

The Potential of Micro Health Insurance in Malawi

Dr. Spy Munthali, University of Malawi
Dietmar Ilsen, University of Cologne



Pro MHI Africa “Pro MHI Africa” is kindly funded by the ACP-EU Cooperation Programme in Higher Education (EDULINK). A programme of the ACP Group of States with the financial assistance of the European Union. This document has been produced with the financial assistance of the European Union. The contents of this document are the sole responsibility of the project and can under no circumstances be regarded as reflecting the position of the European Union.

Outline

- The Malawi Health System
- Conclusions from Literature Review
- Results of Household Survey
- Conclusion

Health Systems and Caveats in Service Delivery

- Malawi has a Free Public Health Care System
- System is held together by the SWAp and EHP
- WHO Commission on Macroeconomics recommends US\$34 per capita
- EHP estimated at per capita expenditure of US\$28
- Actual Per Capita Health Expenditure is US\$15
- Financial and Human Resource Gaps have been highlighted
- Health Sector Reliance on External Resources unsustainable (60%)
- Incomplete Decentralization of Decision Making
- Obvious Indications of Government Failure

Selected Health Indicators

- Malawi is Ranked 166 out of 177 countries on HDI (UNDP)
- Child Mortality is 110 per 1000 children under five years
- 7 children out of 10 die of preventable diseases
- Health Care Expenditure estimated at 9.8% of GDP
- HIV/AIDS prevalence estimated to stabilize at 12%
- More than 1.4 m OVCs, 12.4% of children 0-17 years
- Life expectancy on gradual increase from 39 to about 50

Implications on the demand side

- Government Failure entails Financial Risks on the part of the population
- Failure means services are delivered inefficiently (poor quality)
- Inadequate quantities delivered mean more OOP expenses for clients (Substitution)
- Forgone treatment means more exclusion from access to care
- Treatment acquired from more distant facilities (transaction costs)

What Contribution could MHI make?

- The MHI could help in resource mobilization for Care
- MHI would enhance community participation in Health Care Decisions
- Improved availability of own choice health care (quality and type)
- Reduction in OOP Expenses & disposal of Assets (risk pooling)
- Reduction of transaction costs
- More inclusion and empowerment

Conclusions from Literature Review

- Impacts of MHI in Sub-Saharan Africa:
 - + Good Evidence:
 - + Reducing out-of-pocket expenditure
 - + Increase in utilization of health care services
 - + Overcoming financial barriers -> Inclusion
 - + Offering Social Protection against financial risk of illness
 - Grey Evidence:
 - Reaching “the poorest of the poor”?
 - Quality improvements through community participation
 - Overall magnitude of resource mobilization

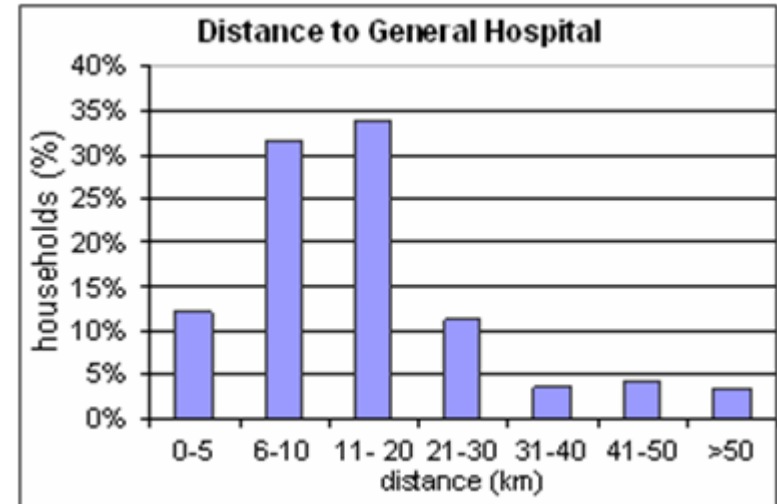
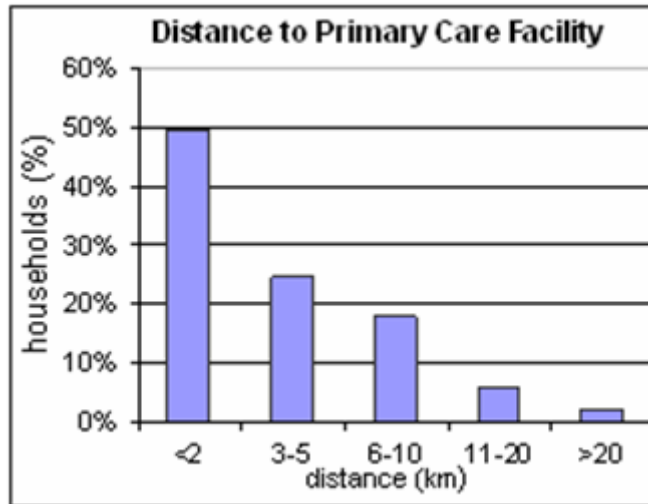
Conclusions from Literature Review

- Two pre-conditions for the feasibility of Micro Health Insurance:
 - Availability of quality health care services
 - Existence of health care facilities
 - In reachable distance
 - Perception of health care quality as sufficient
 - Financial barriers to health care treatments
 - Direct costs (user fees, expenditure for medicine)
 - Indirect costs (i.e. transportation for patient and accompanying caretaker, food at hospital, etc.)
 - Opportunity costs (travel and waiting time, lost income, interest on loans)

The Pro MHI Malawi Household Survey

- In Malawi 829 interviews were successfully conducted in March 2009
- Three districts: Blantyre, Lilongwe and Thyolo
- The focus of research was set on the possibilities of supply of micro health insurance products by Microfinance institutions
- Therefore half of the interviewees (409) were member of our local partner organizations:
 - Malawi Union of Savings and Credit Cooperatives (MUSCCO)
 - Foundation for International Cooperative Assistance (FINCA).
- The common household questionnaire included a.o.:
 - a section on availability of health care providers
 - a module on utilization and spending on health including illness episodes in the preceding three months
 - a section on willingness to pay for micro-insurance and services to be included

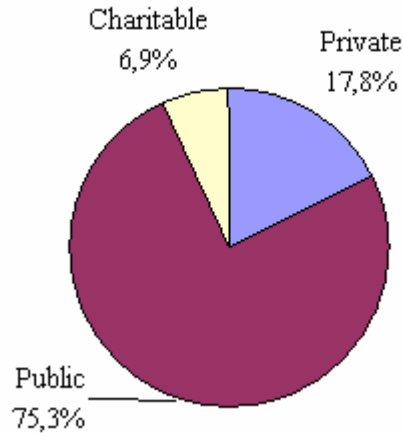
Availability and Access to Health Care Services



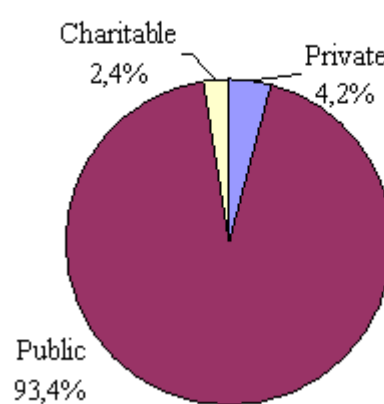
- Average distance PC: 4.6 km; HP: 16.8 km
- => Facilities within reachable distance for most households
- Average travel time: Urban: 35 min ; Rural: 80 min
- Median waiting time: Public: > 2 hrs; private: 30 min
- => Immense transaction costs in terms of travel and waiting time

Utilization of Health Care Facilities

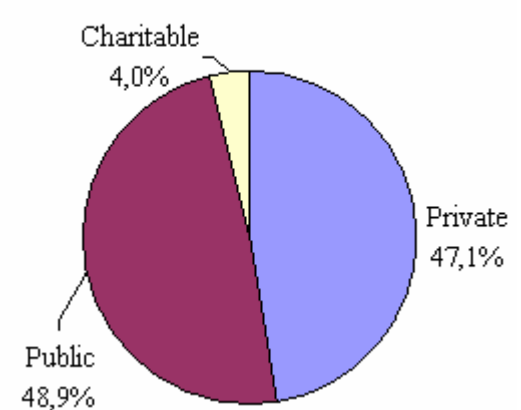
Type of Primary Care Facility normally used



Type of General Hospital normally used



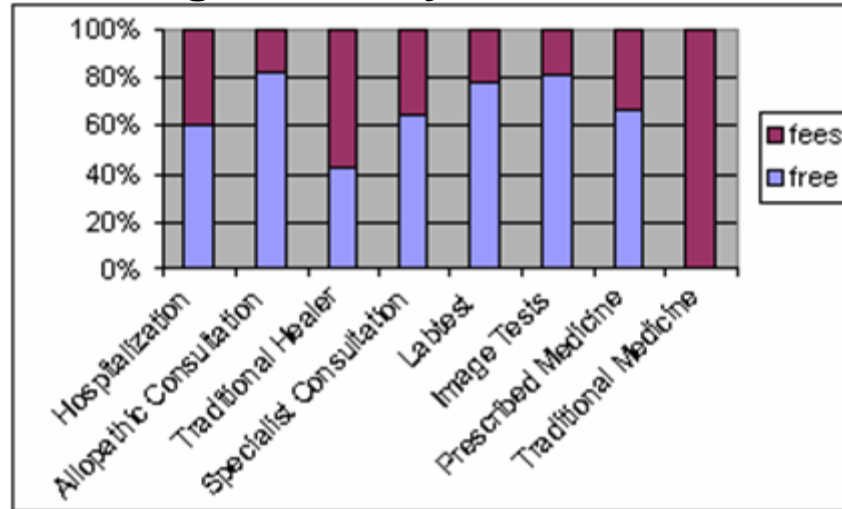
Type of Pharmacy normally used



- Public Facilities are most frequently used, esp. hospitals
- 1/6 of the households seek private primary care
- Most frequently used private facilities are Pharmacies (only about 60% of households ever used a pharmacy)

Prevalance of direct treatment costs

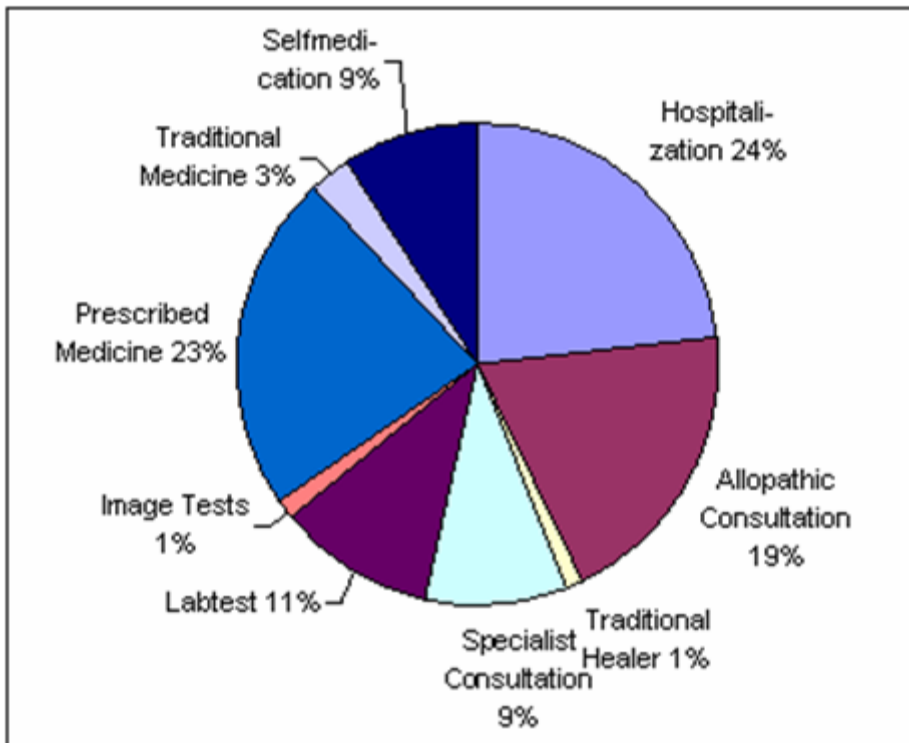
Percentage of costly and free treatments



- Almost 40% of the households with illness report of treatment costs for hospitalizations, consultation and medicine
- > 20 % for laboratory and image test (x-ray)
- 219 (42%) households paid at least one treatment, 299 nothing
- ~ 2/3 of all illnesses reported were Malaria infections

Prevalance of direct treatment costs

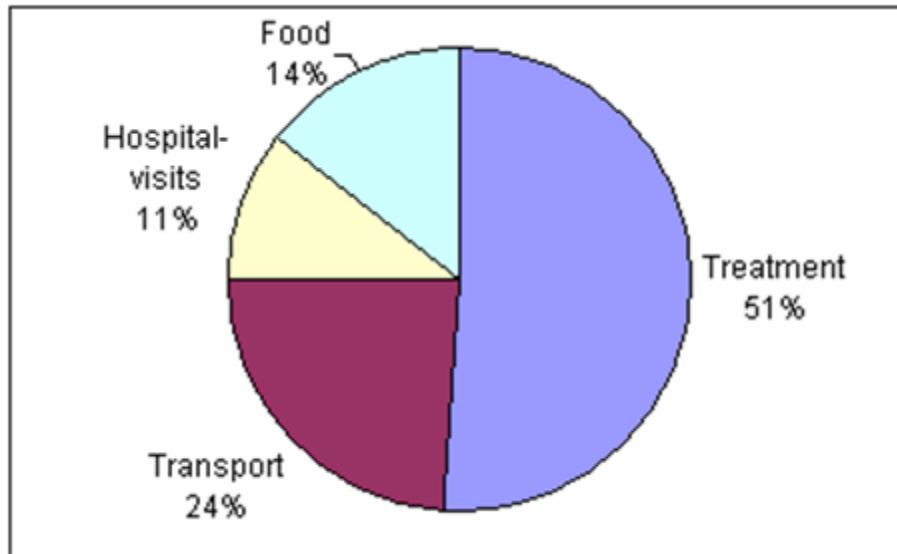
Proportion of treatment expenditures



- Average costs: 2000 MWK (~ 9 Euro) for the 219 hh
- Overall average: 530 MWK per hh for 3 months
- Maximum: 21,500 MKV (~100 Euro)
- Hospitalization: low frequency + high costs
- Medicine & Consultations more frequent

Indirect Costs for Seeking Health Care

Shares of health care related expenditures



- Direct treatment costs make out only 51%
- Ratio transportation to treatment expenditure: ~ 1:2
- Transportation costs were reported by 179 Households (22%)
- Sometimes the only expenditures (58 hh)

The extent of opportunity costs of illnesses

- Average income loss due to hospitalization: 840 MKW (> treatment costs)
 - 273 households used savings to cover their health-related expenditure, (-> reduced investments or lost interest)
 - 12 households sold part of their assets (-> income losses)
 - Spent travel and waiting time for outpatients can lead to income losses
 - Some households even report of lost jobs because of illnesses within the last year before the interview
- => The opportunity costs of illnesses and hospitalizations can outnumber the costs for treatment and form a threat to the households income situation

The households' priorities for health insurance

- A “Service Ranking” showed the diversification of interests:
 - Coverage for hospitalization was most frequently demanded (63%) and ranked most important
 - High interest (57%) and priority in compensation for lost income due to illness
 - Followed by coverage of transportation costs (56%), medicine (58%) and primary care (44%)
- => Households recognize wherefore costs (could) apply
- => Especially (inpatient) hospitalizations are recognized as costly risk (maybe if seeking better quality service)
- => Opportunity costs in form of income losses are recognized as costly side effects of illness

Summary and Conclusion

- The free public health system is not satisfying the demand
- 42% Households with at least one illness period report of direct treatment costs
- Transportation costs are an important factor at least for some households
- Opportunity costs of illness and hospitalization can lead to immense loss of income
- **Health Care Expenditure is a heavy burden for the Households in Malawi**
- **There is a potential for MHIs in Malawi to support Households by reducing their out-of-pocket payments and offering social protection**
- **Households expressed priority for protection against cost of hospitalization**

Zikomo kwambiri
Thank you very much for your attention!

Contact:

spymunthali@gmail.com

d.ilsen@uni-koeln.de

www.microhealthinsurance-africa.org