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Article

# Combining Private and Social Health Insurance in Low- and Middle-Income Countries

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## Abstract

An increasing number of low- and middle-income countries (LMICs) have turned to social health insurance (SHI) to achieve universal health coverage (UHC). Gaps in the provision of UHC, however, has turned attention back to PHI, with health planners wondering what the appropriate role of PHI is. This paper seeks to shed more light on whether voluntary PHI markets can exist in LMICs, and whether it is feasible to use unsubsidized or subsidized PHI to fill the gaps left by tax-funded public health systems or SHI. The paper argues that PHI is best positioned to offer supplementary coverage to those who remain part of SHI, and for those who opt out (for the rest of their lives), PHI should offer the minimum essential package or the minimum plus supplementary coverage. It finds that implementation of SHI legislation may be the catalyst for the emergence and growth of PHI, and health planners who prefer PHI should consider starting their reforms with SHI. PHI can help achieve UHC objectives as long as private insurers do not operate in a vacuum without public regulatory oversight and as long as the dynamics of insurance buying and selling under PHI is not so different from SHI.

**Keywords:** low- and middle-income countries; private health insurance; social health insurance; taxation

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## Introduction

Over the past decade, researchers have sought to shed light on the role of private health insurance (PHI) in achieving universal health coverage (UHC) in low- and middle-income countries (LMICs). Whilst an increasing number of LMICs have turned to social health insurance (SHI), UHC gaps has drawn attention back to PHI.<sup>1,2</sup> Putting aside medical savings accounts (which is self-insurance without the transfer of financial risks to an insurer), PHI could take the form of free-markets where competing PHI charge risk-rated premiums, and controlled (regulated) markets where competing PHI charge community-rated premiums supported by risk adjustments and risk equalization systems. In the latter, community-rated premiums can be modified (adjusted) to reflect age of entry or membership of specific (presumably high risk) groups. Cross-country comparisons<sup>1</sup> suggest that free- or controlled-market PHI in most cases offer supplementary benefit packages though sometimes they provide complementary coverage of deductibles, copayments and coinsurance in benefit packages offered by public health insurance. The general recommendation is that LMICs should rely on progressive methods of funding health insurance through taxes or SHI, and turn over specific population groups to PHI where taxation and SHI struggle to achieve UHC objectives.<sup>1,2</sup>

This paper seeks to shed more light on whether voluntary PHI markets can exist in LMICs, and whether it is feasible to use unsubsidized or subsidized PHI to fill the gaps left by tax-funded public health systems or SHI. The role of the private sector in LMICs is not limited to financial risk protection<sup>3</sup> but here we concentrate on health insurance financing and not healthcare delivery. Arguments in support of PHI in LMICs include (1) a narrow tax base consisting of mainly formal-

sector workers, imperfect tax collection systems and the excess tax burden of collecting more taxes, (2) an unfavorable political climate and a general unwillingness of governments (and/or citizens) to devote more to health insurance and medical care, and (3) corruption and distrust of government or large-scale government-funded programs. The case for PHI is even stronger when one considers failures of tax-funded government-run health systems to provide an insured basic, minimum, essential package (I<sup>E</sup>) of benefits.<sup>4,5,6</sup> It is, however, difficult to clearly characterize the nature of the problem. When government interventions (and reliance on taxes) fail to provide a beneficial good or service in demand, we expect the emergence of private markets to correct the welfare loss of underproviding that good or service, and if private markets fail to emerge or correct the welfare loss, we turn back to governments. It is easy to see how LMICs could get trapped in a cycle of reforms that maintains the status quo or fails to make significant strides towards UHC. The growing interest in SHI is a way of breaking this cycle of events, but why not PHI?

The well-known concern with PHI is its benefit have negative equity implications.<sup>1</sup> For a given level of coverage, PHI premiums, unrelated to incomes, can be afforded by mostly high-income groups, or if lower premiums are to be offered, either coverage levels will have to be reduced considerably or insurers must offer fixed indemnities that might be less than medical expenses incurred. The preferred solution is, however, getting private insurers to charge income-related premiums for at least I<sup>E</sup> coverage. The reason is: PHI in LMICs is most likely to emerge if it provides comprehensive cover for physician, drug and hospital spending. Drug only or physician only coverage in particular will not generate large PHI demands.<sup>5</sup> The alleged regressive effects of income-conditioned coverage therefore depends on how PHI is designed, and how well it fits with existing systems for financial risk protection. This is the focus of this paper. For reasons outlined in the subsequent sections, the paper argues that LMICs are right to put their hopes in SHI – but this path does not need unqualified objections to PHI without considerations of all possible health insurance arrangements. Depending on UHC policy design, PHI can be a friend, not a foe.

## 2. Friend or Foe?

To understand how PHI can help achieve UHC objectives, it is necessary to consider why PHI may fail to emerge, and if PHI does exist, why it might fail to help achieve UHC. Even for supporters of SHI, an adequate understanding of why PHI might fail in LMICs is needed to implement SHI designs that will offer more in benefits than in costs.

PHI comes in three forms: (1) mutual or community-based health insurance (CBHI), (2) nonprofit private health insurers and (3) private-for-profit private health insurers. In LMICs, CBHI schemes haven't been able to make much progress because of poor management (governance), correlated health risks among community members (insurance works best with independent uncorrelated risks or loss probabilities) and generally a lack of direct entrepreneurial incentives to set up CBHI schemes. The problem is compounded by limited demands for health insurance and/or the absence of trustworthy suppliers willing to insure risks.<sup>4,6</sup> A way out is to get government to set up and fund mutual CBHI schemes, as in the case of the Rajiv Aarogyasri Scheme (RAS) in the Indian state of Andhra Pradesh. Even here problems RAS encountered in relying on an intermediary to control moral hazard and supplier-induced demand has called for full outsourcing of CBHI operations to a more capable risk bearer, non-profit or for-profit.<sup>7</sup> So, in LMICs, large scale provision of insurance protection (needed to achieve UHC) rests with SHI and nonprofit or for-profit private insurers. Nonprofit private insurers could, in theory, serve higher aggregate insurance demands since premiums will not include surcharges for marketing expenses or profits, and any excess of premium revenues (over payouts) can be returned to consumers as lower increases in premiums.<sup>4,5,6</sup> But without "profits" it will be difficult to mobilize capital (equity) to support the startup and day-to-day operations of nonprofit insurers, as "profits" are what remains after an insurer has accumulated adequate reserves to remain solvent. For-profit private insurers avoid this problem but the premiums they charge (which will include markups for administrative costs, marketing expenses or broker commissions, and profits) may not lead to the large enrollment rates that characterizes UHC.

Voluntary demands for PHI may not be large enough for UHC but, as long as supply is available, it will not be zero either. For a select group of LMICs, it has been found that risk premiums (a measure

of the value of health insurance), estimated on the basis of variations in out-of-pocket expenditures over a 3- or 6-month period and assumed coefficients of absolute or relative risk aversion, exceed loading (administrative) costs of private for-profit insurers.<sup>5</sup> However, with loading costs taking up 20-30% of premiums, tax-funded subsidies (in the form of paper or electronic vouchers) will be needed to match UHC targets. Without premium subsidies, the best private insurers can do is to offer coverage levels positively related to incomes. Aggregate demands will be higher if persons in low-income groups can purchase lower levels of coverage at lower affordable premiums. Income-related coverage is better than private insurers (because of concerns about solvency) offering fixed indemnities of \$Y or fractional payments of the costs of all services consumed.<sup>5,6</sup> However, income-related coverage doesn't fit well with UHC since without a minimum I<sup>E</sup> coverage, citizens will be exposed to financial risks over their lifetimes. For this reason, low-premium low-coverage insurance should only be seen as starting points for more efficient PHI that in long-run will provide or supplement at least I<sup>E</sup> coverage for all citizens.<sup>2</sup> If I<sup>E</sup> is to be the basic package for everyone, private insurers will have to do more than just adjusting premiums according to age, sex, health status (risk level), location or depth of coverage. For the basic minimum, even risk-rated premiums must be related to household incomes. Doing so then justifies government support for PHI and the provision of tax-funded premium subsidies.

Nevertheless, there are other reasons why health planners are skeptical of or vehemently opposed to PHI. Private health insurers may treat persons with pre-existing disease conditions (from birth) as uninsurable. For those considered insurable, private insurers may be reluctant to offer guaranteed-renewable (GR) coverage for some X years or over a lifetime when household incomes (of a large majority of informal workers) are irregular.<sup>6</sup> Guaranteed renewability is basically a promise by an insurer to minimize, over time, variations in premiums or better yet to keep premiums constant at the same level irrespective of whether a person's health (risk) deteriorates. A risk-averse person will not only want protection against catastrophic medical expenses within each year of life but also protection against variation in premiums year after year. Lifetime GR coverage is preferred but even if GR coverage is offered for X years, it is still better than facing uncertain high jumps in premiums at a time of low income. There are two ways GR coverage can be supplied; either via (1) community-rating premiums, which requires a constant resupply of low risks to keep premiums low or (2) frontloading risk-rated premiums to cover the expected additional costs of becoming a high risk.<sup>8,9,10,11</sup> PHI in Australia and Ireland rely on the first approach (lifetime community rating) bolstered by penalties (premium loadings) for late voluntary enrollment by older low-risks. In Australia, late entry by those  $\geq 30$  years attracts a penalty loading of 2% of the base community-rated premium per year, and in Ireland, late entry by those  $\geq 35$  years attracts a similar penalty rate.<sup>12</sup>

Beyond the efficiency gaps in providing GR coverage lies a problem both PHI and SHI has to confront: the relatively large segment of informal workers in LMICs. Insurance-buying choices of informal-sector workers just do not seem to fit well with expected utility theory.<sup>13</sup> For informal workers, risk aversion, increasing healthcare costs or expansion of benefit packages alone may not generate adequate aggregate demand for insurers to be solvent. There is a need to raise local awareness of the benefits of health insurance – and good local governance (responsible management) of insurance schemes to build trust.<sup>13</sup> The need for these measures doesn't change if one adopts an anthropological view of health insurance.<sup>14</sup> Low risk-aversion and zero demands (framed as “I don't have any money to buy health insurance”) is what we will observe if an informal worker's anticipatory activities exclude uncertain future medical expenses, economic and environmental risks, responsibilities to care for oneself and others, inequalities in healthcare access, or community expectations to be a moral person. We will observe limited insurance demands derived from considerations of the financial value of coverage (= how immediate and frequent insurance payouts are) and not on maximization of expected utility (= the reduction of risk or uncertainty). To avoid situations where informal workers only purchase insurance after first- or second-hand experiences of catastrophic medical expenses<sup>14</sup>, large demands for PHI or SHI should be created in the informal sector through social marketing (educational outreach programs or meetings). This is more so where household heads and members have differential willingness-to-pay for health insurance *and* insurance-buying choices are made collectively. A risk-averse person will remain “uninsured” in

households where the head or other members have little value of insurance because payouts are not immediate or frequent.<sup>13,15</sup> Misperceptions or inaccurate anticipation of future risks are, however, not the only reason why voluntary demands for PHI or SHI by informal workers will not be steady. Irregular incomes cannot sustain health insurance demands but this can be corrected via savings accounts that provide informal workers with small loans or credit to pay their premiums at times when their irregular income streams do not allow them to do so.<sup>16</sup>

Nonetheless, without good local governance, educational outreach programs and/or encouragement to enroll as a household unit, reliable premium payment by informal workers is no guarantee health insurance will be supplied or demanded. Other barriers to be surmounted include (1) limited incentives to create nonprofit mutual or CBHI schemes, the slow growth of CBHI schemes and their low survival rates; (2) the difficulty for-profit private insurers have in providing affordable coverage without income-related premiums and/or premium subsidies, and (3) the general absence of or reluctance to supply GR coverage.<sup>5</sup> These concerns (barriers) plus citizens or health planners skepticism of for-profit PHI means consideration should be given to SHI. The benefit of SHI is that everyone is mandated to get I<sup>E</sup> of coverage. Relative to voluntary purchases from private or nonprofit insurers (if they exist), SHI is expected to achieve UHC (quicker). For this to become reality, SHI must be designed to resolve all the potential drawbacks (disadvantages, failures) associated with PHI. For e.g., SHI, just like PHI, must find a way of getting around the informality problem in LMICs. Below we identify three conditions for SHI to perform better than PHI.

One, providers of SHI must keep loading (administrative) costs in the range of 10-20% of premiums, lower than what typically prevails in competitive PHI. Two, SHI with community-rated premiums must insure all those with pre-existing disease conditions (from birth) and provide GR coverage for at least *X* years or preferably over a lifetime. To do so, there should be zero insurer competition in SHI, or if insurer competition is allowed, SHI must be supported by risk adjustments and risk equalization systems. Without risk-adjustment or equalization, the costs of insurer competition in the form of risk selection is likely to outweigh the benefits.<sup>17</sup> We believe these measures are not well suited for LMICs; given the administrative difficulties of setting up an insurance plan offering basic coverage, it is hard to imagine LMICs instituting effective risk adjustment systems. Zero insurer competition only means strategic purchasing functions cannot be neglected at any point in time. Three, SHI must be better than PHI in enrolling informal workers with irregular incomes; it must offer premiums subsidies to those who are too poor to demand health insurance. In addition, SHI must link community-rated premiums to incomes, such that high-income earners who become low-income earners, and vice versa, will still have affordable minimum coverage.<sup>16</sup> If these conditions are not met, it will be hard to justify the choice of SHI over PHI. But even if the conditions are met, implementing SHI doesn't mean there is no role for PHI. In any LMIC, there are bound to be some (high-income) individuals who will want more than I<sup>E</sup> coverage. These demands can and should be satisfied through PHI. Unshakeable positions that SHI is better than PHI, or PHI is better than SHI does more harm than good – it ignores the fact that PHI and SHI are both substitutes and complements. In the next section, we elaborate on this point using historical examples from Germany and the US.

### 3. Some Useable (Useful) History

#### 3.1. Lessons from Germany

In Germany, statutory health insurance (another name for SHI) coexists with PHI. SHI premiums are not risk-based but community-rated with mandatory participation and open enrollment. Premiums are based on annual labor income with an income ceiling above which additional premium contributions are zero. However, rich individuals with incomes above a defined ceiling are allowed to be uninsured or otherwise purchase PHI.<sup>10</sup> This is a common description of SHI in Germany but when it was first established in 1883 under Chancellor Otto von Bismarck, enrollees were all blue-collar (industry or factory) workers. In 1885, just 10% of population were covered by 18,776 nonprofit sickness funds. In 1914, coverage was extended to transport, commercial office, agricultural and forestry workers; domestic servants, itinerant workers and white-collar workers. In 1918, unemployed workers were included.<sup>18</sup> By 1987, SHI was mandatory for 70% of the population.

Adding voluntary enrollment by self-employed and white-collar workers earning above the stipulated income ceiling raised the proportion of population covered to 88%. It is worth noting that, in 1883, insurance payouts included sick pay of up to 50% of wages for a maximum of 13 weeks as well as service-in-kind benefits for inpatient care costs. In 1903, sick pay was doubled to a maximum of 26 weeks. Offering sick pay alongside healthcare benefits is in fact welfare improving as this insures not just losses due to medical costs but also productive time lost due to illness.<sup>19</sup> Fast forward to 1993, insurer competition was introduced in German SHI and supported by risk adjustment and risk equalization systems. By 2007, the Statutory Health Insurance Competition Strengthening Act (SHI-CSA) was passed, which required mandatory universal coverage to be provided by SHI or PHI. This Act introduced a uniform contribution *rate* for SHI and aimed to ensure “nobody lost their PHI coverage through no fault of their own”. In other words, everyone was required to have GR coverage for a lifetime either through SHI or PHI.<sup>18,20</sup>

Mandatory participation under the 2007 SHI-CSA was intended to reduce to zero the number of uninsured individuals who constituted 0.2% of the population. Prior to 2007, individuals could opt out of SHI if their incomes within a single year exceeded the ceiling. This provision was also revised under the SHI-CSA. To make it difficult for high-income low-risks to opt for PHI, their incomes had to exceed the ceiling for three consecutive years.<sup>20</sup> The combination (mixing) of SHI with PHI in Germany is such that individuals are not faced with a simple dichotomous choice of SHI or PHI. Self-employed and those with incomes above the ceiling who choose to stay with SHI could privately purchase supplementary coverage. Civil servants could also purchase privately supplementary GR coverage to expand their benefits under the *Beihilfe* program that covered only 50-70% of costs. In addition, insured individuals had the leeway to switch private insurers or opt out of PHI. Citizens could do so for five reasons: incomes falling below the ceiling, low risks search for lower premiums from competing insurers, change in work status from self-employed to wage earner, emigration and death.<sup>10</sup>

The PHI component of this mixed system is best described as oligopolistic with insurers charging, for lifetime GR coverage, frontloaded but level risk-rated premiums that are unrelated to income. These are estimated assuming life expectancy of 102 years and the markup (frontloading over and above risk-rated premiums for low risks) allow insurers to accumulate enough reserves to pay for higher expected expenses of those who experience a chronic illness that persists for years.<sup>10</sup> However, level GR premiums in Germany are not so different from frontloaded but declining premium schedules used by private insurers in the US.<sup>9</sup> In fact, annuitized frontloaded but level GR premiums can be reconstructed as the present value of a sequence of frontloaded but declining GR premiums.<sup>21</sup> The choice between the two forms of frontloading depends on lifetime income profiles. In a world of imperfect capital markets, where there are borrowing constraints, frontloaded but level premiums, in contrast to frontloaded but declining premiums, are more suited for low-income earners or young people whose accumulated wealth will be low at the time of purchasing GR coverage.<sup>10</sup> Frontloaded but level premiums, in turn, are not so different from (modified) community-rated SHI premiums that are roughly constant over a lifetime period. In fact, it is safe to say that, in Germany, the dynamics of buying and selling of PHI are not so different from SHI. PHI premiums for the basic (minimum essential) I<sup>E</sup> package are not to exceed the maximum SHI premium given the income ceiling, and PHI premiums can be lowered if they exceed a certain percentage of income. PHI premiums for the basic package are effectively income-related and additional risk (changes) cannot be fully reflected in premiums. German private insurers for all practical purposes offer a GR basic package “without medical underwriting”.<sup>20</sup>

### 3.2. Lessons from the US

In the US, in the 19<sup>th</sup> century, industrialization increased the frequency of illness among blue-collar workers, who covered the costs of care through savings, help from coworkers, charities and nonprofit sickness funds organized by employers or unions. In 1915, the American Association for Labor Legislation attempt to implement a bill for mandatory health insurance coverage failed as it was only supported by a fraction of workers.<sup>22</sup> Most workers were interested in only sick pay and rejected the constraints on voluntary choices (preferences) that compulsory enrollment brought. A

seemingly generous sharing of premium obligations (contributions under the bill required 40% from employers, 40% from employees and 20% in state subsidies) was not enough to appease the bill's opponents as workers did not want to be insured against "unwanted" services. In spite of this, by 1920, 30-40% of the industrial workforce were insured, representing 10% of the population. Only young workers with low valuations of insurance coverage and older workers who had accumulated adequate precautionary savings remained uninsured.<sup>22</sup> In the early 1930s, PHI emerged in the form of the nonprofit Blue Cross and Blue Shield plans to fill the gaps left by failures to implement national universal health insurance. Success of the nonprofit saw the entry of for-profit private insurers, who, given tax-subsidized employer contributions, actively sold insurance coverage to employers in the 1940s.<sup>23</sup> In the 1950s, private insurers were successful in competitively picking off healthy (low risks) from community-rated nonprofit Blue plans, who responded to competition by offering similar coverage plans. In the process, differences between the for-profits' objectives and nonprofits' long-held commitment to principles of solidarity disappeared.<sup>24</sup>

By 1959, 737 for-profit private insurers in the US constituted a "booming competitive industry" offering experience (risk) rated coverage policies that were partial and limited in scope. Benefit packages covered, for e.g., catastrophic surgical and in-hospital expenses, and not less-expensive doctor visits, eye checks and glasses, and dental care. PHI was, however, largely employment-based, leaving out those over 65-years old and those uninsurable high-risks with pre-existing disease conditions who were certain to use medical care.<sup>24</sup> Recognition of the gaps left by PHI in the 1960s led to a proliferation in US government interventions, notably the implementation of tax-funded Medicare and Medicaid programs. Medicare provided insurance coverage for the elderly over 65 years and individuals at any age with proven disabilities including persons with end-stage kidney disease, who are certain to require expensive dialysis or kidney transplants. Medicare Part A provided hospital insurance, whilst Medicare Part B covered doctor visits and other services. Medicaid, on the other hand, covered the poor living below or close to the poverty line and those considered "medically indigent", i.e., persons who were once socially productive but had become poor because of catastrophic medical expenses. In 1997, Medicare Part C (also called Medicare Advantage) was introduced to encourage Medicare beneficiaries to join for-profit private insurers, and in 2003, Medicare Part D was introduced to get Medicare beneficiaries to voluntarily join prescription drug benefit plans.<sup>24</sup>

That US government intervened to correct failures of the PHI market is not to say that private insurers do not respond to gaps in social welfare without government regulation. For instance, the Health Insurance Portability and Accountability Act (HIPAA) passed in 1996 required all private coverage sold to individuals to be "guaranteed renewable". But prior to HIPAA, some private health insurers did offer GR coverage without regulation.<sup>8,9</sup> Gaps in GR coverage existed because although, by 2000, employer-based health insurance covered 66.8% of nonelderly Americans, the implicit GR coverage offered (with consumer commitment enforced by job lock<sup>25</sup>) was tied to the fortunes of employers and businesses. Employees lose their GR coverage once they lose their jobs or switch employers.<sup>23</sup> That aside, expansion of tax-funded public insurance in the US served as a catalyst for better PHI uptake. Recent literature<sup>26</sup> has shown that expansion of Medicaid in the late 1990s and early 2000s to cover non-poor high-risks who may become medically-indigent (and not just low-income earners) increased PHI coverage rates over the period 2003-2008 in states where regulations required community-rated premiums. Prior to the expansion of Medicaid, cycles of adverse selection led to a fall in PHI coverage rates after states enacted community-rating regulations in 1993. Coverage rates reached a "low-point" in 1996-1997 but recovered post-2002. It appears competitive PHI markets work better when high-risks (unhealthy adults) and those close to being uninsurable are covered by public health insurance.<sup>26</sup>

#### 4. Implications for LMICs

Section 3 is not meant to suggest that LMICs should replicate health insurance arrangements in Germany or the US. Its purpose is to provide a historical perspective on how SHI evolve and change with the emergence or absence of private markets. In the US, we see the gradual emergence and growth of sickness funds (the precursors of employment-based health insurance), nonprofit insurers

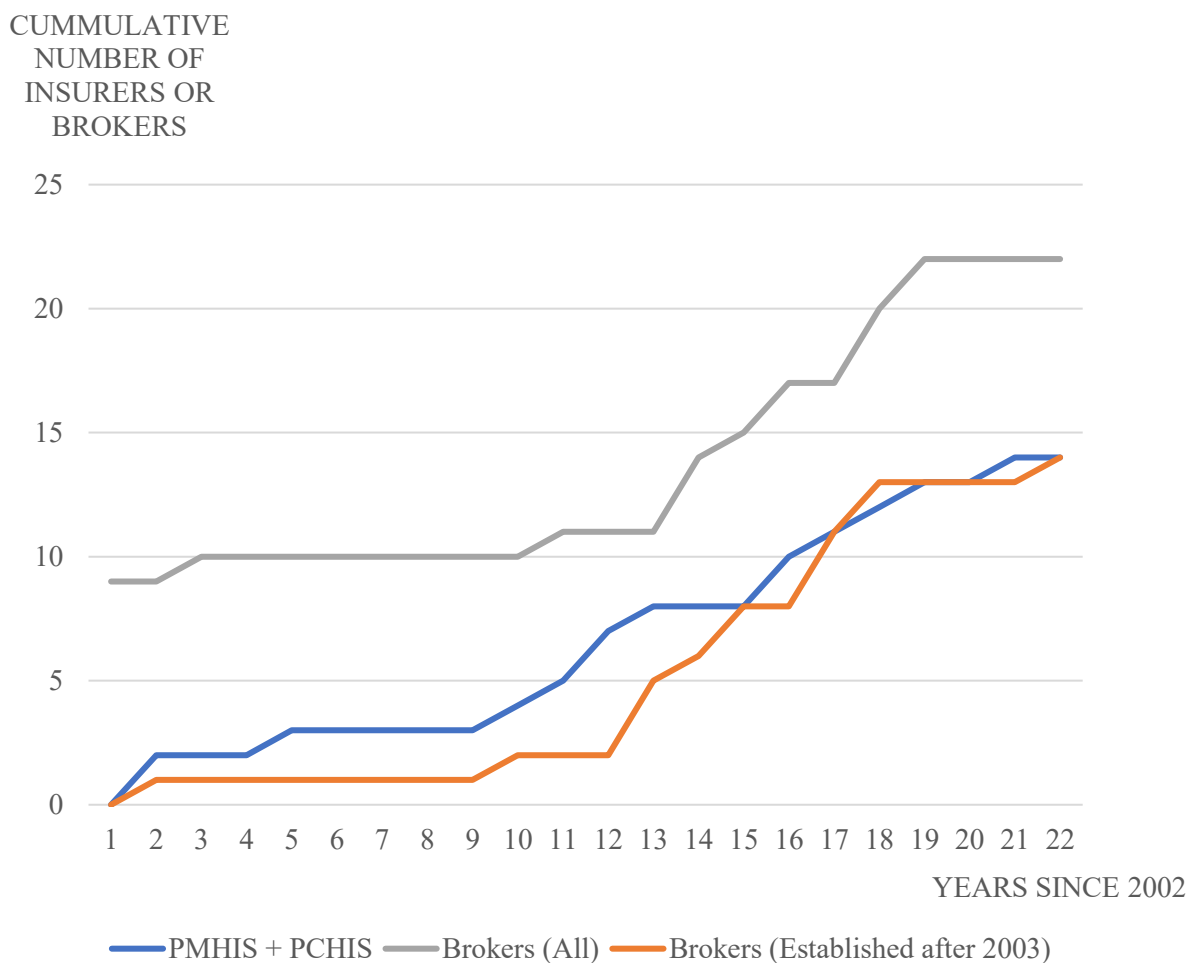
and later growth of for-profit private insurers. In contrast to Germany, the configuration that emerged in the US is a larger PHI market supported by publicly-provided health insurance. Although US Medicare and Medicaid are largely tax-funded funded programs (and do not fit the usual definition of SHI that requires mandatory premiums), Section 3 describes the expected evolutionary path for UHC. When government interventions (and reliance on taxes) fail to provide a beneficial good or service in demand, non-profit or for-profit private insurers will emerge to correct the welfare loss of underproviding a beneficial good or service. And, when private markets fail to emerge or correct the welfare loss, governments will intervene (again) to correct the gaps in welfare. The choice between PHI, SHI or tax-funded public-health-insurance is therefore, in most cases, *not* mutually exclusive.

In LMICs, vibrant private markets have generally not emerged to provide the commodity called health insurance. Brazil, Chile, China, Namibia, South Africa, Uruguay and Zimbabwe are notable exceptions with more than 20% of total healthcare expenditures covered by PHI. These figures, however, do not always match up with UHC targets. For instance, whilst PHI expenditures in South Africa are over 40% of the total, less than 20% of the population are covered by PHI. In Uruguay, PHI accounts for less than 40% of total expenditures but more than 60% of the population are covered by PHI.<sup>6</sup> Considering the absence or limited scope of PHI in LMICs, the limitations of tax-funded budgets, and the excess tax burden of attempting to raise more, SHI seems the best forward. But PHI can help relieve pressure on taxes and SHI as long as it doesn't operate in an institutional vacuum without public oversight and policy harmonization, accountability or coordination with public system. The following are some regulatory measures for steering PHI towards public interests. First, PHI should not operate without risk adjustments or equalization systems when competing insurers are required to charge community-rated premiums.<sup>2</sup> Second, even if PHI is to offer small-sized supplementary coverage, this should be guaranteed renewable for X years or a lifetime. Third, complementary coverage to cover modest deductibles, copayments or coinsurance should be prohibited since the costs of moral hazard (excessive consumption) should be fully reflected in premiums paid. Fourth, individuals who prefer more than I<sup>E</sup> coverage can be allowed to opt out of SHI to purchase the basic minimum plus supplementary packages from private insurers. Individuals who opt out should, however, not be allowed to opt back in to SHI. Opting in and out of SHI will undermine the implicit GR coverage offered as high-income low-risk can opt out of SHI, purchase PHI coverage that may or may not be guaranteed renewable, only to return to SHI as low-income high-risks (living below the poverty line). Fifth, to ensure PHI is not so different from SHI, individuals who opt out of SHI should be required to purchase GR coverage for X years, not single-year contracts.

In LMICs where PHI has shown promise, health planners will be justified to support its growth, especially when SHI covers (1) people considered medically or actuarially uninsurable by private insurers or (2) people who cannot afford PHI premiums without subsidies. In this case, expansion (reductions) in the size of the minimum benefits package should go hand-in-hand with reductions (expansion) of supplementary coverage offered by PHI. Private insurers (and their brokers), however, have to first pass the test of providing risk protection at premiums affordable to the general population living above or close to the poverty line. If PHI can provide coverage at low premiums, health planners may even consider handing over the supply of guaranteed-renewable I<sup>E</sup> coverage to private insurers. Socialized consumption of essential insurance protection will then be privately provided. That said, we will argue below that health planners who prefer PHI should still consider starting their reforms with SHI. This is not just because SHI helps fill gaps left by PHI in LMICs but, as observed in Ghana, SHI implementation may be the stimulus for the emergence and growth of PHI.

Ghana implemented SHI under the National Health Insurance Act 2003, Act 650 and the revised Act 2012, Act 852.<sup>27,28</sup> The object(ive) of the now repealed Act 650 was to establish district mutual health insurance schemes (DMHIS) for formal workers, private mutual health insurance schemes (PMHIS) and private commercial health insurance schemes (PCHIS). PCHIS together with PMHIS are referred to as private health insurance schemes (PHIS). Under the revised Act 852, the national health insurance authority (NHIA) was established to implement a national health insurance (NHIS), and to register and supervise PHIS. The NHIS offers a defined package of I<sup>E</sup> benefits and in Section

27 of Act 852, NHIS members are allowed to become members of PHIS. PHIS must be licensed by the NHIA (Section 63) and can only do business with healthcare providers accredited by the NHIA (Section 100).<sup>28</sup> Act 852 also allows for the establishment of a bureau to deal with complaints related to the actions and operations of PHIS, redefined to include insurers, reinsurers, brokers, loss adjusters and third-party administrators. What is most interesting is that, out of all the PMHIS and PCHIS with valid licenses till year 2026, only four existed prior to implementation of Act 852 in 2012.<sup>29</sup> The change in legislation (a 10-year transition from DMHIS to NHIS) seems to have engineered a small but vibrant PHI market; a market vibrant enough to attract brokers and third-party intermediaries. The Figure below shows the number of brokers working with PHIS since 2002.



**Figure 1.** Private health insurers and brokers (intermediaries) in Ghana. *Source:* Author. *Notes:* Analysis is based on data obtained from the Ghana NHIA website<sup>29</sup>, and from a general web search for the year each company (insurer, broker or third-party administrator) was established. Brokers established before 2003 include those initially operating as private providers of auto (motor), marine, life or general insurance.

An insurer-broker system should not (par default) be considered a wasteful use of societal resources. Brokers (and agents) serve as intermediaries helping (1) consumers to purchase the right coverage plan and (2) insurers in underwriting these plans by providing accurate information on health risks and other characteristics on which basis insurers can set (risk-rated) premiums for individuals or firms (employers) purchasing insurance on behalf of their employees.<sup>30</sup> The information brokers collect could be the difference between having a stable competitive market or adverse selection, an unsteady patterns of coverage and market unravelling. Without brokers, insurers might be more reluctant to bear risks. The information brokers collect also helps reduce consumer search costs and facilitates comparison shopping by matching consumers to insurers on the basis of premiums, benefit packages, cost-sharing measures and preferred choice of healthcare

providers. For society, broker fees (preferably volume or profit contingent commissions) should cover their costs and be less than the value created. A competitive PHI market therefore needs competition between brokers, to at least reduce insurers' loading costs and premiums.<sup>30</sup> Evidence from the US suggest competitive brokering does lower premiums, reduce the variance in premiums and increases the likelihood that small firms (prone to averse selection) will offer coverage to their employees.<sup>31</sup> However, in Ghana, the insurer-broker system that emerged after Act 852 doesn't fit well with the arguments above.

To exploit economies-of-scale in performing the broker function, a single broker typically will be an agent for different insurers and serve a large pool of customers. Insurers in turn are able to diversify the risks they bear by (1) dealing with a smaller number of brokers, each bringing in a large volume of business, or (2) dealing with a larger number of brokers, each bringing in a smaller volume of business.<sup>30</sup> In Ghana, one observes the latter with the number of new brokers equaling the number of private insurers (see Figure). This, however, might be a sign of excessive entry or the absence of broker competition; in fact, brokers' licenses that expired in 2025 have not been renewed at the time of writing this paper.<sup>29</sup> Time will tell whether this marks the end of the insurer-broker system – with private insurers choosing to underwrite or sell coverage themselves. Beyond this, there are question marks about how efficient the insurer-broker system is in Ghana. Competitive PHI is supposed to be better at matching different types of coverage policies to consumer preferences, but not if citizens are allowed to choose whatever level of coverage they want (in whatever form). Leaving unspecified what benefit packages PHI should offer is an unsure way of achieving UHC. Better to specify whether private insurers are to just supplement I<sup>E</sup> or provide more than I<sup>E</sup> of coverage. Ghana's Act 852 is silent on whether PHIS are to provide supplementary or complementary coverage alone, I<sup>E</sup> coverage alone, or I<sup>E</sup> plus supplementary or complementary coverage. In addition, Act 852 does not specify the nature of contracts signed between consumers and the PHIS: whether contracts should be community or risk rated, short-term (annual) or GR long-term contracts. Nor, does it require private insurers to serve all customers and not just teachers and other formal-sector workers.<sup>32</sup> Clearly, the current policy and regulatory framework within which PHIS in Ghana operates should be revisited.

## 5. More on Regulating PHI

To effectively combine SHI with PHI, health planners in LMICs must in place appropriate market rules and regulations for both private health insurers and the brokers (intermediaries) they rely on. The decision to combine SHI and PHI itself, and the set of PHI regulations chosen must be informed by sound technical analysis and cross-country policy lessons. The series of regulations often required should be chosen not just because "PHI has to be regulated" but to steer PHI towards provision of universal access to affordable GR (comprehensive) insurance coverage. The importance of doing so is most evident in Chile and South Africa's experience with PHI.

Unlike Ghana, PHI in South Africa emerged without any stimulus from SHI legislation to cover the failures of public sector provision of care. Calls for UHC in South Africa can be traced back to the 1920s, but in the absence of UHC reforms, PHI emerged mainly in the form of non-competing not-for-profit employment-based schemes.<sup>33</sup> In accordance with the 1967 Medical Schemes Act, non-profits offered a minimum benefits package and charged premiums that were positively related to incomes but not health status. The 1980s saw the emergence of for-profit schemes who lobbied to have the ability to develop premium contribution tables for different employers and individuals for a common benefits package. In 1989, schemes were allowed to risk-rate premiums for a minimum mandatory package; premiums thus varied by age, sex, income, health status, geographical area, size of benefit packages, size of insurance groups and period of membership.<sup>34</sup> However, beyond formal employers, risk rating did not generate significant demands by individual buyers – and the apartheid regime did not help boost demand. Low PHI demands call for higher premium-loadings (to accumulate adequate solvency reserves) but without insurer and broker competition, premiums will rise significantly. Between 1993 and 1994, increasingly unaffordable risk-rated premiums for a prescribed minimum package led to 200,000 people losing insurance coverage.<sup>33</sup>

In 1994, requirements for mandatory enrollment in PHI and a minimum benefit package were removed, allowing even government employees to voluntarily choose schemes. For-profit insurers

could therefore offer a variety of benefit packages smaller than the previously prescribed minimum, presumably to make insurance affordable.<sup>34</sup> With high risk-rated premiums and brokers receiving (above normal) commissions for selling both short- and long-term insurance contracts, it did not take long before private insurers were accused of siphoning profits through brokers or via reinsurance contracts with entities owned by or colluding with the medical schemes. By 1998, PHI rules and regulations had been revised again. This time, the regulations, implemented in 2000, included (1) open enrollment but with community-rated premiums, (2) minimum solvency requirements for insurers, (3) accreditation of brokers and regulation of commissions received, and (4) reinstatement of mandatory minimum benefits with particular emphasis on catastrophic expenses. The new regulations also included waiting periods, late-joiner penalties, and rewards for continuity in membership. The minimum package was set at 35% of what will be described as comprehensive coverage. And, with no room for risk-rating, private insurers offered a variety of “risk-sifting” packages larger than the minimum including comprehensive coverage.<sup>34</sup>

Following these regulations, there was a wave of insurer consolidation, spurred on by the formation of a government employees medical scheme in 2005. The number of for-profit schemes fell from 220 in the 1990s to 100 by 2010, a process that resulted in the emergence of *national* private medical schemes. Two of the national medical schemes accounted for 41% of privately insured persons, most of whom were of high socioeconomic status. Declining PHI demands and consolidation of schemes in turn led to a reduction in the variety of benefit packages offered.<sup>34</sup> The reduction in number of package options is not necessarily welfare reducing since less variety is possible under community-rating and insurer competition if a majority of low- and high risks consistently choose a specific coverage plan. The only safety net is that subsequent to the death of any coverage option, individuals will not be left uninsured but with a minimum I<sup>E</sup>. However, whilst a 35% minimum package will be affordable to many, it does not provide adequate risk protection even for those fortunate to be privately insured. With a vibrant PHI market serving only 16% of the population, South Africa eventually implemented a National Health insurance Fund (NHIF) in July 2019 to be financed by general taxes and payroll taxes (= premiums paid before or after other tax deductions).<sup>33</sup> Institution of the NHIF then requires new regulations governing its interplay with PHI. At least, regulations must specify whether PHI premiums will be risk- or community-rated; whether annual short-term contracts will be allowed or only long-term GR contracts should be offered; and whether PHI should provide only supplementary non-NHIF benefits or basic plus supplementary coverage should be offered to those who choose to opt out of the NHIF.

Similar lessons can be drawn from Chile, where PHI covering 15% of the population coexists with a public health insurance system. SHI in Chile has done a good job of covering the less healthy and less wealthy, allowing PHI to flourish. SHI in Chile did not crowd out PHI.<sup>35</sup> However, and although private insurers offer GR contracts, the absence of clear regulations meant that consumers were left insecure from exposure to fluctuations in risk-rated premiums that were more frequent than one will expect from a promise not to modify premiums with changes in health risks, and/or from indexing base premiums to inflation. Consequently, consumers frequently dropped GR coverage. Lapsation (= coverage dropping) rates were estimated to be circa 20% annually, meaning less than 27% of insureds stay with their insurer 70 months after purchasing GR coverage.<sup>36</sup> Income fluctuations (uncertainty) is one reason why insureds may drop GR coverage as premiums become unaffordable. But if the essence of GR coverage is to guarantee a certain (not an uncertain) premium path for *X* years, PHI regulations must put restrictions (limits) on how often premiums can be adjusted for each risk class (actuarial category). These restrictions may include a cap on GR premium increases, for e.g., that premium changes cannot be more than 1.3 times the weighted average across all coverage plans or private insurers.<sup>36</sup> High lapsation rates and a bad insurer reputation may be an effective deterrent to the practice of arbitrarily increasing GR premiums but PHI should not operate without regulations, more so when it is combined with SHI.

To sum up, health planners in LMICs shouldn't treat PHI as a separate, unworkable solution. Once PHI shows promise in covering a sizeable fraction of the population, it is certainly worth experimenting on how best to combine PHI with SHI. Whether SHI preceded PHI, or SHI emerged after PHI, the two financing mechanisms put together can help achieve more than UHC objectives.

For this to be possible, the dynamics of insurance buying and selling under PHI should not be distinctly different from SHI.

## 6. Concluding Comments

The welfare case for health insurance of all sorts is overwhelming<sup>19</sup>, whether this takes the form of taxation, SHI or PHI. It is up to health planners in LMICs to choose insurance arrangements that are more likely to achieve UHC objectives. In this task, it is not helpful to see PHI as a foe but rather an alternative way of covering insurable financial risk. A comparison of health-insurance history from Germany and the US suggest that the mix of SHI and PHI depends on (1) whether private markets emerge and grow to supply guaranteed-renewable insurance protection, (2) whether the growth and geographical spread of private insurers supports the supply of long-term protection at low premiums that low-income people can afford, and (3) whether private insurers will be willing to insure those considered medically or actuarially uninsurable. In LMICs, private markets do not exist or have a small geographical reach, and this justifies the current preference for SHI. But SHI itself must be designed in a way that improves on what can possibly be achieved via PHI. For instance, by substituting insurer competition with a strategic purchaser, health planners must ensure everyone in community-rated non-competing SHI pools including the poor and uninsurable enjoy affordable coverage without incurring debts or delaying provider reimbursements. To replicate this outcome in competitive PHI, government must turn to tax-funded public insurance or SHI to cover the uninsurable, and provide subsidies to those who cannot afford GR premiums quoted by private insurers and brokers.<sup>5,8</sup>

In LMICs, PHI is best positioned to offer supplementary coverage to those who remain part of SHI. For those who opt out (for the rest of their lives), PHI can offer the minimum essential package or the minimum plus supplementary coverage that is guaranteed renewable for at least X years or where feasible over a lifetime. Combining SHI and PHI is the way forward, and we also know implementation of legislation to support SHI may actually be the catalyst for the emergence and growth of PHI. We conclude by restating the argument made in Section 2: unshakeable notions that SHI is better than PHI, or PHI is better than SHI does more harm than good. It creates an artificial wedge between two ways of providing health insurance that can be both substitutes and complements. As long as private health insurers do not operate in a vacuum without public oversight and policy harmonization, accountability or coordination with tax-funded systems and/or SHI, PHI is a friend, not a foe.

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