advanced services and benefits that go beyond social assistance. The key to this strategy is to extend the bank-based transfer to a basic bank account and then using this basic bank account as a platform for other financial services, such as microcredit and insurance.

Health insurance is regulated by a separate regulatory regime. The other three regimes concern general (non-life) insurance, life insurance, and private pension funds. SUSEP’s mandate does not extend to health insurance, which is regulated by the ANS (National Agency for Supplementary Health). This is a result of health insurance not falling under the Insurance Act, which governs all other forms of insurance, but falling under the responsibility of the Ministry of Health.

Unlike other insurance, health insurance may also be offered by cooperatives. These cooperative are owned and managed by its members and are a specific form of community-based health insurance schemes. They play a significant role in the Brazilian health insurance market. Furthermore, owners and operators of hospitals or healthcare providers may also operate their own insurance schemes. However, due to the restrictions of the Insurance Act, this is not allowed for insurers. The Insurance Act does not allow insurers to operate any other business except insurance, i.e. they are not allowed to operate their own healthcare facilities.

Overall, health insurance policy is slightly restrictive concerning the potential scope of health microinsurance. The government’s regulation imposes strict rules for “supplementary health plans” in order to achieve equity in access to care, thus making health insurance expensive compared to other microinsurance policies. This puts health microinsurance out of reach of the low-income segment. Nevertheless, demand for healthcare cover is strong, as shown by the fact that health benefits (e.g. hospital cash benefits, drugs cost) added to non-health policies aimed at the low-income market have proved to be very popular.

The Commission decided upon the following definition of microinsurance: Microinsurance is “insurance protection, provided by entities authorised to operate in the country, which aims primarily to preserve the socio-economic, personal or family situation of low-income population, protecting them against specific risks, in exchange for the payment of premiums that are proportional to the probability and costs of such risks, in accordance with the law and internationally accepted insurance principles.”

The main findings, as per the CNSP Consultative Commission’s final report, are:

- Microinsurance is an important risk mitigation instrument for the low-income market. It does not only square with insurance market development and financial inclusion, but also with the social protection agenda. This is important because the Brazilian government is strongly committed to extending social protection, has achieved impressive and high profile results with its Bolsa Familia scheme and sees risk protection and social inclusion as a central piece of its development policy. Thus, microinsurance contributes to achieving social inclusion/protection through several approaches:
  - Reduction of fiscal contribution and responsibility
  - Effective and efficient outreach to informal groups
  - Cooperation in outreach and risk coverage according to comparative advantages

- The defining characteristic of microinsurance, and its main differentiating aspect to “popular insurance,” is its targeting of the low-income market.

• Separate regulation is needed for microinsurance because of its special characteristics. Microinsurance providers need to be authorised and supervised, but further research and subsequent decision is needed with respect to whether specialised microinsurance providers should be established or traditional, existing insurers may be used. Initially, regulation should recognise and authorise microinsurance products that fall under three categories: credit life insurance, group life insurance and personal accident cover, and funeral insurance.

• Further research is needed in aspects that may help to reduce the costs of microinsurance and in respect of ensuring the regulation’s compliance with international standards.

Thus, it can be said that microinsurance in Brazil is an alternative as well as a supplement to social insurance: For those currently not covered by social insurance, it is an alternative that is often chosen because the existing social insurance programmes are unattractive or inaccessible. For those already members of social insurance, it provides a supplement that tops up benefits.

The potential microinsurance market is estimated at two thirds of the population or approximately 128m individuals. Already, 23-33m people have some form of microinsurance, but it is worth noting that microinsurance does not cover all the risks of these clients. The same applies to the social insurance beneficiaries, who receive social security benefits only for some of their risks. This points to a strong role for microinsurance in Brazil, while also showing the need for continued and expanded extension of social security coverage.

The importance of social security becomes obvious when considering that major lifecycle and income risks, such as health, disability, and death of a family member, may not be covered by microinsurance currently. Microinsurance providers, so far, have shied away from such policies because of the inherent complexities of such products and the regulatory uncertainty. However, a strong role of the state is obviously required to provide such protection to broad sections of the society, especially the poor.

Therefore, in June 2010, SUSEP decided to establish a “Microinsurance Project,” which will take forward the recommendations of the Commission. The project takes “internal actions”, such as drafting microinsurance rules, which set out the main parameters for microinsurance products and providers. The “external actions” will focus on the partnerships with the stakeholders identified by the MI commission.

iii. Conclusions

Brazil is one of the few countries that has chosen a structured process for defining the role of microinsurance within the social protection system [as well as in financial inclusion]. The relevant authorities, including the ministries responsible for finance and social protection, the regulatory bodies, academic institutions, etc., implemented this process jointly.

Brazil recognises microinsurance as an important element of its social protection system but states clearly that the active support of microinsurance is dependent on it having advantages over other forms of social protection. This is in line with experiences from other countries, like Rwanda and Cambodia, where microinsurance is seen as only a transitory instrument towards comprehensive social insurance coverage.

Furthermore, the motivation for the process that helped to define the role of microinsurance appears to have come from the tremendous growth of the microinsurance market, the commercial interest of the insurance industry in the low-income client base and the recognition of the government that it will have to regulate the market as well as define its policies towards microinsurance in order to facilitate market development. Notably, it appears that the process was not established because of a perceived insufficiency of the social protection framework and a search for additional instruments of social protection.

Microinsurance is an integral part of a social protection system. This approach is valid for community-based, not-for-profit insurance as well as commercial microinsurance. Governments that actively investigate the potential of microinsurance conclude that its development and growth are important for achieving universal coverage of integrated, pluralistic social protection systems that provide relevant risk management instruments to all members of society.

Nevertheless, the research conducted for this study concluded that only very few countries have actively and tangibly defined the role of microinsurance within their social protection systems, i.e. with respect to their role in extending coverage, achieving quality of benefits, and improving overall efficiency and effectiveness of the system.

Governments that regard microinsurance as an important aspect of social protection usually regulate microinsurance so that it fits with the overall social protection objectives and system in the country. This method may be counterintuitive, especially for community-based insurance, which is usually fiercely “independent” from public policy and the government. However, it is an important strategy to ensure that microinsurance is aligned with other social protection instruments in the system, as well as overarching aspects such as financial stability and consumer protection.

Rwanda and Cambodia are countries that have assigned a specific role, mainly with regard to extending population coverage, to community-based health insurance. The key motivation for this is the governments’ commitment to achieving universal healthcare coverage.

The governments have identified micro health insurance as an instrument for moving towards this goal; however, microinsurance as an alternative or substitute to social insurance is not a long-term proposition. Rather, government sees these roles as transitory on the path towards a unified, public social health protection scheme. Currently, microinsurance is “tolerated” because of resource constraints and the inability of the current social protection institutions to reach broad segments of the population.

In Rwanda, the majority of health care coverage is funded through CBHI, but schemes are significantly regulated and subsidised by the government. Therefore, CBHI in Rwanda is a hybrid model, in which government defines the institutional and policy design and ensures financial viability but uses typical CBHI features such as community-based management for the operations.

In Cambodia, the Health Equity Funds and CBHI had, originally, two well-defined target groups, namely the poor for the HEF and the near-poor for CBHI. The latter must convince its potential clients of the value of health insurance membership and then also ensure regular contribution payment. The absence of mandatory enrolment of the CBHI target group and also financial subsidy makes this difficult. Furthermore, it is likely that HEFs are capturing potential CBHI clients as well, due to the dynamic nature of poverty, which means that a clear-cut differentiation between “the poor” and “the near poor” may not be possible.

The case of Brazil shows how broad participation of government entities and other relevant institutions can support development of a sound and broadly accepted concept of microinsurance. It is a useful example for a process of clarifying the role of microinsurance in the social protection system (and, in fact, also the financial system and overall development strategy). The conclusion of the process in Brazil is that microinsurance is one of several instruments in social protection and that it must demonstrate its relevance and superiority in order to be considered as a specific target group or risk. This points to some scepticism with regards to the general relevance of microinsurance within a social protection system.

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64 A significant portion of the subsidy is funded by external donors.
Overall, it must be concluded that is not yet possible to precisely define the role of microinsurance in these countries. Current reality contrasts with the stated objectives of the Government, as in Rwanda and Cambodia, but the exact path towards these objectives and the eventual role of microinsurance is not yet defined.

To clearly define the role of microinsurance in social protection, further research should be conducted through more country case studies, which could focus on:

- The **efficiency perspective**: microinsurance has proven to be able to extend social protection coverage to as-yet uncovered population groups; however, a comparative analysis of the cost-benefit ratio of extending microinsurance in comparison with other social protection instruments would allow conclusions with regards to whether it is also the most efficient instruments for extending coverage to specific groups.

- The **quality perspective**: so far, the discussion on microinsurance in social protection (including this study) focuses on the extension of population coverage. However, quality of benefits (especially if benefits are services, such as in social health protection) is a very important dimension of social protection. Further research could analyse whether and to what extent microinsurance achieves and ensures quality services, in particular in comparison with other social protection instruments and for specific contingencies.

- The **commercial perspective**: Brazil appears to have recognised that microinsurance is as much a commercial opportunity as it is an operations model for public social protection programmes. It is an opportunity for public-private partnership, like contracting commercial insurers to execute insurance programmes in the public interest. Examples of such partnerships exist in India’s RSBY social health insurance programme, but have not been analysed comprehensively with regards to quality, efficiency, or coverage.
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<tr>
<th>Acronym</th>
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<tr>
<td>CBHI</td>
<td>Community-Based Health Insurance</td>
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<td>EDPRS</td>
<td>Economic Development and Poverty Reduction Strategy</td>
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<td>CBI</td>
<td>Community Based Insurance</td>
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<td>RAMA</td>
<td>La Rwandaise d'Assurance Maladie</td>
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<td>MMI</td>
<td>Military Medical Insurance</td>
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<td>HEF</td>
<td>Health Equity Funds</td>
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<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<td>SUSEP</td>
<td>Superintendência de Seguros Privados</td>
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<td>CNSP</td>
<td>Conselho Nacional de Seguros Privados</td>
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<td>BACEN</td>
<td>Banco Central do Brasil</td>
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<td>CNSeg</td>
<td>Confederação Nacional de Seguros Gerais</td>
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<tr>
<td>ENACOR</td>
<td>Brazilian trade union for insurance and investment broker industry</td>
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<td>ANS</td>
<td>National Agency for Supplementary Health</td>
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REFERENCES


The Microinsurance Network is a member-based network of organisations and individuals active in microinsurance. The mission of the Network is to promote the development and proliferation of good-value insurance products for low-income persons by providing a platform for information sharing and stakeholder coordination.

The Social Protection Working Group aims to increase the knowledge about the different roles of microinsurance within social protection frameworks, and its potential and possible contribution to an enhanced access to social protection.

FOR MORE INFORMATION ON:

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www.microinsurancenetwork.org

Any feedback or comments can be sent to info@microinsurancenetwork.org

Thomas Wiechers wrote his master thesis on the financial viability of community-based health insurance in India. When graduating with a Masters Degree in Economics in 2006, he joined GIZ as a junior adviser on microinsurance. In 2007, he moved to GIZ’s health programme in Indonesia, where he worked with the Indonesian government on the introduction of a social health insurance scheme. Afterwards he worked for the International Labour Organization for three years, first as a Health Policy Officer at headquarters in Geneva and then as Social Security Policy Adviser in Zambia, where he was also involved in ILO’s microinsurance market development activities. After leaving the ILO, he wrote this publication based on his experiences and insights gained during his previous assignments. Since June 2012, he is back at GIZ, where he works as Social Protection Adviser. A key focus of his role is on microinsurance.