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Private health insurance: elite luxury or mass market?

By **ELEANOR WHITEHEAD**

With urban middle classes expanding more Africans are willing to pay for health protection, giving the insurance industry a boost - but coverage for the masses remains elusive

Over half of Africa's total annual expenditure on healthcare, estimated at around $55bn, comes from the private sector. Across sub-Saharan Africa, not only are most countries still a long way from achieving the targeted 15 percent government budgetary spend on health, but they were actually spending less on the sector in 2010 than in 2001, according to the 2010 World Health Report.

For most of the population, the necessary private spend means out-of-pocket payments which often exceed patients' means, proving crippling to families and damaging to economies. Health insurance is one avenue through which to reduce those payments. And with urban middle classes expanding, more and more people are now willing and able to pay for protection.

"The real opportunity for private companies is in the growth of populations who are now able to afford private insurance and have decided they've had enough of using state facilities," says Ryan Lobban, healthcare analyst at Frost & Sullivan.

"It has been a recent development that when we talk to pharmaceutical and medical device companies in Africa about what's driving the market, the response we get is that there is a bigger uptake in private insurance amongst consumers," he observes.

One group capitalising on the demographic shift is the Germany-based African Development Corporation (ADC), a financial services group which invests in "highly profitable" African banking and insurance sectors. Last year it acquired a 25 percent stake in medical insurance provider Resolution Health East Africa Ltd. (RHEAL) for around $2.3m.

For Andrew Lee, ceo of ADC Insurance Investments, health insurance potential is defined by two markets: "[The] middle class, and companies that feel obliged to insure their workers." Kenya, where RHEAL is headquartered, ticked both boxes. "It is a country with an established private health insurance market and a growing middle class which can afford it."

The investment should support RHEAL's intentions to expand into other parts of East Africa, while ADC will looks elsewhere for similar opportunities. "There is less than 1 percent market penetration in Nigeria," Mr Lee notes. "And Ghana looks good because it's becoming less and less socialist and the market is reasonably regulated." Mozambique, because of its economic growth, and Zimbabwe, based on its strong skill set and history of private insurance, are also of interest, he says.

But the market for private insurance remains narrow, with most schemes targeting high income populations. Even in South Africa, the continent's biggest economy, the private insurance market – "which is very mature, very lucrative and very inelastic in terms of the effects of economic downturn " - only covers around 8m people, points out Frost & Sullivan's Mr Lobban. In Kenya, RHEAL has more than 70,000 customers – making it one of the country's largest health insurers. However, around 70 percent of these there are corporate, Mr Lee estimates. In Tanzania, that figure stretches to 80 percent.

Mass insurance or minority cover?

The problem, says Richard Leftley, president and CEO of MicroEnsure, is that private insurance "for the masses" remains elusive. "In Africa there are a number of domestic national health insurance programmes, there's a range of private insurance which is mostly top-end, Bupa or Allianz-type projects for expatriates, and there's very little in between: Just some cooperatives and mutuals in West Africa, and then only a very few groups trying to work out health insurance for everyone else."

MicroEnsure rolled out its first health insurance products in India, and sees "massive demand" in Africa. The group faced challenges in the market – not least the absence of local insurance companies willing to underwrite products, and a dearth of third party administrators; organisations that can adjudicate claims between healthcare providers and insurance firms. In both cases, it responded by establishing its own in-house capabilities.

After experimenting with various distribution strategies, the group partnered with Dutch NGO PharmAccess which was already paired up with

the 300,000-strong Kilimanjaro Native Coffee Union, and was trying to establish an outpatient service financing scheme.

“We were involved in designing that service and enrolling people in it… but recently we’ve seen that if you enrol a few thousand people in one year on that sort of product, that is a major effort,” Mr Leftley says. MicroEnsure has now started experimenting with a ‘hospital cash’ product, in which members are paid a fixed sum for every night they are hospitalised. The offering is less comprehensive in that it doesn’t meet members’ exact medical needs, but its simplicity makes it quickly scalable – especially when selling it through local cell phone providers. “For the first time millions of people are going to have access to some kind of health insurance,” he envisions.

PharmAccess has been working elsewhere on the continent to try to insure those working in the informal sector. In 2007, it partnered with the Dutch Health Insurance Fund (HIF), whose Investment Fund for Health in Africa (IFHA) invested in Nigerian health maintenance organisation Hygeia, to create The Hygeia Community Health Plan in Nigeria. The solution now offers coverage to just under 200,000 people.

While micro-insurance remains largely in the donors domain, it may emerge as a viable commercial market. IFHA began life as an HIF initiative, given a six-year grant of €100m in 2006, but apart from counting the Dutch development bank FMO and IFC among its investors, private companies such as Goldman Sachs and Pfizer have also put their money in the equity. MicroEnsure, set up under a Bill and Melinda Gates Foundation grant, started looking to raise equity in 2011 and has been, “overwhelmed by interest from insurance, reinsurance, mobile phone companies and private equity firms”, Mr Leftley says.

Public partners

There may also be a role for such insurance groups in supplying back-office functionality to governments trying to roll out national health insurance schemes. “The NHI schemes have really struggled in Africa because, I think, there is no strong back office provision – no one networking hospital,” Mr Leftley says. “In Ghana, for instance, hospitals submit their paperwork to the NHIS who have no computer systems, so those files sit in an office and when they have not been paid, clients resubmit the claim and there is a mountain of paperwork and no one can say how much money is owed between the government and these hospitals.

“We are trying to work out what back office functionality is needed to deliver these products.”

For those without access to private coverage, public schemes have been the main safety net in a number of countries. South Africa started piloting its much awaited national health insurance scheme in April. Countries like Rwanda and Ghana have had successes in rolling out theirs, which both reach over 80 percent of their populations. But others have found it harder. Nigeria, which has been grappling with health insurance in various forms for decades, has so far achieved coverage of only five percent; a point of concern to the government.

“When the scheme started a decade ago it just insured federal government employees, with the premiums paid by the government, and it was a voluntary scheme otherwise,” explains the country’s health minister Muhammad Ali Pate. “Because of that we didn’t get the traction that we needed.” The government has recently rolled out a voluntary scheme, as well as a community based health insurance scheme, but these are both “very nascent”, he admits.

“The most important thing Nigeria can do is decide whether we want a voluntary contribution scheme or a mandatory one, and I think that given the size of out-of -pocket spending, a mandatory contribution scheme would most quickly enable us to reach universal access.”

In the meantime, the government wants to see a more dynamic private insurance market, he says: “At the moment, a certain segment can afford insurance for its care and the rest are paying out of pocket, so better insurance mechanisms makes sense.”

Additional reporting by Chiponda Chimbelu

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