How Effective Are Efforts to Raise Voluntary Enrollment in Health Insurance?

Much of the world is in the midst of a push toward universal health coverage. One of the biggest challenges facing developing countries is extending insurance coverage to informal sector workers. These workers are very mobile, and since they are also typically self-employed, they do not have employers who can be required to deduct premium contributions from their salaries. Since they are not officially poor or marginalized and because they represent a sizable fraction of the population, many countries are reluctant to fully subsidize their coverage, though some have done so (Thailand is an example).

Many countries have instead used partial subsidies to encourage enrollment either in a new government-run scheme, as in China and Mexico, or in the government’s existing social health insurance program, as in the Philippines and Vietnam. Some countries (including China and Mexico) have achieved high coverage levels, but they have ended up almost fully subsidizing coverage. Countries such as the Philippines and Vietnam have not, and these are better tests of the voluntary enrollment model, unhappily for the governments concerned, growth in enrollment among informal sector workers in these countries has been sluggish.

The question naturally arises as to what additional steps governments such as those in the Philippines and Vietnam might take to raise voluntary enrollment rates and thus move closer to universal health coverage. Surprisingly little is known about the relative cost-effectiveness of alternative measures.

A new study by Capuno, Kraft, Quimbo, Tan, and Wagstaff presents evidence from two randomized experiments conducted in the Philippines, where despite numerous initiatives the informal sector remains the population group with the lowest coverage rate.

The main experiment tested the effectiveness of a combination of information and a premium subsidy in raising enrollment in the voluntary government-run Individual Payer Program (IPP). From a sample of 243 municipalities, 179 were randomly assigned as intervention sites and 64 as controls. In early 2011, 2,950 families were interviewed, and unenrolled IPP-eligible families in intervention sites were given an information kit and a 50 percent premium subsidy voucher valid until the end of 2011. The randomization process worked as planned: the control and intervention sites were “balanced” at baseline—that is, they were similar in terms of variables likely to influence IPP enrollment. By January 2012, 9.9 percent of eligible individuals in the control sites had enrolled, compared with 14.9 percent in intervention sites. This represents an appreciable increase in enrollment but falls well short of the sort of coverage rate that would be considered universal.

In February 2012 a second experiment was therefore launched, focusing on the families in the “treatment” municipalities that had declined the subsidy offer and had chosen to remain unenrolled. The aim was to see what further steps beyond providing information and a subsidy might be taken to raise enrollment rates. All IPP-eligible families that had opted not to enroll had their voucher extended, were sent the enrollment kit a second time, and received Short Message Service (SMS) reminders about the subsidy offer. Half these families, selected at random, were given a further “treatment”: they were told that in April 2012 the enumerator could help them complete their enrollment form, deliver the form to the insurer, and arrange for their identification card to be sent in the mail. This assistance “treatment” worked: enrollment was 3.4 percent among families that did not receive assistance from the enumerator but as high as 39.7 percent among those that did.

The dramatic increase in coverage in the second experiment points to the importance of the transport and time costs associated with health insurance enrollment—costs that were highlighted by one participant who texted in reply to one of the SMS reminders that she had missed the boat and therefore could not get to the provincial insurance office that day. This experiment is also sobering, however, even with all the assistance provided to the treatment group, 60 percent chose not to enroll. With the costs of providing such “hand-holding” factored in, the results are hardly reassuring for policy makers planning to achieve universal health coverage by subsidizing voluntary health insurance enrollment.