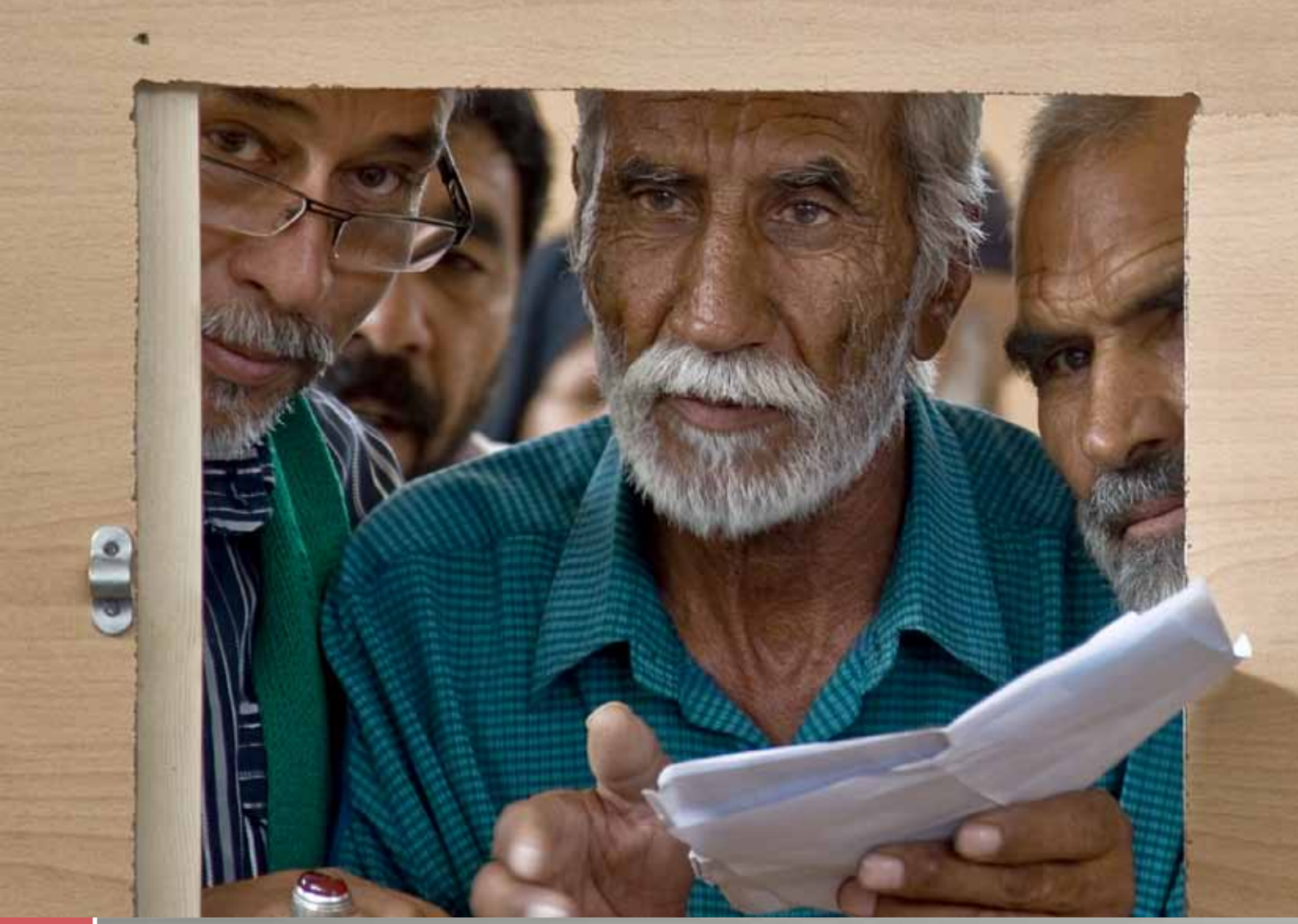

A Guidance Note on Health Insurance Schemes for Refugees and other Persons of Concern to UNHCR

UNHCR
The UN Refugee Agency

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Iran / UNHCR

INTRODUCTION

The health of refugees and other forcibly displaced persons is a key component of protection and a priority for the United Nations High Commissioner for Refugees (UNHCR). The Refugee Agency works closely with governments and partner organizations who implement health programmes in a range of challenging settings. Health and nutrition programmes are delivered within a public health and community development framework, with an emphasis on primary health care (PHC) and support for secondary and sometimes tertiary hospital care. The objective of these programmes is to minimise mortality and morbidity among refugees and other persons of concern to UNHCR.

UNHCR advocates that essential PHC and emergency services be provided free of charge to refugees during an emergency. Furthermore, certain essential services such as childhood vaccinations, antenatal and delivery care, and communicable disease control (e.g. tuberculosis) should be provided free to all refugees during the post-emergency phase. Fees for all others services depend upon the context, but UNHCR advocates that they should not be higher than those prices charged to nationals. Furthermore, vulnerable refugees should be identified and a suitable safety net provided for them to ensure access to preventative and curative health services. The agency advocates that government services are accessible to and used by refugees whenever possible.

This document is aligned with *UNHCR's Public Health Guiding Principles* (http://www.unhcr.org/4b224d5f9.html), *Operational Guidance on Refugee Protection and Solutions for in Urban Areas* (http://www.unhcr.org/4e26c9c69.html) and *Principles and Guidance for Referral Health Care for Refugees and Other Persons of Concern* (http://www.unhcr.org/4b4c4fca9.html). The focus of this guidance note is on refugees and asylum seekers (henceforth referred to as refugees), but in some contexts it may apply to stateless persons, internally displaced persons and returnee settings.

Insurance schemes do not cover all costs of health services. In most countries where insurance schemes are available, there will also be several co-existing health financing mechanisms. Resources for health services come from many sources including but not limited to: taxation (e.g. from the central and/or local governments), general budgetary support (e.g. donors to the central government), the private sector, individual out-of-pocket payments (e.g. user fees), grants, and payments by civil society organisations and international agencies. Individuals and communities may also make *non-financial contributions* by freely giving their

labour in the construction of a health facility, or health workers and community volunteers working benevolently. A full understanding of the health financing mechanisms relevant to the health services accessed by refugees needs to be assessed and understood according to the specific context where refugees live. Any health financing schemes, including insurance schemes, need to be combined with a way of financially protecting the poor and other potentially vulnerable persons and groups in order to enable them to access health services as readily as people who are better off or less vulnerable. Clear and objective eligibility criteria need to be designed to identify these persons and groups.

CIS/Georgia/UNHCR/A.Hoffmann/July 1999

AN OVERVIEW OF HEALTH INSURANCE SCHEMES

Health insurance schemes can be national, community or private (e.g. managed by a company for its employees). They can be *mandatory* or *voluntary*. Mandatory schemes are usually national, in which there is a legal obligation for people to pay into them and are based on the principle of social solidarity. Contributions are community-rated (i.e. based on an average expected cost of health service). These are usually called *Social Health Insurance* or, if covering the whole population, *National Health Insurance*. They are generally collected through payroll deductions. Costa Rica (see example below) uses a combination of mandatory social health insurance and increased taxation to generate near universal health coverage.

There are also voluntary health insurance schemes. Voluntary or private insurance schemes may be managed on a *for-profit* or not-for-profit basis. *Community-based health insurance* schemes are usually run by community-based or non-governmental organisations (NGOs), and may also be referred to as *mutual health insurance, micro-insurance or community health funds*. Insurance schemes often have high administrative and revenue collection costs.

A recent systematic review of insurance schemes worldwide (although most were in the USA) identified six key strategies for expanding health insurance to include vulnerable people. These strategies were:

- Changing the eligibility criteria for insurance.
- Increasing public awareness.
- Making premiums more affordable.
- Innovative enrolment strategies
- Improving delivery of health care.
- Improving management and organisation of the scheme.

WHY CONSIDER HEALTH INSURANCE FOR REFUGEES?

There may be numerous direct and indirect benefits in providing health insurance to refugees. Improved access to health services and financial protection are clearly the two largest benefits. Indirect benefits include an official piece of documentation (the health insurance card) that may protect refugees from harassment by authorities and provide refugees with a sense of belonging and security. More data about refugees may be provided to UNHCR and its partners to allow for an objective decision as to who is vulnerable as well as data from health insurance companies about who uses which services where and for what reason. The improved protection benefits as well as the provision of data from different sources may allow for improvement in other sectors and programmes.

Although equity is an important component in health care, it must be one of many factors to be considered in making a decision regarding health insurance. While a scheme may exclude a group of especially vulnerable refugees or those with specific illnesses, it may still be cost effective for some or the majority of refugees to be able to voluntary have the opportunity to have health insurance.

Democratic Republic of the Congo (DRC) /
UNHCR / J. Ose / July 2005

GUIDANCE

GUIDANCE ON INTRODUCING HEALTH INSURANCE SCHEMES FOR REFUGEES

a. **Is introducing an insurance scheme in the best interest of refugees?** All options must be considered and the conclusions from any available evaluations of these schemes taken into consideration as they are reviewed. While a scheme may potentially increase access to health services and financial protection for refugees, it may not be equitable and may not be available to the poorest or most vulnerable. However, while a scheme may exclude a group of especially vulnerable refugees or those with specific diseases, it may still be cost effective for some or the majority of refugees. UNHCR and its partners can attempt to find alternative arrangements for those who cannot be insured. Other indirect benefits may also occur as discussed previously in the section why consider health insurance for refugees.

b. **Integration into schemes available to nationals**. Insurance schemes should be chosen that are available to nationals. National health insurance schemes are likely to be more equitable and more cost effective for refugees than other providers; however, all options should be considered.

c. Insurance schemes will likely only be appropriate for refugees residing in a country in the **medium to long term.**

d. **Need to understand socioeconomic context for each setting.** Insurance schemes can never cover all health care costs. A careful analysis of spending on health care, including out-of-pocket payments (typically including transport, consultations, medicines, laboratory tests, and hospital care) may help determine the actual cost of health care versus the buying-power of refugees as well as what niche services the schemes would be most suitable for. In countries where most refugees have some disposable income, the priority need for insurance may be on helping to cover the cost of more expensive clinical and surgical care in hospital. In Malaysia, for example, many refugees have sufficient income to meet their PHC needs but need support for hospitalisation costs. In very low income settings, UNHCR advocates that refugees access PHC and emergency services in a similar manner to that of nationals, many of which may well be free. Insurance for specialist outpatient services is often too expensive and

complex to administer, but all possibilities need to be examined, especially in middle income countries where refugees may live for many years with potentially very high health care costs.

e. **Most appropriate provider**. Insurance schemes provided by government companies and possibly by NGOs and community-based organisations are likely to be more equitable, cost-effective and easier to administer than those by private companies. But this may not always be the case and all opportunities must be explored. An examination of premiums, co-payments, ceilings for payment, exclusion criteria that restrict older refugees and those with pre-existing illnesses, antenatal and natal care, methods of reimbursement, and other important factors must occur.

f. UNHCR **promotes the government health care system**. Wherever possible, insurance schemes should work to encourage refugees to access available government health services rather than private providers. The former are usually less expensive and are what the majority of nationals use. Certain government health facilities in appropriate geographical areas may be designated. UNHCR advocates that refugees pay the same as nationals at these facilities.

g. **Sustainability**. Where possible, refugees themselves should pay the monthly insurance premium. However, this is dependent upon them having sufficient livelihoods and disposable income. A socio-economic survey should ideally be undertaken to determine the financial capacity of refugee households, with sustainability considered by UNHCR from the outset. There is likely to remain a certain percentage of refugees who are vulnerable and for whom ongoing support may be needed.

h. **UNHCR can contribute financially** to insurance schemes in several ways that include complete or partial payment of premiums and funding to pay the co-payment for the costs of the service (generally for vulnerable refugees; however, when refugees incur a catastrophic event with very high costs, a relatively well-off refugee can suddenly become financially vulnerable). In other circumstances, UNHCR may be able to provide expertise, funds and equipment to those health centres and hospitals used by the health insurance scheme that would allow for a more favourable deal for the refugees.

i. **Support of vulnerable refugees**. Vulnerable refugees should be included in insurance schemes with UNHCR covering some or all of the premium and the insurance co-payments for services. Clear criteria designating who is vulnerable must exist. UNHCR should advocate that needs of vulnerable refugees should be covered by the host government when feasible.

It is important to identify the possibility for refugees to benefit from *government-provided welfare support* whenever possible. This is not social insurance but rather payments to vulnerable people with government resources that comes from direct taxation. In South Africa, for example, refugees with disabilities are eligible to apply for disability grants. This includes some categories of people with chronic illness who are unable to work and the terminally ill. But in practice very few refugees will be able to benefit from such government welfare programmes, and UNHCR should work with other agencies to attempt to provide such assistance in proportion to the amount that would be received under the government scheme, when feasible.

j. **Piloting**. It is difficult to calculate all the costs involved in any insurance scheme in advance. Only by piloting a scheme in a region with a certain number of refugees can the real costs, benefits and disadvantages of a scheme become apparent. Generally, schemes should be piloted before being rolled out to a very large number of refugees. A pilot will also give an indication of the extra administrative and technical burden that an insurance scheme might encumber UNHCR staff with.

k. **Flexibility**. When possible, a single insurance scheme should have flexibility to allow refugees to apply for different levels of insurance depending on their choice and financial means. This would not detract from the need to ensure that the poorest and most vulnerable benefit as fully as possible from the scheme. Alternatively, UNHCR can help to negotiate for a group insurance policy. The choice depends on the buying power of the refugees and the level of cost contribution by UNHCR.

l. **Participation**. Refugees should be involved at all stages of consideration and adoption of insurance schemes that concern them. It is vital to know how acceptable a scheme would be to refugees, the various options of the scheme and whether they understand the positive and negatives of participation. A comprehensive and appropriate communication strategy must be devised and implemented. UNHCR should facilitate a process through which refugees participate in the funding of their own health insurance, contributing to increased autonomy and ownership of refugees of their health service needs.

GUIDANCE ON NEGOTIATING HEALTH INSURANCE SCHEMES

Engaging in negotiating a health insurance scheme is complex. The small print in an insurance contract is extremely important. Every scheme for refugees will be different in every country, and even within a country there may be more than one scheme offered. The following points should be considered when negotiating a scheme:

a. **Cost benefit analysis.** Careful cost calculations are needed to ensure that there will be considerable costs benefits in paying into the scheme for the refugees and UNHCR compared with existing services provided and payment mechanisms for existing services.

b. **Who is covered?** It needs to be clear if only those individuals that are named and paid for in the scheme are covered or if all (or some) family members are included in the same scheme.

c. **Inclusion/limiting the effects of exclusion.** UNHCR must negotiate for the widest possible inclusion of refugees into the health insurance scheme. Schemes may not insure, for example, people with HIV and AIDS who require antiretroviral therapy or people with disabilities needing reconstructive surgery. However, this does not mean that people with HIV and AIDS or disabilities should be excluded from receiving standard benefits (e.g. hospital care for medical and surgical problems). Particular attention should be considered to the inclusion of pregnant woman and newborns. Ideally, these services would be provided free by government services, but this is not always the case. Insurance should cover all deliveries and not be limited to a stated number of pregnancies. Some schemes will not ensure corrective surgery for congenital malformations, but these babies should still be entitled to life-saving support and all standard care available for other newborns including premature babies.

   Even the most inclusive insurance policies are likely to exclude people with certain conditions such as kidney failure needing dialysis. UNHCR must negotiate so that exclusion criteria are as limited as possible, while making other assistance available for these people (e.g. charities, NGOs, sponsors). The ideal is a scheme that has no-exclusion for pre-existing disease or disability. Where possible, UNHCR can negotiate separately for people with certain diseases or disabilities who may need to receive extra medical and income support from the government in similar ways as nationals.

d. **Read the small print**. Particularly be aware of **co-payments, ceilings, exclusions of certain diseases, limited hospital days, and emergencies**. It should be quite clear what services are covered, how much the scheme pays for these services, over

what time period, how much the co-payment is, and if there is a ceiling (e.g. insurance company will pay 80% of a hospitalisation up to $8,000. It should be made clear in the policy document exactly what services will be included in the scheme (e.g. **outpatient services, inpatient services, laboratory tests, investigations, medications, ambulance**). Such an assessment will require an eye for detail and discussion about individual diseases and treatments. For example, are glasses for refractive errors covered in the scheme? How about dental care? Would refugees with cancer receive cancer treatment; if yes, which ones and for what time period and total cost?

It should also be made clear as to what happens when an insured person fails to pay the (monthly) premiums (e.g. notification of non-payment, notification of non-coverage).

Are emergency treatments including ambulance costs covered? In some countries the national public health system provides free emergency care and transport while others do not. What are the rules for informing the insurance company when hospitalised? What happens if the patient is transported to the closest hospital that is not covered by the insurance and is in the intensive care unit? What happens in response to a natural disaster or armed violence/war?

e. **Care outside of the country** in which the refugees are residing? Care may not be available in-country to treat certain medical conditions. Some countries do have parastatal insurance schemes that pay out up to a maximum claim limit for the specified condition that can contribute to care outside of the country, but this is very unusual.

GUIDANCE ON IMPLEMENTING HEALTH INSURANCE SCHEMES

a. **Effective communication**. UNHCR should plan with the government and partners effective communication strategies for implementing insurance schemes in order to fully inform refugees about the existence of the scheme, its advantages and disadvantages, the documentation process when applying, and seeking treatment and reimbursement. Refugees will also need to be made aware of their rights within the scheme and their obligations (for example the amount of co-payment they would be making and how quickly they have to inform the insurance company of their admission to hospital).

b. **Monitoring of the scheme**. UNHCR and partners should monitor the scheme closely and regularly to ensure that the agreement is being followed, refugees are

accessing services and receiving reimbursement, and ultimately that the scheme is cost-effective and non-discriminatory according to what has been agreed upon. A further socio-economic survey may be undertaken in countries in which very large numbers of refugees have enrolled to measure the impact of the insurance scheme on the household economy and levels of poverty amongst refugees. UNHCR and partners should continue to monitoring the public health status of both enrolled and non-enrolled refugees to compare the impact of the scheme. Such monitoring will require a clear plan and require financial and human resources.

c. **Continued negotiation**. UNHCR and partners should continue to negotiate with the insurance company to ensure that insurance premiums are not unduly raised and that the best deal possible has been obtained for refugees. As numbers of subscribers increase, UNHCR may be able to renegotiate reduced premiums and co-payments by refugees and/or increased ceilings. Analysis of disaggregated data according to services may allow for improved negotiations. Other schemes and alternative financing mechanisms to the current insurance scheme should be assessed to ensure that the best option has been chosen at that moment.

d. **Continuing advocacy**. UNHCR and partners should continue to advocate that the government meets the public health needs of refugees. This could include, for example, the government taking on more of the costs of an insurance scheme, negotiating a better deal on behalf of the refugees or making more PHC services available at no or low cost to refugees on the same basis as for nationals.

e. **Continued integration.** UNHCR and partners should continue to advocate that refugees be given the same rights to public health services (e.g. immunisation, antenatal care, HIV and AIDS treatment, tuberculosis treatment) as nationals.

f. **Ensuring quality**. UNHCR and partners should continue to advocate that refugees access quality health services at a level that is similar to nationals. Furthermore, when the care is insufficient, UNHCR and partners should work with the government to improve the services. This may involve ongoing work with governments, partners and a wide range of actors to monitor and support improvements in government facilities and to strengthen the government's public health system.

DESCRIPTION OF EXISTING HEALTH INSURANCE SCHEMES AVAILABLE TO REFUGEES

UNHCR's Public Health and HIV Section in the Division of Programme Support and Management has analysed different health financing options for refugees. Insurance schemes have sometimes not been adopted for refugees as they were either not available or not sufficiently advantageous. This situation is beginning to change as more cost-effective and beneficial health insurance schemes for refugees are becoming available.

This section presents some schemes that were assessed; some were rejected and others were implemented. There is no 'one size fits all' scheme for refugees. In every country health insurance schemes will need to analysed and compared with all other financing options.

CAMBODIA

Since March 2012, UNHCR has enrolled approximately 100 refugees and asylum seekers living in Phnom Penh into the SKY health insurance scheme developed by GRET, an NGO involved in creating sustainable development. SKY is a voluntary community-based health insurance scheme and targets the "near-poor" (workers in the formal and informal sectors). The monthly premium is USD4.5 single rate, and USD6, USD7 or USD8 depending upon the size of a family. Seven public health facilities including 2 major hospitals are directly accessible by the members. They are scattered in different locations of Phnom Penh ensuring good geographical coverage. The treatment of most acute medical conditions is covered by the scheme, but longer term treatment for chronic diseases are not. UNHCR is in the process of negotiating a complimentary arrangement with GRET to extend the health insurance coverage to some chronic diseases.

By becoming SKY members, health benefits for refugees and asylum seekers are being enhanced while the cost for UNHCR is expected to be significantly reduced. SKY receives external financial support to cover its administrative cost, and the collection of premiums allows them to meet the medical expenses. Costs were reduced by changing the physicians prescribing practices over many years. UNHCR is planning to introduce a cost sharing system for the monthly payment of the premiums. The agency has also begun to support various income generating activities that will help refugees be able to pay for their premiums.

COSTA RICA

The Costa Rican health system, considered one of the best in Latin America, principally behaves as a National Health Service offering economic and geographical access to all. This applies to all refugees and asylum seekers for emergency treatment, and to all children under 18 years and women in need of reproductive health services. No one is denied needed health care in these cases, independent of their migratory status. But for other health needs (consultations for men and women not in reproductive health) there is a national health insurance scheme that in principle is mandatory for all nationals and residents (including refugees).

Refugees or asylum seekers with no membership card can be excluded from access to adequate health care. Dependents are covered automatically. Monthly contributions are shared between employers, employees and the State. The State is also supposed to cover the costs of those with no capacity to pay (i.e. indigents that are formally recognized as such even without a card, but no refugees have so far been able to benefit from this scheme). Those refugees with capacity to pay do register and contribute from their own resources, but many cannot afford to do so. UNHCR does cover some vulnerable refugees on an ad hoc basis, but this is rather limited due to the cost, and only asylum seekers and refugees with chronic illnesses currently benefit from this opportunity.

ISLAMIC REPUBLIC OF IRAN

The Islamic Republic of Iran has been very generous in hosting over one million refugees over the past twenty years, mostly in urban settings. A recently concluded re-registration exercise (Amayesh 7) conducted by the government now places the number of registered refugees at approximately 900,000.

UNHCR and the government have assisted nearly 350,000 refugees to enrol in a voluntary health insurance scheme. Refugees, like Iranians, have to pay for health services apart from those suffering from haemophilia, thalassemia and renal failure who benefit from a special government-provided health insurance scheme. The government provides, almost free of charge, PHC that includes antenatal care, family planning, vaccination and treatment for tuberculosis to both nationals and refugees. UNHCR and the government analysed three private and government health insurance organisations and chose one scheme that was believed to most benefit the refugees.

The chosen scheme is run by a public-private company that was selected by the Iranian Ministry of the Interior and UNHCR. It operates a subsidised insurance scheme with very

few exemptions (and unusually, no exclusion or pre-screening for pre-existing illness). At the time of planning in late 2011, UNHCR estimated that approximately half of the registered refugees (approximately 534,000) would choose to subscribe to the scheme with a monthly subscription cost of the equivalent of USD2.60 a month per refugee. UNHCR makes three different payments into the scheme: 1) pay a lump sum to reduce the overall premium for refugees (down to USD1.43/month); 2) pay the premiums of approximately 10-15% of those refugees who are considered vulnerable; and 3) pay part or all of the co-payments of vulnerable refugees. At present, nearly 350,000 refugees have enrolled into the scheme representing 40% of registered refugees in Iran (based on Amayesh 7 statistics); a little over 200,000 beneficiaries met the vulnerability criteria of UNHCR (the estimation of vulnerability turned out to be much higher than originally estimated); and, approximately 20,000 beneficiaries have utilised the services and received reimbursement from the insurance company.

UNHCR encourages refugees to only use government hospitals where costs are less than in the private sector. Significantly, UNHCR chose a scheme that will meet the costs of hospital services (including emergency care, childbirth, imaging, cardiac and neurosurgery and ambulance transport) but not primary and referral outpatient consultations. The reason for this was that only one insurance company would offer to cover the cost for consultations, but with significantly higher premiums. Furthermore, it would be cumbersome for refugees to get reimbursed for this care and create a substantial administrative burden for UNHCR. Significant exceptions to coverage in the scheme include treatment of psychosis, mental disability, childbirth above three births (as is the case for Iranian nationals) and the effects of natural disasters.

UNHCR will also continue to support the Iranian government to ensure that refugees continue to benefit from those previously mentioned heavily subsidized PHC services. The agency has identified 200 Iranian government PHC facilities across the country that it encourages refugees to use. UNHCR and the government agency responsible for refugee affairs has undertaken a preliminary evaluation of this large health insurance scheme and is negotiating with the insurance company to reduce out-of-pocket expenses, increase reimbursement ceilings, and encourage equitable access for all refugees, particularly the poorest and most vulnerable. UNHCR's office in Tehran has improved the standardised eligibility criteria for identifying vulnerable registered refugees, which includes those that have lost their jobs and who have no income, destitute and single-parent families, unaccompanied minors and elderly, refugees with life-threatening illnesses, and pregnant women with high risk pregnancies. UNHCR will continue to work with the relevant government agency to conduct strong community sensitisation programmes for the scheme. The agency has proposed that its involvement in the scheme will be time limited.

JORDAN

In 2009, when UNHCR Jordan explored the insurance scheme for the Iraqi refugees, primary and secondary health services were provided by UNHCR's implementing partners- Caritas, the Jordanian Red Crescent and the International Medical Corps. Thirty-six percent (36%) of Iraqi refugees over 18 years had a chronic illness. The poorer third of Iraqi refugee families spent between a quarter and half of their family budget on health expenses. In 2009, UNHCR conducted an analysis of a private health insurance scheme to assess what benefits it could potentially offer. The analysis came to the following conclusions:

- The health insurance scheme would exclude many categories of people. These included non-Iraqi refugees, those aged 65 years and over (16% of Caritas' clients), newborns with congenital and hereditary diseases (such as thalassemia), people with sexually transmitted infections, and those with neurological diseases and mental illness. Thus, an implementing partner would still be needed to provide services for many people depending upon their age and type of disease.
- It would cost 26% more to provide health services using the health insurance scheme than with the current service providers; the scheme only paid for 53% of average annual costs for a person with diabetes, and only 29% costs of someone with ischaemic heart disease.
- UNHCR would require increased administrative and technical capacities to oversee the private insurance scheme.
- UNHCR would require a stable budget allocation rather than incremental increases of budget targets over the year in order to best plan for the numbers of refugees to be covered by the annual insurance scheme.


Iran / UNHCR

GEORGIA

UNHCR Georgia, as part of its integration policy for refugees, disengaged from individual health assistance provided by a local partner as of 31 March 2011, and successfully financed access for all refugees to health insurance on a group basis. A suitable insurance company was selected, and a community sensitisation campaign was undertaken. Subsequently, the insurance company covered the costs of numerous refugee medical cases including emergency ambulatory and stationary services as well as deliveries and surgeries. UNHCR has not yet succeeded in including refugees in the national health insurance scheme as available to Georgian citizens. This is the ultimate goal, but certain national legislation still needs to be amended.

KINSHASA, DEMOCRATIC REPUBLIC OF CONGO

In Kinshasa, refugees benefit from a voluntary mutual health insurance scheme run by the Catholic Diocesan Medical Service (BDOM - *Bureau Diocésain des Oeuvres Médicales)*. Refugees access 11 out of a total of 52 health centres run by BDOM, one referral health centre, and one general hospital. Referral between levels occurs systematically with refugees normally having to access the health centres before being referred on with a UNHCR authorised transfer note. All referrals are internal within the BDOM system. Transport is provided either by BDOM for emergency cases or by UNHCR's implementing partner in Kinshasa. Although it works well for refugees, the numbers involved are very small (approximately 1,600 consultations per month). UNHCR pays USD30 per family per month for the insurance. There are no exclusion criteria for refugees. Most of the BDOM insurance budget for refugees is spent on hospitalisation for secondary care. BDOM considers that refugees are, on average, higher health care consumers than other population groups in their scheme.

WEST AFRICA

An analysis was undertaken on insurance schemes in several countries. One of the main obstacles to introducing a scheme was that UNHCR rarely had a sufficient budget to cover essential PHC and emergency health care costs of refugees, yet alone engage in a health insurance scheme. UNHCR in **Gambia** and **Benin,** for example, had less than a tenth of the budget needed to pay for the schemes during their initial phases.

The overall strategy was that UNHCR's contribution would decrease by 20% per year while that of the refugees' would increase by the same percentage, so that after 5 years, refugees would meet the total cost of the health insurance schemes. However, in practice, nearly all

refugees in **Ghana, Togo and Burkina Faso** found it difficult to increase their payments; thus, UNHCR continued to pay nearly the entire premium for the refugees. Due to limited funds and differing contexts, UNHCR employs different scenarios in different countries. For example, in some countries, only vulnerable groups have been enrolled, and the criteria differ according to context.

In **Ghana,** many Liberian refugees did not want to enrol in the government's district health insurance scheme because they believed it would decrease their chances of being resettled in a third country. It was, however, *positively* discriminating for people aged over 70 years who only had to pay a registration fee but not a monthly premium. Ninety-five percent (95%) of diseases and conditions were covered by the scheme. When some refugees did enrol, the costs of meeting illnesses not covered by the scheme were usually unaffordable for the refugees and for UNHCR. Furthermore, refugees had to wait an initial three months before being able to access the public and private accredited services supported by the scheme. Most of the urban and camp refugees registered in the national health insurance scheme, which are over 6000 persons, are vulnerable persons.

In **Guinea**, UNHCR provided financial support to a private mutual health insurance in order for it to establish itself in the refugee hosting areas in Nzerekore and Conakry the following year. Both refugees and host had equal access to the system. UNHCR did not pay for refugees' registration. Refugees accounted for 30% among total enrolees in Nzerekore the first year.

In **Nigeria**, UNHCR recently signed an agreement with a private mutual health insurance scheme enrolling approximately 3,000 urban refugees in Lagos. Within this scheme, those inscribed will be covered at 100% as long as they attend a network of selected health facilities, but there are some medical conditions that are not covered with this insurance.

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