Social Health Insurance for Developing Nations

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January, 2006

A monograph jointly sponsored by the World Bank Institute and Harvard University for the teaching of social health insurance.
Draft Forward

In dozens of developing countries, special technical groups are busy advising Ministers of Health, Ministers of Finance, Vice-Presidents and Presidents on the feasibility of Social Health Insurance (SHI) as a way of mobilizing revenue for health, reforming health sector performance, and providing universal coverage. Yet, evidence and ‘how-to- guides on the aims, design and implementation of social health insurance (SHI) derives largely from relatively rich, developed countries. Such countries can be sharply distinguished from low income, developing countries in terms of relatively high per capita expenditures on health, large urban/formal sectors, relatively low dependency ratios, ample administrative know-how, and diversified provider markets that can serve and satisfy clients. In contrast, evidence on the design and implementation of SHI in developing countries is hard to come by. This is precisely the reason for this book.

The authors begin with a review of design and implementation issues that challenge SHI in low and middle income countries. This sets the stage for five case studies on Ghana, Kenya, Philippines, Columbia and Thailand that shed light on the trials and tribulations of implementing SHI in contexts far less hospitable than in relatively rich countries. Accordingly, the case studies provide a rich roadmap of the design options, aims and intentions, mid-course revisions, successes and pitfalls involved in SHI. The authors conclude by presenting lessons learned and policy implications.

Perhaps the most important message of this volume is that social health insurance should not be seen as a ‘magic bullet’ that will solve the woes of health care financing and provision in developing countries. It clearly holds potential to make a positive contribution, but success comes slowly because many potential drawbacks and risks lie ahead. It is hoped that by contributing to awareness of these issues that this volume will assist policy makers in developing nations to chose the right things, and then, once chosen, to do them right.

Acknowledgement

Note: an acknowledgement – to be drafted later – would explain that this volume evolved as part of the research agenda in support of the Flagship Learning Program on Health Sector Reform & Sustainable Financing, jointly developed by the World Bank Institute and faculty from the Harvard School of Public Health. It is expected the volume will be used widely in WBI Flagship course offerings to Bank client countries around the world.
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Chapter 1: Introduction, Context, and Theory

William C. Hsiao

I. INTRODUCTION

Good health is necessary for our well-being. Even billionaires can’t enjoy life when their health is poor. Good health is also required for economic and social development (World Health Report 1999). Workers have to be healthy to work and children have to be healthy to attend school and partake in other activities. Yet most developing nations lag far behind what they could achieve in health for their people. At the same time, poor health has another critical impact: it causes poverty. Large health expenditures bankrupt families. Studies show that health expenditures are a primary cause of impoverishment (Fu 1999).

In developing nations, besides poor nutrition and unclean water, poor health is principally caused by inadequate prevention and lack of reasonable access to basic health care, and impoverishment is caused by the lack of risk pooling and insurance (WHO 2000). Both of these causes can be attributed to under-funding of health care. Moreover, many countries compound these problems with inefficient use of their scarce resources.

Most low and lower middle income nations face difficulties in funding their health care. While nations declare similar admirable goals to provide their citizens with equal access to a reasonable quality of health care and to prevent health caused impoverishment, the reality is starkly different. The exalted aims are not backed-up with adequate public funds or a rational financing system. As a result, poor health, impoverishment and disparity are prevalent. Now, many nations place their hope in social health insurance (SHI) as a solution.

A wave of SHI initiatives has swept across Africa and Asia. The World Health Assembly just passed a policy resolution for the World Health Organization (WHO). It decided to use SHI as the strategy to mobilize more resources for health, pool risks, provide more equal access to health care for the poor and to deliver better health care. WHO is encouraging its member states to move ahead with SHI and they will provide technical support for nations to develop SHI (WHO, May 25, 2005).

Besides its capacity to mobilize additional funds for health care, SHI also has the potential of three other advantages. It can:
• Target public funds more effectively to the poor in comparison to providing free public health services for all.
• Shift the subsidy from the supply side to the demand side, which may improve efficiency and quality of health services if the SHI agency becomes a prudent purchaser of services.
• Improve insured’s access to health care by utilizing the capacity of private sector providers.

This paper examines the principles, design and practices of SHI for low and lower middle income nations and the necessary conditions for its viability and sustainability. We particularly focus on the design and implementation issues. In planning and implementing SHI, we rely on simple theory of insurance, logic and experience around the world. A nation has to overcome many barriers to establish a successful universal SHI and this paper aims to aid readers to understand these barriers and design measures to overcome them.

Five Case Studies

Five country cases follow this concept paper, offering evidence and greater details on the operations of SHI to illustrate the key issues brought out in this paper.

The Kenya case shows good intentions embodied in the SHI law and its desire to overcome the organizational deficiencies of its current Hospital Insurance Fund, but the implementation of the SHI law has been delayed because cost and financing were not adequately considered in the planning and legislative process. Also there was inadequate political consultation in the passing of SHI law.

Ghana moves ahead of Kenya, entering its initial implementation stage with a plan and budget that may cover 25% of its population under its SHI. Ghana adopted an ingenious approach by relying on a community financing approach to build its SHI. It remains to be seen, however, whether Ghana can afford its specified generous “minimum benefit package” for its people, how effective the district level community-based health insurance schemes can be in enrolling the eligible people, and whether they can manage the health service delivery satisfactorily.

Philippines implemented its SHI a decade ago, and its coverage reached 81% in 2004 with large government subsidies to increase the enrollment of the poor during the election year. Since then the government reduced the subsidies for the indigent, and enrollment has fallen to 63%. PhilHealth (Philippines’ SHI agency) encountered a significant evasion rate (estimated as high as 70%) among the small employers and major barriers in enrolling the non-poor farmers and informal sector workers. Moreover, PhilHealth acts mostly as a traditional health insurer, paying claims instead of protecting the insured from price “gouging.” It permits providers to balance bill the patient for what PhilHealth does not pay. As a result, the insured are not receiving the risk protection intended by SHI.
Moreover, one study found that payments by PhilHealth to private providers largely went to them as “rents” (profits) rather improved health services.

Colombia also adopted a SHI scheme a decade ago and committed significant additional tax revenue plus a significant portion of the contributory regime’s premium to subsidize the poor. They benefited from the insurance coverage and improved access created by the SHI. Nonetheless, a decade later only 70% of the people are covered and the benefit packages for the poor and near poor are substantially less comprehensive than the one for the employed workers. Managed competition deployed by Colombia to improve the efficiency and quality of health service delivery has not yielded the expected results. Meanwhile, SHI seemed to have given the most benefit to public hospitals and their staff with higher income and wages when Colombia was unable to reduce its supply subsidy to public hospitals while they are also being paid by SHI. Adverse selection has also emerged as a serious problem under the Colombian SHI.

Thailand attained universal coverage with its SHI by committing general tax revenue to pay the premiums for all the poor, near poor, self-employed and informal sector workers. SHI acts as an active and prudent purchaser by paying providers based on a capitation method. Such a measure has improved the efficiency and quality of health service delivery. Thailand continues to face the challenge that civil servants and employed formal sector workers have more generous benefit packages than others (i.e. the poor and informal sector workers).

Structure of this chapter

This chapter examines the requirements and necessary conditions for low and lower middle income countries to provide universal SHI to their people. The biggest challenges are to raise enough funds to pay the premiums for the poor, collect premium from the non-poor self employed and informal sector workers, and establish an effective SHI agency that serves as an active and prudent buyer of health services for the insured. Section II presents a general context in which SHI is being developed. We first examine the reasons for poor health system performance. Hence we can reflect on what problems would be addressed by SHI. Next we assess the current funding sources for health care and analyze how SHI may fit into the current financing conditions. Then we present the typical starting point from which a universal SHI may evolve, highlighting companion reforms must take place if SHI is to succeed. Section III explains the theory and definition of SHI which provides a framework for analyzing the role of SHI and how it can be use effectively to pool risks, target subsidy to the poor and mobilize additional funds for health.

Chapter 2 examines the key issues in designing and implementing SHI and we use five country cases (Kenya, Ghana, Philippines, Colombia and Thailand) to analyze these issues. The first section presents the key design issues in developing SHI. The laws, policies and experience of the selected countries are used to illustrate the choices made by these nations and their impacts. The details of practices and experiences of the five nations are given in the cases. Section II presents the key implementation issues, using the
experiences of these selected nations to show their approaches to implementation and their success and failures.

II. THE CONTEXT

SHI needs to be understood in a context. SHI is a financing approach to mobilize funds and pool risks. The newly mobilized funds should be allocated for the poor and near poor to improve their financial access to health care. SHI may be a solution for a critical part of a nation’s systemic problem in health care, but not necessarily a solution for the whole problem. We begin with an examination of the causes for the poor health conditions in many developing countries in Section A. We investigate where SHI provides a solution and where companion reforms have to take place to achieve the desired outcomes. In Section B, we assess the current sources of financing for health in many developing countries. In examining the sources of financing, we establish a basis to examine where and how nations can mobilize more financial resources for health. In Section C, we present the starting point of the typical system of financing and delivery of health care in most developing nations. Countries usually launch SHI to move the current health system in a new direction to improve health and reduce poverty. A nation has to know its initial starting point so the government can navigate from its present position to a new destination.

A. The Context

Poor health prevails in so many developing nations. The average infant mortality rate in many African countries still exceeds 100/1000 live births as compared to the 4/1000 live births in advanced economies. Asian nations usually do better, but still show poor results. Indonesia has infant mortality rate of 31/1,000, India 63/1,000, China 30/1,000 (World Bank 2005). Another grave concern pertains to the large disparity in health status between the poorest and richest within a country. For example, the infant mortality rate is 6/1000 in urban China compared to 56/1000 in poor rural regions of China. Immunization rates are still below 80% for many countries such as Nigeria and Uganda. Obviously, we can do better.

What evidence do we have to explain these unsatisfactory outcomes in developing countries? Besides under-funding for health, studies found at least four other reasons:

- Poorly targeted public resources tend to favor the rich.
- Many countries are unable to manage their public health services efficiently and effectively. In other words, they are unable to transform money into efficient and good quality health services.
- The location and organization of public sector primary care do not match rural people’s demand.
• Health risks are not appropriately pooled, thus the poor, low-income, elderly and less healthy people are excluded from insurance.

Many countries have not been able to manage their public health services efficiently and effectively. Public facilities operate under bureaucratic rules and managers have little power to make financial and personnel decisions. Often, operational funds do not reach the public facilities on a timely basis. Consequently, we observe low staff productivity and facilities that run out of drugs and supplies regularly (Mills 1995, Foster 1993, World Bank 1993).

Moreover, even when facilities are built and staffed and funds spent, they are not located near all the people and/or do not produce the services that are demanded and valued by the people. As a result, these facilities are under-used (Bitran 1995, Gilson 1995, Zere, McIntyre, Addison 2001). In the rural areas, qualified practitioners often do not want to work at the sub-district and village level (if the public service even reaches this level). Frequently, physicians simply evade or do not regularly attend the facilities, and/or they provide poor customer service. Yet, people want primary care within an hour or two of walking distance (Hjortsberg, 2002; Diop et al, 1998; Liu et al, 2002). This means the services for rural residents have to be at the village level. However, governments persistently establish primary care at the sub-district level which is far away for most rural residents. As a result, when villagers become sick, most of them use their meager income to pay traditional healers, private practitioners and drug peddlers who are located close-by. When a serious illness strikes, villagers flood into and overcrowd the public and charity hospitals.

Studies have documented that most developing countries allocated their governmental resources to the public hospitals located in urban areas. These public facilities were mostly used by the more affluent urban people, particularly the use of tertiary hospital services. As a result, public funds were disproportionately spent for the rich (Castro-Leal et al. 1999).

Another cause of the access barriers involves risk pooling. Most developing countries do not rely on the insurance mechanism to pool their health risk. When they do, the risks are pooled only for the civil servants and perhaps for workers in the formal sector. These people are employed and tend to be more affluent. The poor and the less healthy people are not able to benefit from these insurance pools (Dror and Jacquier 1999).

The combination of under-funding, inefficiency, far away primary care facilities, and the lack of risk pooling leads to the unmet health needs in developing countries. Mobilizing additional funding for health care only offers a partial remedy for the systemic health problem. When a country embarks on a SHI strategy, there is no assurance that more and better health care will be delivered. The government also must plan how the funds can be transformed into effective services. Each country differs. For example, India seems to spend close to a reasonable amount (6% of their GDP) for health, but their health systems are not able to provide effective services for the rural and poor population (Peters et al. 2002). In contrast, India’s neighboring country Sri Lanka spends a modest amount (3.7%
of their GDP) and has produced enviable results in health status and risk protection (WHO 2005). In comparison, we have greater confidence that additional public funding by Sri Lanka could yield significant gains while we cannot say that about India unless it adopts companion reforms.

B. Sources of Funds for Health Care

SHI is a method often used in developed countries to mobilize funds and pool risks, but has not been used frequently in low and middle-income countries. They rely mostly on general revenues and direct out-of-pocket payments as sources of health care financing. Figure 1 shows the sources of financing for selected developing countries. It illustrates that general revenues and out-of-pocket payments are the dominant sources. Meanwhile, SHI plays a very minor role in low-income nations, but as their national income grows, the share of health care financed by SHI increases.

![Figure 1: National health accounts for selected low- and middle-income nations](image)

Until recently, many countries only paid attention to the amount spent by the government for health care, failing to recognize that perhaps the public spending made up only a modest part of the whole. Patients’ out-of-pocket payments are a significant portion, and these payments are inequitable, placing a greater financial burden on the less healthy and poor people, and deterring patients from seeking necessary health care. Equally important, individual out-of-pocket payments do not pool risks. Figure 2 shows the extent of out-of-pocket payments and how their role varies among nations.
Under-funding and Capacity of Government to Spend More

Literature has extensively documented that health spending as a share of GDP varies significantly between developing countries (for example, World Health Organization 2002). Nonetheless, most developing countries are under-funding health (i.e. resources spent are measurably below the “needed” level.) One obvious cause for under-funding is that governments allocate too few dollars to health. However, the amount of tax funds a nation can spend on health is limited by the government’s ability to collect tax revenue. Another consideration involves the political economy of a nation that influences the budget allocation between health services and competing priorities.

Small and narrow tax base

Most developing countries have a narrow tax base because of their small industrial base and large shadow economies characterized by labor working in the informal sector. It is extremely difficult to collect taxes from the shadow economy. Moreover, most developing nations do not have a strong infrastructure and administrative capacity to collect tax effectively. These factors limit these countries from generating large sums of tax revenue.

As a nation develops economically, its tax base increases because both its shadow economy shrinks and its administrative capacity improves. The tax revenue rises as a result and the country has more resources to support a larger public sector. Figure 3 compares the size of the public sector for countries at different income levels.
Figure 3: Average Tax Revenue by Countries’ Income Level

<table>
<thead>
<tr>
<th>GDP per capita</th>
<th>Low-income (&lt;$760)</th>
<th>Lower-middle ($761-3030)</th>
<th>Upper-middle ($3031-9360)</th>
<th>High-income (&gt;9360)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Total Tax Revenue of all Countries in Income Group</td>
<td>14.6%</td>
<td>29.4%</td>
<td>22.3%</td>
<td>30.9%</td>
</tr>
</tbody>
</table>

Source: IMF 2002: Mobilization of Domestic Resources for Health

**Budget Allocation**

Many international health experts and NGO’s have argued that the government should reallocate their budget and spend more for health. Within a government, health has to compete with other programs for government resources. The political economy of a nation determines the share of the general revenue to be spent on health. Most developing nations allocate only between 6-10% of their government budget to health (World Bank 2005). More importantly, the governments have not allocated adequate public funding for the basic health care for the poor. The poor and low-income people usually have little political voice and influence on government decisions. While many African nations have signed the Abuja Declaration to allocate 15% of the government budget for health, no nation has actually achieved this goal. Table 3 compares the shares of government budget allocated on health and the share of health budget that comes from international donors.

| Table 1: Government and External Donors’ Expenditures on Health, Selected African Countries, 1995 and 2000 |
|----------------------------------|-----------------|-----------------|
| Country                      | Government Expenditures on Health as % of Total Government Expenditures | External Resources for Health as % of Government Expenditures on Health |
| The industrialized nations (other than the United States) use general revenue or compulsory social insurance to pay and provide health care for their citizens working in the non-formal sector. |
|---------|------|------|------|------|
| Eritrea | 4.1  | 4.0  | 32.8 | 60.7 |
| Ethiopia| 5.8  | 5.5  | 17.9 | 35.6 |
| Ghana  | 8.3  | 7.9  | 15.8 | 24.1 |
| Kenya  | 6.6  | 8.1  | 32.3 | 38.3 |
| Lesotho | 9.6  | 10.8 | 5.5  | 6.8  |
| Malawi | 11.3 | 14.6 | 50.2 | 86.7 |
| Nigeria| 1.7  | 3.0  | 33.4 | 32.2 |
| Tanzania| --  | 8.1  | --  | 50.0 |
| Uganda | 9.2  | 9.5  | 84.0 | 96.0 |
| Zambia | 11.5 | 11.2 | 22.0 | 24.8 |
| Unweighted Average | 7.6 | 8.2 | 32.6 | 45.5 |


Donor Dependency

Many Sub-Saharan African nations rely heavily on donors. Figure 4 shows the share of total national health expenditure that comes from donors. These funds are channeled through the government and can be the source for more than 25% of the public health budget. Donor financing raises two issues: to what degree are a nation’s health priorities being driven by donors and are their priorities compatible with domestic priority? Second, how stable is donor financing, and will the health programs be sustainable if the donors withdraw their support?

Figure 4: Donor dependence – share of total national health spending from external sources
C. The starting point – the prevailing three-tiered system of financing and provision of health care in developing nations.

SHI mobilizes additional funds for health care. However, more funds do not necessarily mean more and better health care. Companion reforms must take place if the additional funds are to be transformed into effective and efficacious services. To assess what companion reforms are necessary, a nation has to know where its national health system is now. Only when we clearly know where we are, then we can plan where to go and how to get there. We describe the common characteristics of health care system in most developing countries to illustrate where the likely starting place.

Public health, prevention, maternal and child health services, and HIV/AIDS programs usually receive inadequate priority and funding from domestic governments (WHO 2005). When international donors give priority to these programs and support them with funds, most governments have to establish vertical programs to deliver the specified services. Each vertical program creates its own bureaucracy, clinics, and supply systems. The programs often overlap with each other, competing for the limited number of trained health personnel and fighting over the few available vehicles and other resources. In addition to impairing other preventive and primary care services, the sustainability of these vertical programs is a serious concern because of their dependence on unstable external funding.

Beyond the preventive and special vertical programs, the government takes responsibility, on paper at least, for organizing, managing and delivering primary, secondary and tertiary curative services to all citizens. However, governments in developing countries can seldom fund these services adequately and rarely have the capability of delivering these services efficiently. Consequently, the financing and provision of curative health services is segmented into three tiers according to patients’ ability to pay (Stiglitz 1999).

In the top tier, affluent households demand high quality services, which are mostly provided by private sector physicians and private small hospitals that charge high fees. The affluent patients pay directly out-of-pocket for these services. However, affluent households obtain tertiary (highly specialized and expensive) services from public teaching hospitals because they require large capital investments that the private sector usually does not make.

In the second-tier, middle-income households finance and obtain their health services differently than the affluent. Many developing nations have insurance programs for civil servants and some large employers (such as banks) also cover their employees under insurance programs. These insurance programs (some may be social insurance) select and contract with the better public and private facilities to provide services. These facilities generally charge the insurance plan on a fee-for-service basis. If a developing country has adopted social health insurance, often the SHI plan operates its own clinics and medical facilities that offer higher quality services than the public facilities.

In the third tier, public clinics and hospitals service the vast majority of the population—poor and low-income households. In Africa, charity hospitals also play an important role
serving this population, charging them on a fee-for-service basis but reducing the fees for the poor. Although public health services are nearly free, the waiting line is often long, health centers are far away, physicians may not be on duty, clinic hours are inconvenient, facilities are dilapidated and crowded, drugs and other supplies may not be available, and providers are unfriendly. Because of these conditions, when people suffer from non life-threatening illnesses, they often resort to self-care, or seek care from indigenous practitioners. Household expenditure surveys consistently find that poor and low-income households spend a significant portion of their income on drugs and indigenous medicine (for example, Ha et al. 2002). Only when they are seriously ill, requiring hospital care, they are compelled to rely on public hospitals.

When a nation starts with a three tiered system with people having vastly different quality of health services, the critical issues are: how to reorganize the segregated public and private health care delivery systems under SHI; how to integrate the vertical programs into the general health system; how to use resources and modern management to improve efficiency and quality of preventive and medical services; and how to assure all the insured have equal access to similar quality of health services.

III. THEORY AND PRINCIPLES

Social health insurance had been developing for more than a century when Bismarck established it for Germany in 1883 (Saltman and DuBois 2004). Basic principles, theories and practices have long been published in insurance and actuarial science literatures. In recent decades economists and political scientists took an interest in this subject and offered their interpretation of SHI from their respective disciplines. This section first provides a brief summary of the theory of SHI based on insurance, actuarial and economic literature. Next we turn to a practical aspect—the preconditions that make SHI viable.

Theory of SHI

The uncertainty of illness underpins the theory of social health insurance (Rothschild and Stiglitz 1976). Annually, a small number of people suffer from serious illness and disability. These medical problems can incur large medical expenses unaffordable to most. But faced with life and death decisions, people would still seek expensive medical services and the costs would bankrupt those patients and their families. Consequently, most people want to be insured against these risks because they are risk averse. On the other hand, some people may not demand insurance because they believe illnesses and accidents would spare them, or they suffer from myopia or ignore risk of impoverishing their families. Their irrational choice could create serious social problems. Moreover, people are also selfish. If health insurance is voluntary, the young and healthy people do not want to pool their low health risk with high risk people such as the elderly and the chronically ill. This leads to adverse selection, a critical problem under voluntary group insurance.
Meanwhile, the poor and low-income households can’t afford the insurance premium, so they require subsidization. For all these reasons, nations that desire universal health insurance must look beyond a purely voluntary system.

SHI pools low and high risk people, avoids adverse selection and myopic vision, and enrollees contribute according to their ability to pay. SHI creates an exchange in a public market where the insured pay a designated amount (premium) and receive a set of benefits. Hence, the premium does not come from government’s budget (general revenues), but instead from a designated compulsory premium, usually assessed as a percent of salary. The free-standing nature of SHI financial operation makes it transparent and accountable in terms of how much people pay and what they pay for. In short, SHI is a modern socioeconomic program to promote equity and create solidarity. It widely pools risks and redistributes income (i.e. the monetary value of health insurance) between the rich and the poor, the healthy and less healthy, and the old and young.

As SHI evolved, it took on an additional function: prepayment. Basic health services and drugs may be affordable to many people and they could be rationed by price—having people pay out-of-pocket. However, price rationing could deter many people from seeking early detection and treatment of illnesses until they become serious acute illnesses. Studies found prevention and primary care are more cost-effective in improving health than secondary and tertiary medical services, but people often do not demand enough primary care because their illnesses are not so obvious or acute (Somers 1984, Fries et al. 1993, Leaf 1993).

There is an evidence-based theory for SHI to cover small health expenses (i.e. prepayment.) Studies of voluntary purchases of health insurance found that people prefer insurance plans that not only insure against catastrophic medical expenses, but prepay for smaller health expenses, because there is a greater chance the insured would receive some payout from these plans. History of early American private insurance showed that most people would purchase prepayment plans over catastrophic insurance (Somers and Somers 1961). For these reasons, modern SHI becomes more than an insurance plan that insures only against large medical expenses. Instead, SHI systems are also designed to serve as a prepayment plan for less expensive health care such as preventive services and primary care. Prepayment encourages people to use more of these cost-effective services. However, prepayment and insurance creates “moral hazard” and people may demand unnecessary services and drugs (Pauly 1974). Copayment and coinsurance are designed to reduce moral hazard.

**Definition of SHI**

Social insurance has three distinct characteristics. First, social insurance is compulsory, the major feature that distinguishes social from voluntary private insurance. Under social insurance, everyone in the contributory regime group must enroll and pay the specified premium (contribution). The contribution is most often specified as a percent of wages; the economic literature calls it a dedicated payroll tax. For the poor and certain special
categories of population (such as aged and children), the government may decide to pay the premium on their behalf. They are called the enrollees in the subsidized regime.

The second distinguishing characteristic pertains to eligibility. Citizens only become entitled to the benefits when they have paid the required premium. In other words, SHI is not necessarily universal, unlike general revenue financed national health insurance where every citizen is covered (such as the Canadian system).

Social insurance has a third distinguishing characteristic. Its premiums and benefits are described in a social compact, usually expressed in a legislation that established the economic exchange between the two parties—the enrollee and the social insurance plan. The legislative process creates an implicit bargain and a social contract between the SHI and those covered by it. Citizens agree to pay a certain amount, with some confidence that it will be used fairly and effectively to fund health care for all who are part of the system. The benefit package specifies in writing the benefits the insured are entitled to, in exchange for the payment of the premium. The contribution rate and benefits are secure, and not subject to government’s annual budgetary decisions that tax-funded systems like Canada faces.

Recent development introduced a modification in the definition of SHI. Developing countries embark on SHI aiming for universal coverage, but realize that it is not possible to achieve it in the near future. Nonetheless, the SHI scheme gives a comprehensive framework for all the people to be insured eventually. At the start, some category of the people would enroll voluntarily because the SHI agency lacks the ability to compel all affluent people to pay. The voluntary groups usually consist of the non-poor farmers and workers in the informal sectors. In the long-run, when a nation reaches more advanced stage of socioeconomic development when most of its citizens become employed in the formal sector, the SHI could become universal, compelling all non-poor to enroll.

**Major pre-conditions for SHI**

**Incentive for people to pay premiums**

There has to be a motivation for people to be willing to accept and pay for SHI, even in compulsory systems. People have the incentive to prepay only if they currently have to pay for their health services. If adequate and good quality public sector services are provided free or nearly free, why would people who use these services want to enroll and pay for SHI? People will not want to pay for SHI unless user fees are high, or if patients have to purchase drugs and supplies, or if public services are so poor that many patients pay out-of-pocket for private providers.

A comparison of the Ghanaian and Tanzanian experience can be instructive. Ghana shifted to the “cash and carry” (user fee) system in 1999 and patients had to pay fairly high user fees. Consequently, voluntary prepayment plan such as the community-based Mutual Health Organizations (MHO) flourished, growing from 4 MHO funds in 1999 to 157 by 2002. In 2003 Ghana was able to pass legislation to establish SHI nationwide. On
the other hand, Tanzania does not have high user fees. Since 1996, Tanzania has tried to attract and enroll its population into its district-based insurance, Community Health Funds (CHF). The government subsidizes 50% of the premium, regardless of income level. However, the enrollment rate remains very low, ranging from 5%-20% of the eligible population. Those who enroll tend to be the elderly and the sick.

*Certification of qualified providers*

Generally, developing nations have paid little attention to the safety and quality of services rendered in the private sector, other than established minimum standards such as licensing requirements. Following initial licensing, the actual safety and quality of health services are hardly monitored or regulated. In the rural areas, drug peddlers and indigenous doctors have a free run because regulations are not enforced. Moreover, the governments rarely require private facilities to be publicly transparent in their financial operations or adopt modern financial and medical record systems. Under such condition, quality of private sector health services is highly variable and it is difficult to detect fraud and price “gouging” when SHI pays claims.

There are also problems with the publicly provided health services. Governments manage public facilities with bureaucratic rules in which modern accounting, financial and clinical information systems are likely to be absent. The average clinical quality level of public facilities might be better than the private facilities, but is highly variable. All of these deficiencies have to be remedied before (or concurrently) for SHI to gain sustained public support, perform its role to assure reasonable quality of health care and sustain its operation financially.

The SHI administration should prudently purchase health care for its insured. A prudent purchaser has to ensure the safety and quality of services and drugs meet certain standards. Equally important, SHI has to be able to control fraudulent claims and supplier-induced-demand for unnecessary services, “inside” dealings between doctors, pharmacies, and testing laboratories, etc. The conditions in the health service delivery market often require SHI to set safety, quality, financial and audit standards beyond what currently exist in order for the SHI to be a responsible and prudent purchaser. Under such circumstances, SHI has to develop and implement new standards and enforcement mechanisms to assure the safety and clinical quality of health care, standard medical record and accounting systems and inspection and auditing procedures of providers. Establishing the standards and a system to enforcing them have to be a high priority before SHI can be implemented.

*Rapid Economic Growth*

Rapid economic growth is an important consideration in sustaining a SHI program and to expand it to achieve universal coverage. Health care costs grow rapidly because of inflation, rising expectations and expensive new drugs and technology (for example, in China: Liu and Hsiao 1995). Unless wage rates are rising rapidly, the premium rates for the contributory regime would have to be increased frequently. Meanwhile, governments need rising revenues to subsidize the rising premium rates for the poor as well as expanding the SHI coverage.
Rapid economic growth enables a nation to move towards universal coverage. When a nation’s economy grows, the employees in the formal sector as a proportion of population increases and the poor as a proportion of the total population decreases.
Chapter 2:  
Design and Implementation of Social Health Insurance  

William C. Hsiao  

I. DESIGN  

SHI is a tool to achieve several goals: mobilize more funds for health, promote equal access to reasonable health care for the poor, pool health risks and prevent impoverishment, and improve the efficiency and quality of health care. Essentially, the design of SHI involves maximizing the social benefits under financial and political constraints. The policymakers have to decide on at least seven major questions in order to pursue the goals of SHI. These seven issues are inter-connected. For example, policymakers have to trade-off between the goals of covering as many poor as possible with offering them a comprehensive benefit package. Meanwhile, the cost of the benefit package is also determined by how SHI contracts and pays providers. The seven major questions are listed here, and then each is discussed in greater detail for the remainder of the design section.

1. Who and how many people can be enrolled under the contributory regime and how to collect premium from them? The SHI premiums they pay are the new source of financing that brings additional fund for health, while pooling their risks.

2. How to define poor? How many of the poor should be subsidized, how much would that cost and how will it be financed? These decisions determine the government budget required for funding the poor, how many poor will gain equal financial access to health care and how much health gains will be produced.

3. How to enroll the non-poor self-employed and informal sector workers and collect premiums from them? These decisions influence whether a nation will be able to achieve universal SHI and pool the health risks widely. Also, it would reduce fraudulent claims because often non-covered people “borrow” the eligible cards of the covered people to obtain health services.

4. What is the benefit package for each group and how much will that cost? These decisions determine the premium rates for the contributory regime population, the government budget needed to fund the poor, people’s access to health care and insurance protection.

5. What’s the nation’s fiscal capacity in achieving universal coverage and a projected time table for it? Such a planning disciplines the decision-makers to adapt a long-term strategy for SHI and examine the steps that have to be taken.
to achieve universality in equal access to health care and nationwide risk pooling.

6. How to govern the SHI? Should the SHI agency be a public, quasi-public, or private non-profit? What’s the best and viable administrative structure of the SHI? These decisions influence the efficiency and effectiveness of SHI operations.

7. How can SHI improve health care delivery? How should providers be contracted and paid? These decisions influence the efficiency, cost and quality of health care. In turn they affect the population’s health, the premium rates and government’s budget for subsidizing the poor.

Population Composition

Who Is Likely To Be Covered Under SHI?

The success of a SHI depends largely on the ability to enroll and collect premiums from the contributory population and the government’s capability to subsidize the premium of the poor. The law defines who is eligible to enroll and pay a premium and who will be subsidized. SHI for developing countries usually divides the population into four groups: compulsory enrollment and payment, voluntary enrollment and payment, fully subsidized and partial subsidized. Their premium and benefit package for each group may even differ.

The government can compel and enforce the large employers in the formal sector to enroll and pay the premium for their workers and families. The non-poor self employed (including the farmers) and informal sector workers may have to be treated differently. It is difficult to enforce compulsory premium payment on this group. Often, developing nations have to offer them voluntary enrollment. The poor should be fully subsidized and the near poor may be partially subsidized.

We use Uganda to illustrate the potential coverage of SHI by the four categories of population. As conveyed in Table 2, only about ten percent of the Ugandan working population work for firms with 10 or more employees, the poor people comprise close to 50% of the population, and near poor an additional 20%.

These statistics indicate that those who pay for social insurance comprised, at best, about 10% of the households. However, enrolling these 10% of households into social insurance could significantly benefit the poor. Usually these 10% live in cities and consume close to 35% of the government tax funded public health services. Under a well-designed SHI system, these households would pay their own health expenses through premiums, and the money the government previously spent for them could be used to pay the premiums of the poor.

<table>
<thead>
<tr>
<th>Employment</th>
<th>Income→</th>
<th>High</th>
<th>Middle</th>
<th>Low/ Poor</th>
<th>Total Economically Active Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed in formal sector</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td></td>
<td>25,000</td>
<td>232,000</td>
<td>---</td>
<td>257,000</td>
</tr>
<tr>
<td>Private</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer with &gt;10</td>
<td></td>
<td>110,000</td>
<td>358,000</td>
<td>100,000</td>
<td>568,000</td>
</tr>
<tr>
<td>Employer &lt;10</td>
<td></td>
<td>30,000</td>
<td>200,000</td>
<td>398,000</td>
<td>628,000</td>
</tr>
<tr>
<td>Employed in informal sector and self-employed</td>
<td>80,000</td>
<td>200,000</td>
<td>537,000</td>
<td></td>
<td>817,000</td>
</tr>
<tr>
<td>Farmers/ Hunters</td>
<td></td>
<td>250,000</td>
<td>750,000</td>
<td>4,760,000</td>
<td>5,760,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>415,000</td>
<td>1,740,000</td>
<td>5,795,000</td>
<td>8,030,000</td>
</tr>
</tbody>
</table>


Population covered under contributory regime

Enrollment and premium collection can be implemented relatively easily for workers employed by formally registered and large enterprises such as banks, manufacturing corporations (often defined as the formal sector). These employers have to maintain accurate and reliable personnel and wage payment records for business purposes and the SHI plan can rely on these records to collect the premiums. Otherwise significant portions of these workers and their employers may evade the premium payment. However, even for the formal sector employees, adverse selection remains a critical problem. To overcome this, SHI has to create incentives for workers to enroll by requiring employers to pay a share of the SHI premium (private group insurance also does the same to reduce adverse selection). Kenya, Ghana, Colombia, Philippines and Thailand all designed their SHI so that employers pay one-half or more of the premium.

Evasion, however, has been a serious problem for the employees of small employers. A significant portion of this population is unwilling to pay, particularly high income employees whose contributions are large when the premium is assessed as a percent of their wage. Worldwide experience has taught us that evasion is the major challenge for successful implementation of SHI. For example, a study found that 10 years after its implementation, 35% of those Colombians who should pay under the contribution system are still able to evade their payments.

Compulsory contributions to social insurance do have economic implications. One question is: will this negatively impact the labor market and economic growth? Employers have a certain willingness-to-pay for various kinds of workers. On some level, they may not care whether this is in the form of wages or fringe benefits. How much the employers’ share of social insurance contributions can be passed back to the workers...
(by paying them lower cash wages) depends on labor market conditions, including the strength of labor unions. For countries with weak labor unions, empirical studies reveal that over the medium run of a few years, workers will pay for the largest share of health insurance premiums (either directly or in the form of lower wages), even in instances where employers nominally contribute a share on their own (Gruber and Krueger 1991). If total labor costs are really not affected by premium changes, then the extent of social insurance’s impact on the labor market and economic development should be minimal.

However, workers may reduce their labor supply when they value cash wage more than the health insurance premium deducted from their pay checks. Meanwhile, when employers can’t shift their premium cost back to the workers, they reduce demand for labor. These negative effects on the labor market could reduce economic growth.

**Population covered under the subsidized regime**

The poor can’t afford the premium. The government has to fully subsidize the poor and partially subsidize the near poor. All nations, rich or poor, provide a government subsidy to the poor for their premiums when they established universal SHI plans. The poor and near poor comprise a large share of the total population of low income countries. Ghana, Colombia, Philippines and Thailand estimate about 40%, 50%, 37% and 17% of its people live in poverty respectively. It would require a huge budget to subsidize more than one-third of the population. Consequently, developing countries design their SHI to gradually phase in the poor. The hope is that a nation’s economy will grow over time, and fewer people will need subsidization, which happened in the more recently industrialized economies such as South Korea (Yu and Anderson 1992) and Taiwan (Lu and Hsiao 2003).

**Non-poor self-employed and workers in the informal sector**

Extending SHI to cover the non-poor, self-employed and employees in the informal sector presents the greatest challenge to SHI. The self employed includes farmers/fishermen/hunters, shop keepers and day laborers. The employees in the informal sector include house maids, waiters in small eateries and hired help in small shops. Their household income is above the poverty line and they should pay the premium. However, they do not work in an organization where the SHI premium could be deducted from their salary. While they are not poor, they are likely to have less ability to pay for SHI because their income is lower, on average, than the formal sector employees. Often, the government has to subsidize these non-poor to provide the incentive for them to enroll. This means the government must commit a substantial amount to subsidize the non-formal sector workers and their families for SHI to become universal.

**How long would it take for SHI to be universal**

While many developing countries mention that they have or desire to have SHI, that does not mean it is universal coverage. Most countries set universal SHI as a goal and move toward it over time. Realistically, universal coverage maybe achieved in two or three decades if developing nations’ economies grow rapidly. The SHI plans can first cover the civil servants and formal sector employees, then move step by step to include other
groups until universal coverage is achieved. Today, nations openly acknowledge that they will take step-by-step actions to expand the coverage from a small portion of population to universal coverage. For examples, Kenya laid out a time table that it will have 62% population covered by 2012, Ghana has the goal of half their population in the next decade, and the Philippines wants to achieve universality by 2010. It took Thailand 25 years to achieve universal coverage, which occurred when its GDP per capita reached US $2,400 ($7,010), and only after the government decided to use general tax revenue to pay the premium for most Thais (i.e. all the workers in the informal sector, the farmers and self-employed, the poor and near poor.)

In summary, worldwide experience tells us that social insurance can be effectively implemented in developing countries for formal sector workers plus those who are largely subsidized by the government budget such as the poor and near poor. Universal coverage can only be achieved when a nation’s economy has grown to close to US$3,000 per person. The contribution regime can be enforced for the workers in the formal sector—civil servants and workers employed by larger formal registered companies (e.g., more than 10 workers). The poor obviously need full government subsidization to pay their premium and the near poor needs partial subsidy. Enrolling and premium collection of the non-poor workers in the informal sector and the farmers is the major hurdle for universal coverage. Nations have tried different approaches to enrolling them; community-based pre-payment schemes seem to hold the greatest promise as being tried in Ghana, Tanzania, Colombia, China and India. In many instances, the governments still provides a modest subsidy to induce the non-poor individual households to enroll in order to minimize adverse selection. Philippines is attempting to enroll the non-poor informal sector workers through guilds, cooperatives and micro-financing organizations.

**Targeting the Subsidy – Who to Subsidize? How much to Subsidize?**

Generally, nearly 50% of people in low-income countries live in poverty. Financing their health care adequately requires significant budget allocation. SHI shifts the government’s subsidy to the demand side instead of the traditional subsidy to the supply side (i.e. budget allocated to public hospitals and clinics to provide free care). Targeting the poor brings up two key issues in designing SHI; defining who is poor and near poor and identifying them fairly and accurately. Identifying the poor usually requires an income test. Accurate assessment of those who are eligible for the subsidy entails complex procedures and detailed income data. The designers of SHI have to balance between administrative complexity (and its associated costs) with prevention of cheaters. Sometimes corruption also creeps in when local officials use their power to award subsidies to their relatives, friends or political supporters. Ghana delegated the eligibility determination for subsidy to the local (district) governments but with strict oversight from the SHI agency. Philippines did the same. Colombia relied on its elaborate and systematic scheme called SIS-BEN that periodically investigated and classified every household into an income class.

Instead of income testing, some countries subsidize easily identifiable groups for which most of them are poor. Examples include farmers in certain poor regions, residents in a
poor district, elderly, orphans and disabled. For example, Ghana subsidizes the elderly and children. This approach might be preferable because it reduces leakage in subsidy and lowers administrative costs.

The amount of subsidy required varies by the premium rate. The premium for the poor is largely determined by the benefit package offered to them and production efficiency of health care. Rationally, the basic benefit package should be designed with actuarial cost estimates prepared to ascertain the budget required to fund it. Balancing the benefit package design with its cost has been a critical political problem in establishing SHI. Political leaders want to promise the most but pay the least. As a result, nations often design a generous basic benefit package and include it in the SHI legislation. However, its cost and budget are not given (perhaps not even analyzed).

Kenya, Ghana and Colombia are good illustrations of this political legislative process. Consequently, the legislation could be an empty promise and can’t be implemented due to lack of funds. Kenya is under-going a painful process now to reconcile the benefits promised and budget required to fund it. Often, a nation has to compromise and give much fewer benefits to the poor. Colombia passed the legislation that intended to give everyone the same benefit package. In the implementation stage, Colombia had to face the reality about the cost of such a uniform scheme and compromised with a three tiered benefit structure (explained in the next section.)

**Modest or comprehensive benefit package?**

A key policy decision in designing SHI involves what services are covered in its benefit package. Cost is directly related to the comprehensiveness of the benefit package. This issue immediately raises the question of what is “affordable” for different population groups.

The benefit package that can be financed by employer/employee contributions may not be affordable by self-employed workers. The question often becomes a choice between, “comprehensive benefits but fewer people covered versus shallow benefits but more people covered.” When a country adopts SHI, its government often is unwilling or unable to allocate enough tax funds to finance the same benefit package for the poor. As a result, the poor and the self-employed get a much smaller benefit package than those who are employed in the formal sector. As the five cases illustrate, all five nations except the Philippines have different benefit packages for different groups. The poor get much less. In the Philippines case, SHI for the poor became a key Presidential election strategy to gain the votes from that group, so full benefits were extended to them. In fact, the poor are the only group with outpatient benefits.

In designing an “affordable” benefit package, a question arises as to what services should be included. The current academic literature argues that cost-effectiveness studies should be the basis for selecting the services to be included or excluded (Gold et al. 1996). In reality, a benefit package can’t be based on cost-effectiveness studies because this field is
still at a primitive stage of development. The benefit package of SHI has to achieve two social purposes: health gains and protection against impoverishment from catastrophic medical expenses. The current cost-effectiveness studies only consider health gains and totally ignore financial risk protection.

**Fiscal requirements to fund SHI**

Beside political considerations, the major technical issue about the viability and sustainability of SHI relates to its cost and whether sufficient funding can be provided for it. While the goal may be to establish SHI to achieve universal equitable access to reasonable health care, the tax funds required to finance it could be prohibitively high. Planning a sustainable SHI requires *several rounds of analysis*. Each round requires a careful specification of the people who are eligible to be covered, a detailed benefit package and actuarial analysis of its cost, and how the cost will be financed. This process is when “rubber meets the road;” when noble visions, however worthy, face a reality test—the fiscal resources required to achieve it.

The Kenya case illustrates the fiscal challenge facing the government. The legislation intends to provide universal SHI. The employees in the formal sector will pay a percent of their wage to cover their full cost and others will pay a flat-rate premium. The government plans to impose an 11% value-added tax to fully subsidize the poor which makes up around 30% of the Kenyans. While the president proposed a legislation to establish SHI and the parliament passed it, the president has delayed signing the legislation into law because he is uncertain the contribution rate will be sufficient in the long term to fund the SHI (see the attached Kenya case.)

Ghana established an SHI program in 2003. Regulations clarifying the intent of the law were issued in 2004. Ghana takes a different strategy than Kenya. It plans to enroll 20% of the total population in three years and 50% of its citizens in 15 years. These seem to be realistic goals but it remains to be seen whether the Ghanaian community-based based insurance scheme can overcome the difficulties in enrolling the poor, the non-poor farmers and informal sector workers to achieve the 50% goal.

Philippines passed a law and established a universal SHI program in 1995. It intended to achieve universality by year 2005. Unfortunately, to date 40% of the population remains uncovered. Most of them are the near poor and non-poor self-employed and workers in the informal sector. Now, the Philippines declares that its goal is to achieve universality by 2010.

Colombia implemented SHI in 1993 that intended to achieve universality within a few years by compromising the benefit package for the poor (which make up 40% of the total population) to be only one-half of what the employed workers received. The government allocated large additional funds to pay the premium for the poor. Still, eleven years later only 67% of the population was enrolled. The near poor and the informal sector workers have largely remained uncovered by SHI.
Thailand has just achieved universal coverage. As the case explains, the successful candidate for Prime Minister put universal SHI on top of his election promises. Once elected, the Prime Minister allocated sufficient government funds to pay the premium for all the poor, the near poor and non-poor informal sector workers. Nonetheless, their benefit package is less than those employed in the formal sector, which leaves Thailand with a multi-tiered system.

Table 4 offers a summary that compares how the five nations (cases) designed their SHI that produced the population covered under the three regimes: contributory, fully subsidized and voluntary enrollment of non-poor self employed and informal sector workers. The cost of the SHI is largely determined by its benefit package design.
<table>
<thead>
<tr>
<th>DESIGN ISSUES</th>
<th>Kenya</th>
<th>Ghana</th>
<th>Thailand</th>
<th>Philippines</th>
<th>Colombia</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of population currently covered by SHI</td>
<td>20% (in current hospital insurance fund)</td>
<td>20% (in three years)</td>
<td>100%</td>
<td>60%</td>
<td>67%</td>
</tr>
<tr>
<td>% of population who contribute</td>
<td>20%</td>
<td>NA</td>
<td>35%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>% of population that is poor</td>
<td>50%</td>
<td>40%</td>
<td>17%</td>
<td>37%</td>
<td>50%</td>
</tr>
<tr>
<td>% of population fully subsidized</td>
<td>Not implemented yet</td>
<td>Elderly, children plus a few poor (limited to 0.5% of each health ins. plan)</td>
<td>65%</td>
<td>23%</td>
<td>33%</td>
</tr>
<tr>
<td>% of pop. non-poor self-employed or informal sector employees</td>
<td>80%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Included in the 30% who contribute. An additional 4% receive partial subsidization.</td>
</tr>
<tr>
<td>% of non-poor self-employed enrolled</td>
<td>0%</td>
<td>NA</td>
<td>NA</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>Benefit package – universal or tiered</td>
<td>Not decided</td>
<td>Intend to be universal</td>
<td>Tiered</td>
<td>Universal</td>
<td>Tiered</td>
</tr>
<tr>
<td>Fiscal capacity for universality</td>
<td>Fiscal worries have stalled the NSHIF before it started – would require large new taxation</td>
<td>Plans to enroll 50% in 15 years, which will require full subsidies for poor and partial for farmers and informal</td>
<td>Achieved universality with lesser benefit package for subsidized regime</td>
<td>Most of the uncovered are near poor and informal workers – remains to be seen if they can be covered</td>
<td>Despite benefit compromises and large allocated funds, most near poor and informal workers uncovered</td>
</tr>
<tr>
<td>Administrative structure</td>
<td>One new independent fund</td>
<td>Competition between community-based organization and private plans</td>
<td>Several funds, trying to merge</td>
<td>One fund</td>
<td>One fund</td>
</tr>
<tr>
<td>Health services delivery improvements</td>
<td>Not implemented yet</td>
<td>Too early to assess</td>
<td>Pay providers capitation</td>
<td>Modest, acts mostly as passive insurer</td>
<td>Managed competition tried without measurable improvements</td>
</tr>
</tbody>
</table>
Governance of SHI

SHI shifts some power from the supply to the demand side to balance the power between patients and providers. SHI empowers the patients to demand satisfactory health services and the SHI agency should act as the wise and prudent purchaser for the insured. But how should SHI be structured to best represent the interests of the insured? Several issues have to be addressed at the design stage.

Governance, narrowly defined, means the structure and process of “control” mechanisms used to hold the SHI agency accountable to the beneficiaries and funders (i.e. government and employers) of the scheme (Savodoff, 2005). Also, governance pertains to the integrity of management. According to economic, political and organizational theories, several critical choices have to be made in governance, taking into account a country’s political structure and institutions, climate of law enforcement and power of interest groups.

- Ownership of the SHI agency—public, quasi-public or private non-profit. Ownership drives the motive and purpose of an organization. Public organizations are controlled by the government and closely tied to politics and political influence while private non-profit organizations are more independent and insulated from political interference.

- Organizational structure—Organization can be analyzed using principal-agent theory. Beneficiaries and premium payers act as the principal who selects and contracts the Board of Directors as their agent to represent and pursue the principal’s interests. In turn the Board contracts with the Chief Executive Officer as the agent to pursue the goals set by the Board. Hence the composition and election of Board members and how they are accountable back to the beneficiaries and premium payers become the paramount concern in the organizational design.

- Management structure—The management team must be given discretion in financial and personnel decisions so they have the power to use the financial and human resources to achieve the goals of the SHI agency. For example, if the employees of the SHI agency are civil servants, then the civil services rules on hiring, promotion and firing would tie the hands of the management.

- Government supervision—The state has to regulate and monitor the operations and performance of the SHI agency for two reasons. First is to assure the SHI serves the society’s interest and the original purposes under which it was established. Second is to supervise the SHI agency because the government usually is a principal funder of the SHI.

When a nation decides to establish a SHI agency as a public or quasi-public organization, it has at least three choices as to which ministry should have the responsibility. It can be given to the Ministry of Health (MOH,) the Ministry of Labor and Social Security, or a new independent ministry, the SHI agency. Most developing nations placed the new SHI agency under MOH, but with other ministers also serving on the supervising board.

Each structure has potential problems. Several studies of SHI agencies under the MOH found discouraging performance. It seemed the Ministries of Health were dominated by
medical professionals who were more concerned about the welfare of the supply side. The additional revenue generated by the SHI often largely benefited the suppliers of medical services. For example, Colombia found the salary of health staff increased more than 40% in real terms in the initial years of SHI. A study on Philippines found 80% of the increase in SHI financing went to providers as profits or higher salaries.

The Ministry of Labor (MOL) may not be able to manage SHI any better, however. MOL managed SHI tends to view insurance simply as a paying mechanism, rather than as a prudent organized purchaser for the insured. MOL managed SHI usually focuses on the fund balance by controlling what the SHI will pay and shifts the remaining liability to the patients. Providers are not prevented from “balance billing” and “extra billing” the patients. These MOL managed SHI systems tend to have low loss ratios and accumulate large surpluses in the SHI fund. In other words, the premiums are not necessarily used for the best benefit of the insured.

When the MOH manages SHI, the ministry has to go through a major transformation. SHI changes the role of MOH from a financier and operator of public sector services to one that sets policies and regulates all providers. Generally, the MOH has focused its attention on financing and managing the public facilities and its staff, while giving less attention to the well-being of the patients. Some Ministries of Health tend to protect the interests of the public providers and take a laissez-faire attitude toward the private sector providers. If a MOH starts at such a point, it would require a major change in its “corporate culture” for the ministry to represent the patients’ interest effectively. Moreover, to become an effective purchaser requires the MOH to reorganize its functions and operations.

**One Solitary Fund or Many Funds**

As explained in earlier sections, when developing countries adopt SHI, generally they have to separate the population into different eligible groups; each may have a different benefit package, premium and subsidy rate, and enrollment procedures. Hence, the question arises whether a nation should have one solitary fund or separate funds and administration for each group. This issue often generates furious bureaucratic competition between the ministry of health and the ministry of labor and social security over who controls the fund(s).

The decision between single and multiple funds influences how well a nation can provide equitable SHI when it approaches universality. Having separate funds for each group with their own administrative organization creates political and bureaucratic barriers to universal SHI with equal access to reasonable health care for all. The major challenge facing Thailand today is how to merge various funds once universal coverage has been achieved, because each fund has its own benefit package, payment method and rates for the providers, and bureaucratic rules. Even more importantly, each fund has established political vested interest group with strong supporters. It takes huge political capital to merge the funds to create a truly universal plan. Germany, the grandfather of SHI, has been trying to gradually merge its funds but still has almost 300 funds in existence (Busse and Reisberg 2004). Korea spent a dozen years mobilizing strong public support and a
presidential commitment before it was able to merge its many funds (Kwon 2003). Such was the case in Taiwan.

In addition to creating barriers to universality, having multiple funds creates duplication in administration and complicates the administrative work for providers who have to satisfy many different rules. Kenya, Colombia and Philippines learned lessons from the advanced economies and created a single SHI fund with one administration managing the overall policy, strategy, actions and subsidy programs. Separate departments and financial accounts were set up to administer the different group plans under one SHI administration.

Contrary to a single fund approach, some academics argue that many competing funds (public and private) would give people more choices of insurance benefit packages, enhancing economic welfare (Zweifel and Pauly 2004). Also, competition among insurers would promote efficiency in producing health services. These arguments overlook two facts: low-income countries lack the human resources and knowledge to start even one fund operation properly and a competitive insurance market becomes crippled by serious adverse selection and risk selection. Even more importantly, the advocates of multiple competing insurance funds have ignored the high sales and administrative costs associated with such an approach. United States, a nation relying on this approach, spends more than 25% of its total national health expenditure for administration, sales and marketing (Woolhandler et al. 2003). Taiwan, with a single universal SHI, spends less than 5% (Lu and Hsiao 2003).

As for the theory that competing insurance plans would promote greater efficiency in producing health services, evidence is mixed. Switzerland, a nation that used this strategy, spent the highest percent of its GDP (11.5%) on health than any nation but the United States (OECD 2005); the US, another nation with competing insurers, did achieve some savings for a decade under its managed care reform. However, the US had a surplus of hospital beds, laboratories and physicians that enabled competing managed care plans to bargain for lower prices and control utilization, producing one-time savings (Light 1999, Sullivan 2000). For developing countries, over-supply hardly exists.

Some developing nations have set up one fund to pool the risks nationwide, but using multiple competing insurance plans to serve as intermediaries for enrolling people and improving health services delivery. This approach will be presented in the next section.

**Improve health services delivery**

The designers of SHI have to consider how to promote the efficiency and quality of health care under SHI. Essentially, there are three strategies: create competition, use rational payment methods, and decentralization. In each strategy, the designer has to consider the role of the private sector and how to create a level playing field between public and private sectors to harness the private sector’s resources and its enterprising spirit.
Private providers (charity and for-profit) play a major role in delivering health services. These resources have to be harnessed and managed for the people’s benefit.

**Competition**

Competition is not an end, but a means to achieve some purpose: enhancing efficiency and the quality of health services. It can be introduced at two levels: insurance or provider. Nations with a single fund can create competition at the insurance plan level by having the SHI agency pay a risk-adjusted premium to competing insurance plans. In theory, they will selectively contract the highest quality providers with the lowest charges (Enthoven 1988). Such contracting would put pressure on providers to improve their efficiency and quality of health services. Ghana and Colombia follow this strategy. Ghana is initiating a system of community-based insurance plans and also allows private plans to compete (but can only enroll the non-poor people). However, Ghana establishes an unlevel playing field between community-based and private insurance plans by subsidizing the former. At this early stage, we have no evidence to assess the performance of Ghanian system. Colombia uses managed competition to establish a level playing field between public and private sector insurance plans. We summarize its ten year experience in the next section (Implementation).

Competition can be created directly at the provider level without competing insurance plans. Money follows patients in a SHI system. A single fund can combine three measures to establish competition among providers. The first measure offers the insured a choice of public and private providers where patients pay the same out-of-pocket payment; the second involves reforming the fee-for-service payment system to create better incentives for providers, and the third reduces the direct subsidy given to the public facilities so they have to compete for patients (subsidy reduction is discussed in the Implementation section).

**Selecting and Contracting**

Instead of being a passive payer of claims, the SHI agency should be a collective purchaser on behalf of the insured. As a prudent purchaser, the SHI agency has to think and act strategically and intelligently in the purchasing of health services. It should focus on outcomes and outputs instead of inputs, it should rely on competition whenever possible to select providers and set prices, it should ask what quality of services to buy, how to buy them and from whom (Preker 2005).

A prudent purchaser would identify the providers that have good or bad quality of health services and selectively contract with these hospitals and clinics. To identify the good or bad hospitals, the SHI agency may establish quality indicators and profile the providers accordingly. For example, the indicators could include each hospital’s risk-adjusted mortality rates, surgical complication rates, hospital infection rates, and hospital readmission rates after surgery. Some studies show that profiling hospitals and making the information public have measurable effects on hospitals’ performance (Hibbard et al. 2003).
The SHI agency may exercise its power as a monopsony to counter-act the superior market power of the medical providers. It can negotiate with hospitals and physicians for lower rates and purchase drugs in bulk through public bidding. However, this monopsony power can be abused by paying too low a price, possibly causing the service quality to suffer. Hence, rules to determine the reasonable cost of production for services have to be instituted. Alternatively, when several providers exist in the same service area, payment rates can be set by competitive bidding.

**Payment**

Health services delivery can be improved by payment method and level. Fee-for-service payment fosters supply-induced demand and health cost inflation. The capitation payment method encourages efficiency as well as any other package payment rates set prospectively (e.g. DRG) (McGuire 2000). Prospectively set package rates give providers the incentive to become more efficient because they can retain savings to use at their discretion. Thailand’s capitation payment system enhanced efficiency in health care delivery. In contrast, Philippines operates as a passive financial intermediary paying claims on fee-for-services basis and evidence shows it has not improved the efficiency of health service delivery.

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**III. IMPLEMENTATION**

Passing an SHI law and implementing it to be a beneficial program are two related but distinct affairs. Passing a law maybe easy, but effective implementation is a challenge. Often in attempt to escape the difficult trade-offs and unpleasant compromises, laws promise lofty goals unmatched with the resources needed to carry them out. Also, laws may not incorporate a practical strategy for achieving the goals, and may not consider the feasibility in implementing the laws. Even if the major questions are addressed in the design phase, the details still need to be worked out in implementation. In implementation, the state has to bring resource and commitment in balance with each other, with practicality prized over ideals; results valued over good intentions.

**Administrative Organization and Reform**

All five nations presented in this monograph decided to place the SHI agency under the MOH as either a public (Ghana and Colombia) or quasi-public (Kenya, Philippines and Thailand) agency. The government will exert strong control and manage the SHI for two reasons: the desire for political control and the government is the principal funder. Business, labor and public representatives serve on the Board but it is unclear how influential they can be.
Implementing SHI effectively requires a capable and efficient organization. Corruption and patronage become a major concern in establishing the SHI agency. Health insurance funds can accumulate a large surplus. The Kenyan Hospital Insurance Fund offers a good example of how a large insurance surplus can be diverted by corrupt officials into their own bank accounts. To prevent such a recurrence, Kenya is trying to structure the Board of the new NHI with a majority of members representing employers, workers and local governments. Other nations such as Thailand, Philippines and Colombia have similar structures. The Minister of Health serves as the chairman of board, and the board reports and is accountable directly to the president. Still, these board members were appointed by the president so corruption remains as a possibility unless other checks and balances are put in place such as independent outside audits, professional actuarial certification, and regular legislative oversight hearings.

The mission and corporate culture of the SHI agency greatly influence who benefits from SHI. Insurance mobilizes money but it has to be transformed into effective and efficient services. Philippines designated the mission of PhilHealth to be a financial intermediary—enroll people, collect premiums and pay claims. Hence, PhilHealth operates like a traditional private insurance company whose primary concern is solvency. It established fees with payment ceilings. On average, PhilHealth’s fee schedule covers only 30-40% of the provider charges. Patients have to pay the remainder. PhilHealth is solvent and has accumulated a large surplus, US $1 billion as assets. A study found that close to 80% of the PhilHealth payment became “profit” for hospitals and clinics, while only 14% of the payment was transformed into more or better health services for the patients (Gertler and Solon 2000).

In contrast, Thailand designated its National Health Security Office (NHSO) as a prudent purchaser of health services for the insured. NHSO selects primary contractors such as general and provincial hospitals and pays them a capitation rate for most of the covered services. NHSO also limits what providers can charge patients. A primary contractor organizes a network of providers by selectively contracting clinics and small hospitals to deliver prevention and primary care. A patient chooses his primary contractor and obtains most of his health care from one network. Under its system, NHSO improves the efficiency and quality of health services.

Another administrative organizational implementation issue is deciding which agency should collect the SHI premium. The Tax Collection Agency would be a logical organization, but as discovered by Colombia, this agency may not agree to this new responsibility. Another possibility is the Social Pension Insurance Agency. Often SHI is established in conjunction with a social pension plan. Thus the social pension plan would also be a logical agency to collect the premium. But they may not want to do it because pension contributions can be as high as 15-25% of taxable wages. Adding another 4% or more for SHI would exacerbate evasion problems.

Social health insurance is a sophisticated and complicated financing method. Managing and operating a SHI system requires many well trained administrators, financial, computer and management information specialists, actuaries and accountants and policy
evaluators and planners. It takes years to build up the human resources and computer and information systems. Ghana encountered difficulties in implementing its SHI because of human resource problems. Colombia tried to rely on the private insurance companies and community-based organizations (i.e. ARS) to enroll people, collect premiums and pay claims. It still has a long way to go after a decade. In comparison, Thailand was able to achieve universal coverage because it had invested in its human resources for policy planning and analysis for close to two decades.

Enrollment, collection of premium, targeting subsidy

**Contributory Regime**
Worldwide experience shows that it is feasible to enroll and collect premiums from civil servants, employees of state enterprises and workers employed in private companies with more than ten employees. Evasion is a problem but a modest one. However, evasion is a serious problem for enrolling workers employed by smaller private companies where some companies may totally evade, others may under-report salaries and some salaries were shifted into the allowance category. Colombia estimates its premium collection is only about 65% of the potential amount that should have been collected.

As for portion of population can be enrolled under the mandatory contributory regime, Kenya and Ghana estimated that 20% and 8% of their respective population could be enrolled. Recently, Thailand, Philippines and Colombia had 30%, 40% and 40% of their population covered under their contributory plans, respectively.

**Subsidized Regime**
Enrolling people who are fully subsidized poses no serious problem. However, if the eligibility criterion is based on income, then income testing is difficult to implement and often has many “leakages.” Colombia conducted a national income study, SISBEN, which investigated every household’s income and assets periodically, then classified each family into an income category. SISBEN categories have been used to determine who is eligible for subsidy. Ghana, Philippines and Thailand all relied on the local governments to assess who met the indigent criteria for subsidy. However, these systems are very susceptible to fraud. Thailand found fraudulent practices by local government officials who used the subsidy certificates to reward their political supporters, friends and relatives.

Commitments have to be matched with resources. Seldom low and lower-middle income countries commit enough resources to subsidize all the poor to enroll in SHI. Ghana, in its first year, subsidized close to 21% of its population to enroll, with approximately 10% children, 3% elderly and 9% adult indigents, while 50% of its population are classified as poverty households (Atim 2004). Philippines had subsidized almost all poor Filipinos in 2004 while its President ran an election campaign promising insurance coverage for the poor. A year later, however, only 20% of the Filipinos were subsidized even though 35% were classified as indigent. Colombia fully subsidized 30% of its population while 50% of households were classified as poor. Universal coverage requires resources to subsidize the poor, but unless the government allocates the necessary funds, it remains an illusion.
Enrolling Non-poor self employed and informal sector workers

Besides the necessary funding to help the poor, enrolling the non-poor self employed population and informal sector workers poses the greatest barrier to universal coverage. These people usually compose 25-40% of the total population in low and lower middle income countries. Nations usually try to have them enroll and pay voluntarily. Thailand tried many voluntary approaches for twenty years with various types of health card schemes. It found adverse selection posed serious problems: patients diagnosed with chronic diseases and pregnant women eagerly enrolled, while healthier people did not. Abuse was also a serious issue: relatives and close friends borrowed the insured’s card to obtain free health care. Finally, Thailand decided in 2002 to use general revenues to cover all those who are not insured under insurance for civil servants and for formal sector workers. Such an approach certainly can successfully achieve universal coverage. However, as pointed out in the Thailand paper, the Ministry of Finance is concerned about the future fiscal burden to maintain this system.

Ghana is trying a different approach to cover the non-poor self employed and informal sector workers. It relies on community-based insurance plans at the district level to enroll them. However, Hsiao (2003) pointed out that the district level schemes often do not gain the trust of the people for them to be willing to pay a premium. Moreover, district level schemes do not engage people’s active participation in managing the schemes and the benefits are not likely to be attractive. Atim (2004) found that district level funds in Sub-Saharan Africa have done badly in attracting people to enroll, but sub-district funds do better, and community funds do even better.

Like other countries, Colombia encountered serious difficulty in enrolling the non-poor self-employed. Recently, the government tried to overcome the barrier by providing some incentive (subsidy) for the near poor to enroll and developed a less generous benefit package so the premium contribution would be lower.

PhilHealth engages in innovative efforts to enroll the non-poor informal sector workers and self-employed through organizations they might belong to such as guilds, cooperatives, and micro-finance organizations. Such an approach could reduce adverse selection and enrollment costs. It remains to be seen how successful they can be in reaching universal coverage.

Long road to universality

It takes decades for a low income nation to develop and expand a SHI program to cover all of their citizens. Figure 5 compares the progress made toward universality by five nations. The dotted lines show the declared intentions of Philippines, Kenya and Ghana. The latter two just embarked on their SHI.
Improve the Efficiency and Quality of Health Care

Contracting

The SHI agency should select and contract providers based on quality of health care and prices. On the other hand, SHI, being a national program, cannot set the standards so high that many existing providers are excluded, because this would lead to a shortage of suppliers. It would also be politically difficult to deprive suppliers of their livelihood, causing closures and layoffs.

As the five nation cases illustrate, the SHI agency sets minimum quality standards and certifies which providers are qualified to serve the SHI enrollees. SHI agencies usually start with the existing governmental accreditation and certification standards and modify them. Most of the standards pertain to inputs such as practitioners’ medical qualifications, hospital staffing ratios, and basic hygiene and safety conditions. Most developing nations do not set outcome standards. The Philippines seems to have done the most to accredit providers with measurably higher quality standards than the usual licensing and accreditation requirements set by the MOH. Quality enhancement approaches such as “pay for performance” have not been adopted by the SHI of developing nations; the information and monitoring systems are too onerous.
The SHI agencies are able to encourage more efficiency and better quality through selective contracting than by merely setting standards. The contracting process sets the price the SHI agency will pay. When SHI uses bundled payment methods such as capitation, per admission or DRG to pay providers, those providers with higher costs would not want to contract with SHI unless they can bring down their cost to the payment level. Hence, the high cost providers are pressured to reduce their cost. Thailand and many Colombian health plans use this approach effectively. In contrast, PhilHealth largely pay providers on a fee-for-service basis and allows providers to do balance billing. Such a contracting approach has little impact in promoting greater efficiency and quality of health care.

**Payment method and rates**

Payment methods and rates influence the efficiency and quality of health services. The payment system creates the incentive structure that affects how health services are organized, their quantity and quality and the production process. Ghana delegates the decisions for payment methods and rates to the District Mutual Health Organizations and private insurers. It’s doubtful that the districts have the technical expertise and data to choose better payment methods and establish reasonable rates. Philippines continues to pay providers on a fee-for-service basis for most health care. Fee-for-service encourages inflation of health care costs and promotes supplier induced-demand. Colombia allows its numerous health plans to decide on their payment methods. A majority have adopted either a capitation payment method or a mix of capitation and fee-for-service method. Thailand, as previously stated, chose capitation payment method and was able to transform its health care delivery system to be more efficient.

**Drug list and regulation of drugs**

The benefit package of SHI has to specify the health services and drugs that will be covered. Just about all SHI programs have specified a drug list for which the SHI will reimburse the providers. The essential drugs have been fairly well defined, but not the drugs used in hospitals to treat complicated cases. New expensive drugs emerge continuously for cancer, arthritis, infection and pain. Most of them have marginal benefits, however small they may be. Most of the developing nations lack a rational procedure and the capacity to make rational decisions about which new expensive drugs should be covered under SHI.

In developing nations, pharmaceutical companies are given wide latitude in their advertisement to the patients (Lexchin 1996). The companies also lobby the SHI agencies to include their products in the reimbursable drug list. None of the five country cases were able to regulate the direct advertisements and the lobby activities.
Reduce Supply Side Subsidies

Under SHI, the public facilities could receive double payment for the patients they have treated. Under the current arrangement, the public facilities obtain their revenue mostly from government budgets for providing medical services. Under SHI, these facilities will also receive payments from the insurance plan for the insured patients they have treated. Understandably, the public facilities would welcome the increase in revenues and various reasons would be given why they need the additional revenues. However, this would be a misallocation of nation’s resources. The additional revenues become economic “rent” for the staff or investment into expensive high-tech medical equipment. An obvious solution is to reduce the supply subsidy when public facilities receive revenue from the insurance plan. Implementing such a policy can encounter serious political difficulties, however.

Figure 6: Hypothetical plan to reduce subsidies to public hospitals

Colombia had planned to synchronize the reduction of the public hospital subsidies with the expansion of its people being covered by SHI. The savings in supply subsidy was going to be shifted toward subsidizing more poor and near poor people to be covered by SHI. However, the political influence of public hospitals and their labor unions have deterred such a reduction. Consequently, the government lacks the funding to expand its subsidy to the near poor. Meanwhile, Colombian public facilities have dramatically increased the compensation of their staff and invested in new capital. Similarly, the previously mentioned study found that the insurance payments made by PhilHealth had largely gone for economic “rent” of the providers and only a modest portion went for improved
access to better services. In short, when introducing SHI, there has to be companion measures taken to simultaneously reducing the supply-side subsidies, otherwise the patients may not benefit much from the new SHI.

III. SUMMARY

Developing countries face several common problems: public under-funding of health care, inequity in financing, poor resource allocation, mismanagement and inadequate manpower. As a result, patients in most developing countries have to pay out-of-pocket large shares of their health expenses (see Figure 2) which creates an access barrier and impoverishes many families. At the same time, the affluent population uses a disproportionate share of the public health services. Poor quality of health services and inefficiencies are prevalent in public health facilities. Clearly, many health systems need reform.

Many health planners see SHI as a magic solution to most of these problems. However, the reality is quite different (summarized in the next section). Nonetheless, SHI does seem to have several strengthens. SHI:

- Can mobilize new, stable funds for health.
- Can pool the risk widely and provide insurance protection.
- Enables the government to target new public funds to the poor.
- Has the potential to shift existing public resources to the poor by having the formal sector employees and their families (usually comprised of 10-15% of the total population) pay for the “free” public health services they use now. Currently, they use a disproportional amount of those public health services, often amounts to more than 30% of public health spending. The government can retarget these spendings to the poor.
- Can be a strategy to reform the health care delivery system to produce higher quality and more efficient services and to make SHI affordable and sustainable.
- Can rely on both public and private facilities for health services provision.

However, a successful SHI requires that several pre-conditions are met. There must be an incentive to motivate people to contribute. This will happen if the pre-reform health system has high user fees or public health facilities offer very poor quality services. Then perhaps people will be willing to pay to remedy the current problems.

The key question in designing SHI is: how to match high-minded goals with scarce resources. Subsidizing the premiums for the poor and near poor requires large additional government funds. Otherwise, universal equal access and insurance protection would be an illusion. Most low-income countries do not have the tax revenues and are unable to reallocate sufficient funding from other sectors to health. Donor funds can cushion the SHI costs during the transitional period, but they are not a stable and sustainable long
term funding source. In establishing SHI, Kenya and Ghana have to impose new taxes to finance the subsidies.

SHI is a financing instrument that can reduce financial barriers for people to access health care. However, the physical supply may not be there. Most developing nations have a two- or three-tiered health care system now. The health care supply for the people in the bottom tiers must be improved if they are to have equal access to reasonable health care. Presently, most rural residents do not have primary care providers located close-by. Drug distribution is sparse and counterfeit drugs are prevalent. The governments have to invest in new facilities and manpower in under-served areas.

To assure quality and efficient health care and protect the insured, the SHI agency has to select and contract qualified private providers, establish rational payment systems, prevent providers from using their market power to “gouge” the patients and coordinate prevention, primary care and tertiary health services. These roles and responsibilities require a sound organization and sophisticated knowledge and skills. It takes years to build up the organization, human resources and information systems to manage and administer SHI soundly.

It takes decades for SHI to become universal. As a result, a nation has to operate a dual system during the developmental years when a significant portion of the population would not be insured. There has to be a health safety net for the uninsured to protect them from impoverishment and assure them some access to basic health care. This implies that the government has to institute a public assistance program or continue to provide somewhat “free” health services to the uninsured. Designing and operating such a dual system is a complex and difficult affair.

In short, it requires decades of complex processes to establish a successful universal SHI program. A developing nation must have rapid economic growth in order to attain universal coverage within a few decades. This implies there has to be continuous political commitment to expand the coverage and move ahead with SHI.
REFERENCES


Chapter 3: Kenya

Designing Social Health Insurance

Andrew Fraker
William Hsiao
CASE STUDY: KENYA

Kenya is a low income country on the Indian Ocean in sub-saharan Africa. It currently has a social health insurance program, though it only covers hospital expenses, and only one-fifth of the population is enrolled. This case study examines the design and implementation issues of their proposed National Social Health Insurance Fund, which has been sidelined because of financial sustainability worries. The proposed scheme would offer comprehensive benefits, and the government would attempt to eventually extend coverage to all Kenyans.

BACKGROUND

Kenya lies right on the equator in East Africa, bordered by Somalia, Ethiopia, Sudan, Uganda, Tanzania, and the Indian Ocean. Formerly part of colonial British East Africa, Kenya gained independence as a republic in 1963. There are 32 million Kenyans, and about 40% of them live in cities.² Forty-two percent of the population are under age 15.

Average income in 2003 was $1,037 (PPP basis), higher than neighboring Ethiopia, Somalia and Tanzania, but lower than Sudan and Uganda.³ Half of the population lives below the national poverty level. About 59% of the population lives on less than $2 per day, and 23% below $1. About three-quarters of the population work in the agriculture sector.⁴ Kenya’s rate of economic growth slowed in the late 1990s, and GDP even retracted slightly in 2000. Since then growth increased to 1.1% in 2001 and 2002, and 1.8% in 2003.

Kenya ranked 148 out of 177 countries in the United Nations’ Human Development Report (2004), and 17 out of 45 Sub-Saharan African countries scored higher. Kenya’s Human Development Index has fallen since 1990. In three decades, Kenyan life expectancy fell from 50.9 to 44.6 in 2002. However the infant mortality rate improved from 96 per thousand to 78 per thousand in the same period,⁵ but now is increasing.⁶ Between 4.7% and 9.6% of adults are living with HIV/AIDS.⁷

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² UNPD 2005, UN HDI 2004
³ World Bank World Development Indicators, 2005, (GDP per capita, PPP, current international dollars).
⁴ CIA World Factbook
⁵ UN HDI 2004
⁶ Sessional Paper 2 of 2004
⁷ UNAIDS, Epidemiological fact sheets on HIV/AIDS and STDs, 2004.
In 2001/2002 Kenya spent 5.1% of GDP on health, $19.20 per person, or about $56 on a purchasing power parity basis.\textsuperscript{8} Thirty percent of total health expenditure (THE) was financed from general government revenue, 54% was from private sources, mostly out-of-pocket payments, and 16% came from donors.

Publicly owned facilities provided services and goods accounting for 60% of total health expenditure, with privately owned facilities making up the remainder.\textsuperscript{9} About 55% of THE paid for care given at hospitals. Of this, 72.1% was spent at government hospitals, 22.1% at private for profit hospitals, and 5.8% at private non profit (mission) hospitals. The next largest group of providers were clinics and dispensaries, which made up 30.9% of THE. The private sector accounted for the majority of this category: 40.0% was spent at private for profit clinics, 24.0% at dispensing chemists (private for profit), 5.5% at traditional healers (private for profit), and 3.9% at private non profit clinics and dispensaries. Only 32.7% was spent at government clinics and dispensaries.

### Table 1. Health Expenditure

<table>
<thead>
<tr>
<th>Provider</th>
<th>Share %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>55.3</td>
</tr>
<tr>
<td>Public</td>
<td>38.8</td>
</tr>
<tr>
<td>Private for profit</td>
<td>11.9</td>
</tr>
<tr>
<td>Private non profit</td>
<td>3.1</td>
</tr>
<tr>
<td>Mental Health</td>
<td>1.4</td>
</tr>
<tr>
<td>Public Specialty</td>
<td>0.1</td>
</tr>
<tr>
<td>Private Specialty</td>
<td>0.0</td>
</tr>
<tr>
<td>Dispensaries &amp; Clinics</td>
<td>30.9</td>
</tr>
<tr>
<td>Private clinics</td>
<td>10.5</td>
</tr>
<tr>
<td>Public disp. &amp; clinics</td>
<td>10.1</td>
</tr>
<tr>
<td>Private chemists</td>
<td>7.4</td>
</tr>
<tr>
<td>Traditional Healers</td>
<td>1.7</td>
</tr>
<tr>
<td>Private non profit disp. &amp; clin.</td>
<td>5.4</td>
</tr>
</tbody>
</table>

### Figure 1. Health Expenditure as % GDP

| Total Health Expenditure as a Percentage of GDP, Selected African Countries |
|-----------------------------|--------------------------|
| Malawi                      | 9.8                      |
| Kenya                       | 7.8                      |
| Uganda                      | 7.4                      |
| Mozambique                  | 5.8                      |
| Zambia                      | 5.8                      |
| Ghana                       | 5.6                      |
| Sudan                       | 4.9                      |
| Tanzania                    | 4.9                      |
| Malawi                      | 4.5                      |
| Ethiopia                    | 3.6                      |
| Congo                       | 2.2                      |

### History of social health insurance

For more than 40 years, Kenya has had compulsory social health insurance for hospital services, however only about 7 million Kenyans, or 20% of the population are covered. Only those employed by the government or by some large formal sector employers are members. The most recent legislation (before the NSHIF bill) was the National Hospital Insurance Fund (NHIF), passed in 1998, which requires employees with income above a threshold to make monthly contributions.

The NHIF suffers from poor management and corruption – only 22% of the fund is actually used to pay for benefits benefits, with 25% going to administrative costs and 53% for

\textsuperscript{8} Kenya National Health Accounts, World Development Indicators for exchange rates.

\textsuperscript{9} 1% of expenditure went to providers whose ownership was not specified.
investment projects, such as the lavish new headquarters. A large portion of the accumulated reserve was lost due to corruption. The NHIF was intended to cover all hospital costs for members, but only paid for the cost of staying in a hospital, not the cost of treatment or drugs. NHIF beneficiaries must pay all of these costs out-of-pocket. Only 4.1% of total health expenditure in 2001 was financed by the NHIF.

Contributions are deducted from the paychecks of workers of known employers in the formal sector. The contribution is only on the salary portion of income—“allowances,” which can make up half or more of most government employees’ income, are exempt. The job of identifying employers and employees and enforcing contribution is left to the 23 NHIF branches. As of August 2003, only one of the branches had a computer network link to the central database, and none received information from tax authorities, with which all business must register. Reviewing claims usually means sending someone to the hospital to make sure that a patient is actually in the bed. The claims are then sent to the headquarters, which remits payment back to the regional hospital, usually a slow process.

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**THE DESIGN OF THE NSHIF**

The NHIF covers only 20% of Kenyans, and the benefit package is severely limited. Members have to pay most of the costs out of pocket. In June, 2004 Kenya’s government proposed the National Social Health Insurance Fund, which would give people access to high quality hospital care that is acceptable and affordable. The system will rely on a spirit of solidarity, requiring the rich and the poor, young and old, and healthy and sick to pool their risk together. Everyone with an income above a certain amount will make compulsory contributions and every citizen will receive hospital care without user fees.

The current system depends too heavily on out-of-pocket payments—even the public hospitals require user fees, and very few of the poor receive waivers. This means sick people often forgo care or else become burdened with debt. The new system seeks to convert out-of-pocket payments into prepaid funding—the current cost-sharing scheme will become a new social insurance scheme.

**Financing requirements and sustainability**

*Who is covered*

The National Social Health Insurance Fund Bill calls for the insurance coverage of inpatient and outpatient hospital care for all Kenyans and residents, regardless of age, health, economic or social status. Everyone will be legally obliged to register for membership.

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However, the government acknowledges that enrolling the entire population will not be easy. Their “gradual implementation scenario,”\textsuperscript{11} projects that it will take five years to cover all formal employees, and 9 years to cover the large self-employed group, consisting mainly of poor informal economy workers and farmers.

<table>
<thead>
<tr>
<th>Table 2. Gradual implementation scenario</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Employed</td>
</tr>
<tr>
<td>Employees</td>
</tr>
</tbody>
</table>

\textit{Benefit Package}

The NSHIF will cover both inpatient and outpatient hospital services. The comprehensive package includes surgical, medical and dental procedures, laboratory and diagnostic tests, drugs and medical equipment, physiotherapy, doctors’ fees, and food and boarding costs.\textsuperscript{12} The board will decide on the specifics within these categories – substantial omissions might be necessary to make the package affordable. Preventive and promotive services and drugs such as the national vaccination programs are not covered by the NSHIF, but provided by the Ministry of Health. Anything outside the benefit package and not provided by the MoH can be purchased out-of-pocket or with prepaid private insurance.

\textit{Supplementary Insurance}

The private sector will be allowed to offer supplementary insurance to high-income earners who are not satisfied with the NSHIF benefit package. The government anticipates that some will want supplementary insurance to cover more comfortable hospital accommodations.

\textit{Who is subsidized?}

The government has not defined who is too poor to pay for the premium, or how they will determine this. In a country with such a large proportion of poor people, the primary challenge to universal insurance is raising the funds to pay the insurance premiums of the poor. Deciding who to subsidize is therefore an essential part of the design of social health insurance, and the Ministry of Health is trying to delay this step until the implementation phase.

\textit{Revenue & expenditure}

The plan is to fund the NSHIF from five sources: contributions of private employers and employees, contributions of the self employed, payroll harmonization for civil servants (public employee contribution), general government revenue to subsidize the poor, and other, such as donations.

\textsuperscript{12} Kenya Gazette Supplement No. 29 (Bills No.10), 2004.
The bill does not specify the contribution rate for formal private sector employees. Originally the government plan was to collect contribution from employers and employees at a ratio of 2:1, but the most recent sessional paper now says 1:1. Since the rates will not be defined until the bill becomes law and the board makes their decisions, the WHO/GTZ mission uses the following possible employer/employee contribution rates in their estimates: 6/3, 4.66/2.33, 2.9/2.9 (as a percentage of the employees salary). The actual rates will most likely fall in this range if the NSHIF ever becomes law.

Paying the premiums of the poor will be so difficult that it seems the government is willing to use any of the NSHIF funding sources for them – a dedicated VAT or contributions out of general government revenue will not be enough. Some of the paying self-employed will also need cross-subsidizing from the formal sector employees. Their 400-450 KShs premium will not be enough to pay for the average number of outpatient visits (3) at even the lowest provider level (212 KShs per visit at dispensaries, 222 Kshs at Health Centers), and that does not include the expected cost of inpatient stays. It will be a major challenge to make the fund balance in any way possible.

To estimate the cost of the NSHIF, the government first attempted to determine the costs of different services, basing their figures on private sector charges, or on NHIF payments plus user fees. The first method yielded estimates of 4,000 KShs for inpatient stays, and 310 KShs for dispensary consultations. Outpatient visits cost 410 KShs using the first method, but only 100 KShs using the second, so they decided a payment of 150-200 KShs should be enough. The latter method was used for district hospitals, which cost about 2,300 KShs per inpatient stay. They acknowledge the need to discuss payment levels with providers. They also estimated usage rates for each level of service.

Together with their enrollment assumptions and the above cost and utilization estimates, the government projects surpluses for the first five years:

Table 3. Projected Expenditure and Revenue, in Billions of Kenyan Shillings, 2004 constant prices

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure</td>
<td>10.86</td>
<td>19.42</td>
<td>25.95</td>
<td>33.55</td>
<td>42.37</td>
<td>51.89</td>
<td>62.84</td>
</tr>
<tr>
<td>Admin. &amp; Reserves</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Health Care</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
</tr>
<tr>
<td>Revenue</td>
<td>24.26</td>
<td>31.94</td>
<td>36.13</td>
<td>40.81</td>
<td>46.05</td>
<td>50.45</td>
<td>55.30</td>
</tr>
<tr>
<td>Contributions</td>
<td>51%</td>
<td>60%</td>
<td>62%</td>
<td>64%</td>
<td>66%</td>
<td>67%</td>
<td>67%</td>
</tr>
<tr>
<td>Government subsidies</td>
<td>45%</td>
<td>37%</td>
<td>35%</td>
<td>33%</td>
<td>31%</td>
<td>31%</td>
<td>30%</td>
</tr>
<tr>
<td>Other (Donors)</td>
<td>4%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Balance (Revenue - Expenditure)</td>
<td>13.40</td>
<td>12.52</td>
<td>10.18</td>
<td>7.26</td>
<td>3.68</td>
<td>-1.44</td>
<td>-7.54</td>
</tr>
<tr>
<td>Balance as % Expenditure</td>
<td>123%</td>
<td>64%</td>
<td>39%</td>
<td>22%</td>
<td>9%</td>
<td>-3%</td>
<td>-12%</td>
</tr>
</tbody>
</table>

The exchange rate from mid-2003 to mid-2005 has been between 71 and 83 Kenyan Shillings to the dollar, with an average of about 78. Source: Oandu.com
Subsidizing public hospitals

The NSHIF will replace government subsidies as public hospitals’ primary income source. In 2001, 10.3bn KShs of the public hospitals’ 18.2bn KShs revenue (56%) came from the MoH. During the transition into NSHIF, the MoH will continue to cover personnel and infrastructure costs. National hospitals are supposed to become financially autonomous from the MoH within 2 years, provincial hospitals within 4, district hospitals gradually over 6-10 years, and health centers and dispensaries within 10. After that, the NSHIF payments will have to cover the additional costs of investment and personnel, or else the hospitals will become under-funded. The government has not yet addressed this issue, and tight budgets will lead to fighting over responsibilities if there is no clear plan for the transition.

Administrative structure

To overcome the corruption and administrative shortcomings of the NHIF, the NSHIF is to be an “independent, autonomous, statutory body with corporate personality.” However the ministry of health will have some oversight. In the extreme case that the minister decides the board members are not operating in the best interest of the fund members or are not conforming to the rules of the bill, the minister can take over operations.

The decision makers will be the approximately 20 members of the board of trustees, including a chairman appointed by the president and a CEO appointed by the minister of health. The composition of board members is designed to reduce the potential for corruption. Each of Kenya’s eight provinces will elect a member, preferably with specialization in medicine, finance, institutional management, or law. Five board members will come from the government – the Permanent Secretary in the Ministry of Finance, the Permanent Secretary in the Ministry of Health, the Attorney General, the Permanent Secretary/Director of Personnel Management, and the Director of Medical Services. There will be between five and seven members from the private sector – one nominated by Federation of Kenya Employers, one nominated by the Central Organization of Trade Unions, one nominated by the Kenya National Union of Teachers, and of the following four nominees, it appears only two will be appointed by the Minister of Health, one each from the Association of Kenya Insurers, non-profit health care providers, the Kenya Medical Association, and the NGO Council.

The board has four important tasks to complete before the insurance program can begin. First they must define the details of the benefits package, including creating the drug formulary. This needs to be completed in conjunction with their second task – determining the necessary member contribution levels to finance the expected costs. The board
will need to make difficult decisions about what to omit from the benefit package to make it affordable. They have to balance the generosity of benefits with contribution rates and availability of other financing sources. The other main tasks to be completed before the program can begin are to certify and contract health care providers.

The board’s important operational duties will include receiving contributions, presenting the Minister of Health with revenue and expenditure estimates for approval, making payments out of the fund, managing the fund, ensuring compliance by providers, and determining changing health care needs.

The CEO’s office will run the day to day operations of the fund. Each of the four departments under the CEO will be decentralized to the districts and lower levels if necessary. Initially most operations will be centralized, but over time responsibilities could be devolved to districts – one idea is to allow premium collection and provider payment to happen at the local level to reduce provider payment lags.

**Preventing corruption**

The existing NHIF is corrupt, so the major concern is to structure the NSHIF to prevent corruption and convince the public that their contributions will go towards providing health care, not to fancy administrative buildings or board members’ Swiss bank accounts. The government acknowledges that “fraud within the fund was seen as one of the biggest concerns that would greatly undermine the sustainability of the fund.” To allay the public’s concerns, the NSHIF is designed with the following safeguards to prevent corruption.

Eight of the twenty board members will be elected, and will have to run for reelection after three years, making them publicly accountable. They can only hold office for two terms. However, there is already a concern among the people that they will not be adequately represented in forming the board – 60% of the members will be appointed, including the two most powerful members, the chairman and the CEO. If anything, the board composition has become less democratic – the original bill called for the CEO to be elected by the board, but now the Minister of Health will appoint the CEO.

The bill contains rules to constrain the board’s behavior. When discussing investments or contracts in which a board member has a financial tie, he or she must declare that interest, not participate in the discussion, and abstain from voting. Another constraint on corruption is the 5% limit on administrative costs and 3% limit on reserves. Reducing the size of the reserve, the accumulation assets, means less potential for corruption. Also, the types of investments the board is allowed to make are explicitly defined.

One thing that stands out in the administrative diagram is the prominence of the Investigation/Anti-fraud/Theft Unit (IAFTU). Insurance fraud is first in the government’s list of challenges to the system. Fraud can occur at three levels: 1. internally by the fund management, including administrators, the CEO, and the Board, 2. by the contracted service providers, and 3. by the beneficiaries. The IAFTU reports to the CEO and can investigate any matter brought to its attention by any other division or person. If investigating the
CEO’s office, it will report directly to the board. It is not clear how independent this unit will be administratively or financially. It seems that it will not be able to investigate fraud at the board level – a completely independent unit that reports to the MoH and the legislators might be necessary.

Another safeguard from internal fraud is the internal audit unit under the finance and administration division. This unit is free to report directly to the CEO when necessary.

To prevent fraud by contracted providers and beneficiaries, both the Finance and Administration and the Quality and Standards units have enforcement and compliance divisions. Section 14 of the bill provides special rights for enforcement officers appointed by the Board. They are allowed to enter any contracted medical facilities or place where an officer has “reasonable grounds to believe that any persons are employed or self-employed.” The officer has the right to question anyone and demand documents. Anyone failing to answer questions, provide documents, or obstructing entrance is liable for a fine up to 50,000 KShs or imprisonment up to 3 years. The officers can use this power to investigate many types of fraud – falsified reimbursement claims, falsified membership cards, providing quality below the contracted level, and failure to make contributions for employees. However, Kenya has a weak judicial system, so the risk of punishment might be low.

### Payment methods and rates

The NSHIF law specified that the program will contract with providers at various levels, including dispensaries, private ambulatory care (curative), health centers (mostly outpatient), district hospitals, provincial hospitals (secondary), and national hospitals (tertiary). Charity Ngilu, the Minister of Health, declared that the fund will not cover care in the 11 private hospitals that cater to the rich, but will contract with all other providers that meet their quality criteria. All possible payment methods are on the table, and are subject to negotiation between the board and the providers. It is expected that in the early going they will pay fee-for-service until cost accounting measures improve. Rates are also subject to consultation and negotiation with the providers.

### IMPLEMENTATION ISSUES

The National Social Health Insurance Fund Bill passed parliament in June, 2004, in a record 30 minutes, but after the finance minister declared that the NSHIF is not financially feasible, president Mwai Kibaki refused to sign the bill into law. 13 President Kibaki sent it back to parliament, wanting them to pass a bill with a plan for phased implementation. The interest groups who had little input into the drafting of the Bill are now trying to

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shape it to their advantage. The following issues are strategies to implement the program, and are constantly evolving.

**Working with the MoH**

The NSHIF is set up to be independent from the government, but the government is not comfortable sacrificing all control. The NSHIF must coordinate with the MoH, and in some cases answer to them.

The Health Insurance Act will empower the Ministry to regulate, supervise, and coordinate all health insurance schemes, including the NSHIF. The bill that will create the NSHIF gives the ministry the power to take any necessary actions if the board is not complying with the law or otherwise not acting in the beneficiaries’ best interest. The Ministry will also need to regulate traditional medicine, 1.7% of THE, and eliminate HMOs, which will have to turn into insurers or health care providers, but not both.

For health services covered by NSHIF to reach most of the population, new infrastructure is required and existing infrastructure needs to be improved. The MoH will need to make sure there are facilities at each province and district, possibly using temporary mobile care in rural areas. In addition to assessing infrastructure needs, the MoH will accredit and regulate facilities, including the necessary education level of various types of employees at each facility level. They will also determine which services from the benefit package will be available at the different provider levels, as well as the referral system between levels.

**Enrollment and premium collection**

There are three groups of the population that pose three different sets of challenges to implementing the NSHIF. They are the formal sector employees, the informal workers who can afford to pay, and the informal workers who are too poor to pay.

**Formal sector**

The government predicts that in the first year it will enroll 80% of the formal sector workers, including both private and public sector employees. In Nairobi, most workers are already enrolled in the NHIF, but compliance is much lower outside of the capital. The NSHIF will have to share information with the tax authorities more than the NHIF ever did. To improve compliance, the bill provides for enforcement officials who can legally enter any suspected place of employment to ensure that all employees are enrolled, and that both the employer and employee and making regular contributions.

Employers might try to rehire their salaried employees as contractors to avoid paying NSHIF contributions. To avoid this, the NSHIF will need to define the difference between contractor and employee, or perhaps try to set self-employed contributions equal to
the sum of the employer and employee contributions to eliminate the financial incentive to shift compensation.

**Informal sector**

The majority of workers do not have formal employment. Some will need partial subsidization, and a large proportion will need to be fully subsidized. However some of these informal workers, especially the self employed professionals, are able to pay the full premium. The government will need to contract existing organizations that might be more efficient than NSHIF branch offices at dividing the self-employed into those who can pay and those who are too poor, and then enrolling them. They have compiled a list of specific organizations that might be helpful in identifying and enrolling these populations, including various cooperatives, artisans associations, women and youth groups, occupation groups, village post offices and banks, utility companies, churches, community based organizations and other non-government organizations. The government will also need to identify the poor formal sector workers and unemployed poor.

Identifying who among the informal workers can pay the NSHIF premium will be a difficult task. Most of the poor are farmers or otherwise self-employed. Many of these receive a large part of their income from subsistence farming, making it difficult to determine their income and whether they can afford the premium. The government hopes to raise about 25% of the funding from the self-employed group. Their revenue estimates assume 75% of the self-employed will pay their own premiums. A major hurdle to implementing the NSHIF will be dividing the self employed into those families that can pay their own premium, and those that the government must pay for.

Realizing that it will take a long time to enroll the informal sector, especially in rural areas, the MoH decided to provide free care at dispensaries and medical centers (which provide outpatient and limited inpatient care), aside from a small registration fee. This will cost 4.1 billion Kenyan Shillings. Although this is intended to be an interim measure to provide care for the poor until they become members of the NSHIF, it might actually slow enrollment in NSHIF. Those in the informal economy who might have been willing to pay the annual membership contribution now can enjoy a large portion of necessary care for free, making paid membership much less attractive than before. This issue could be resolved if the government uses its coercive power to enforce membership – those receiving free care could be registered and subjected to a means test.

Assuming the NSHIF is able to separate the informal workers into those who can pay and those who are too poor, they will still have some difficulties. The act of means testing will require many local employees, which will add to administrative costs. If president Kibaki ever signs the NSHIF bill, it will most likely be phased in, starting with public and private formal workers, followed by informal workers on a voluntary basis. Since enrollment will be voluntary, only the Kenyans most in need of care will enroll initially, and this adverse selection will place a greater financial burden on the formal sector.

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14 From here on “self-employed” includes farmers.
16 The current bill does not plan for a phase in, but makes membership mandatory immediately.
Another concern is corruption over issuing certificates. There will be millions that are not poor enough to qualify for full subsidization, but for whom the $400 K. Shs. per head premium will be a huge burden. This creates an immense opportunity for corruption, especially considering the NSHIF will not be able to afford sophisticated identification cards. Furthermore, poverty is dynamic – people will pass below and above the poverty line all the time. The NSHIF will need a system to reassess who needs subsidization frequently.

**Cost and Financing – feasibility, paying for the poor**

*Problems with sources of financing and rates*

The financing sources of total health care expenditure in 2001, and how a fully implemented NSHIF would change that are as follows:

<table>
<thead>
<tr>
<th>Source</th>
<th>Before NSHIF</th>
<th>With NSHIF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>65%</td>
<td>22%</td>
</tr>
<tr>
<td>Out-of-pocket</td>
<td>53</td>
<td>13</td>
</tr>
<tr>
<td>Employer paid services</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Private insurance</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Non-profit institutions</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Public</td>
<td>35%</td>
<td>78%</td>
</tr>
<tr>
<td>Tax revenue</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Public worker benefits</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>NHIF</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>NSHIF</td>
<td></td>
<td>57</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>70.1 billion Kenyan Shillings under both ($890 million US)</strong></td>
<td></td>
</tr>
</tbody>
</table>

The NSHIF would drastically alter the sources of financing by reducing out-of-pocket payments and increasing public funding. In 2001, more than half of health expenditure was paid out-of-pocket. So where does the funding KShs for the NSHIF come from?17

<table>
<thead>
<tr>
<th>Source</th>
<th>Bn.Kshs.</th>
<th>Share %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Contributions of employees and employers</td>
<td>12</td>
<td>29</td>
</tr>
<tr>
<td>2. Earmarked VAT</td>
<td>11</td>
<td>27</td>
</tr>
<tr>
<td>3. Self-employed</td>
<td>10</td>
<td>24</td>
</tr>
<tr>
<td>4. Previous public worker benefits</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>5. Other (donations, etc.)</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>40</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

About $500 million US

There are serious problems with all of these sources. Starting with source 1., the original plan was for employers to contribute twice the amount of employees, so 8 billion and 4

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17 The financing tables are from Kenya’s Sessional paper 2 of 2004.
billion each. The NHIF only raised 2.8 billion in 2001, almost exclusively from employee contributions. Therefore the NSHIF represents a large new tax on employers, and forbids them from lowering salaries to finance it. It will be politically difficult to raise 12 billion in the face of strong industrial opposition.

The government has already given up on an earmarked VAT (source 2.), instead favoring a general commitment to financing the contributions for the poor. Since this group is mostly rural, and will take longer to enroll, this is not a problem in the short-run. However it will be very hard for future governments to increase existing taxes or introduce new taxes, and it might be preferable to over-fund the system now and invest the surplus to fund projected future deficits. Fears of corruption led to a rule prohibiting large surpluses – the reserve is not allowed to exceed the projected needs for the next three months.

As mentioned previously, collecting contributions from the self-employed (3.) will be difficult. The challenge will be to identify who can afford the annual premium. As for the actual amount to charge, a task force came up with this list of suggested contributions by province. It is not clear if they intend to charge different rates to different regions of the country, which would be more equitable, or if they intend to round the national average to 400 KShs or 450KShs (about $5 or $6 US) and charge all self-employed the same rate, which would be administratively easier. The government also needs to establish contribution rates for high-earning self-employed professionals.

The payroll harmonization (4.) has struck a dissonant chord with the teachers union and other civil servants. The Kenya National Union of Teachers objects to having their medical allowance used as a mandatory contribution. It seems previously they were paid medical allowances regardless of whether they needed care.

Another important financing question was whether contributions should be per head or per family. The two systems could be structured to raise the same level of funds, but the per head system was chosen because it would help eliminate fraud possibilities. Regarding contributions for dependents, one suggestion is to reduce the payments for the dependents of self-employed from 400 KShs to 100. This would hopefully convince more self-employed near the poverty line to enroll, and it will only cost the government 0.7 – 1.3bn KShs in 2006\(^{18}\) (assuming 45% of the self-employed enroll).

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formal employers registered with the government, and 7% are public employees. It is likely that many of the dependents work in the informal economy too. As previously mentioned, about 59% of the population lives on less than $2 per day, and 23% below $1. The national poverty definition places about half the population below the poverty line.

The poor will not be able to pay their own premiums, so originally the government planned to pay for them out of earmarked tax. However their projections show that only 27% of the revenue would have come from VAT, but half of the population is poor by their national definition. This means that they will either expect some of the poor to make contributions, which is unreasonable, or more likely the contributions of the formal sector employees will cross-subsidize the poor.

**Feasibility**

The government’s projections presented earlier in this paper relied on some key assumptions that make them unrealistic. Even with these optimistic assumptions, the system runs large deficits in the long term. Perhaps the faultiest assumption is that 75% of the self-employed will be able to pay 450 KShs for themselves and the same amount for each dependent. Another crucial assumption is that they will be able to negotiate low rates with providers – their high rate scenario is about 66% more expensive.

The following tables present two enrollment scenarios, rapid and moderate. Then calculations are made to determine the amount the government will have to contribute to make the fund balance, given three different levels of employee/employer (both private and public) contributions. The potential employer/employee contributions shares as a percentage of salary are as follows: 6%/3%, 4.66%/2.33%, and 2.9%/2.9%. These seem to be the two most reliable sources of funding – the system can’t depend on the non-poor self-employed making substantial contributions in the early years.

Assumptions were made about the average costs of inpatient and outpatient treatments at each of the 5 levels of care. However, it remains to be seen what rates the NHSIF will negotiate with providers at different levels – much of this will depend on how quickly they become financially autonomous from the MoH, which is supposed to cover personnel and infrastructure costs in the transition.

Other assumptions behind the calculations include 3 outpatient visits per year and 0.26 inpatient days per capita. These could be much higher, because most of the population were previously uninsured and about 25% did not seek healthcare for financial reasons. People might feel compelled to use all of the proposed limit of 5 outpatient visits.

It was assumed that administrative costs will fall to 5% and investments to 3% within 5 years, which is written into the Bill. This is very optimistic.

The scenarios, with the percentage of each group enrolled each year from 2004 to 2012:

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19 These enrollment scenarios and the following calculations are taken from the sixth WHO/GTZ mission paper. WHO/GTZ, June, 2004, “National Social Health Insurance: Financial projections and future bilateral / multilateral cooperation.” See the paper for the assumptions behind the calculations.
### Table 7. Moderate implementation scenario

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependents of SE</td>
<td>52.0%</td>
<td>15</td>
<td>25</td>
<td>37.5</td>
<td>40</td>
<td>42.5</td>
<td>45</td>
<td>47.5</td>
<td>50</td>
</tr>
<tr>
<td>Self-employed</td>
<td>28.0%</td>
<td>15</td>
<td>25</td>
<td>37.5</td>
<td>40</td>
<td>42.5</td>
<td>45</td>
<td>47.5</td>
<td>50</td>
</tr>
<tr>
<td>Public employees</td>
<td>2.5%</td>
<td>80</td>
<td>85</td>
<td>90</td>
<td>95</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Private employees</td>
<td>3.5%</td>
<td>60</td>
<td>62.5</td>
<td>65</td>
<td>67.5</td>
<td>70</td>
<td>72.5</td>
<td>75</td>
<td>77.5</td>
</tr>
<tr>
<td>Pensioners</td>
<td>1.1%</td>
<td>80</td>
<td>85</td>
<td>90</td>
<td>95</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Other dependents</td>
<td>13.0%</td>
<td>68</td>
<td>72</td>
<td>75</td>
<td>79</td>
<td>82</td>
<td>84</td>
<td>85</td>
<td>87</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>26</td>
<td>34</td>
<td>45</td>
<td>48</td>
<td>51</td>
<td>53</td>
<td>55</td>
<td>57</td>
</tr>
</tbody>
</table>

### Table 8. Rapid implementation scenario

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependents of SE</td>
<td>52.0%</td>
<td>37.5</td>
<td>40</td>
<td>45</td>
<td>50</td>
<td>55</td>
<td>60</td>
<td>65</td>
<td>70</td>
</tr>
<tr>
<td>Self-employed</td>
<td>28.0%</td>
<td>37.5</td>
<td>40</td>
<td>45</td>
<td>50</td>
<td>55</td>
<td>60</td>
<td>65</td>
<td>70</td>
</tr>
<tr>
<td>Public employees</td>
<td>2.5%</td>
<td>80</td>
<td>85</td>
<td>90</td>
<td>95</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Private employees</td>
<td>3.5%</td>
<td>80</td>
<td>85</td>
<td>90</td>
<td>95</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Pensioners</td>
<td>1.1%</td>
<td>80</td>
<td>85</td>
<td>90</td>
<td>95</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Other dependents</td>
<td>13.0%</td>
<td>80</td>
<td>85</td>
<td>90</td>
<td>95</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>46</td>
<td>49</td>
<td>54</td>
<td>59</td>
<td>64</td>
<td>68</td>
<td>72</td>
<td>76</td>
</tr>
</tbody>
</table>

The following table presents the required government contribution given three different levels of combined employee/employer contributions (as a percentage of salary). The government contribution is the key to the feasibility of the entire system. If the amount is too high, the government will not be able to pay for it even with new taxes or massive borrowing, and the system is not financially sustainable.

Here are the average contributions by public and private employees under the different contribution rates:

### Table 9. Average contributions by public and private employees

<table>
<thead>
<tr>
<th>Total employer + employee contribution rate:</th>
<th>5.8%</th>
<th>7.0%</th>
<th>9.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average public salary: 60,000, contribution:</td>
<td>3,480</td>
<td>4,200</td>
<td>5,400</td>
</tr>
<tr>
<td>Average private salary: 140,000, contribution:</td>
<td>8,120</td>
<td>9,800</td>
<td>12,600</td>
</tr>
</tbody>
</table>

Here are the required government contributions in the rapid enrollment scenario (in billions of KShs, 2004 constant prices):
Table 10. Required government contribution to balance fund, rapid scenario

<table>
<thead>
<tr>
<th>Total employee &amp; employer contribution</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2009</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.8%</td>
<td>9.0</td>
<td>9.9</td>
<td>12.0</td>
<td>19.4</td>
<td>41.2</td>
</tr>
<tr>
<td>7%</td>
<td>7.0</td>
<td>7.8</td>
<td>9.6</td>
<td>16.4</td>
<td>37.7</td>
</tr>
<tr>
<td>9%</td>
<td>3.7</td>
<td>4.1</td>
<td>5.6</td>
<td>11.4</td>
<td>31.9</td>
</tr>
</tbody>
</table>

In the early years, a low formal sector contribution might be feasible. However, with 60% of the self-employed enrolled by 2013, even with a high contribution rate (9%), the government will have to pay about 32bn KShs (about $400 million US) to cover the financing gap. Ideally the Fund would invest reserves in the early going to plan for the future when large numbers of the poor enroll, but because of the fear of corruption, this is not possible.

Table 11. Required government contribution to balance fund, moderate scenario

<table>
<thead>
<tr>
<th>Total employee &amp; employer contribution</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2009</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.8%</td>
<td>2.1</td>
<td>5.6</td>
<td>11.3</td>
<td>16.1</td>
<td>30.3</td>
</tr>
<tr>
<td>7%</td>
<td>0.5</td>
<td>3.9</td>
<td>9.4</td>
<td>13.7</td>
<td>27.3</td>
</tr>
<tr>
<td>9%</td>
<td>0.0</td>
<td>1.0</td>
<td>6.3</td>
<td>9.8</td>
<td>22.4</td>
</tr>
</tbody>
</table>

The moderate implementation scenario is much more affordable (and more realistic), but will also require higher formal sector contribution rates and high government contributions in the long term, which could be a problem if the government refuses to earmark part of the VAT. The fact that it will be difficult to enroll the rural poor could give the NSHIF the time it needs to become established and to gain grassroots support. If too many poor enroll too quickly, the system will collapse from under-funding. The reality is that the long term feasibility depends either on not enrolling those who cannot pay for themselves, or a very strong spirit of solidarity, as the small group of urban rich will have to pay for millions of rural poor, both out of their contributions and consumption taxes. Already this solidarity has been challenged, with the rich calling for contribution ceilings of 5,000 Kshs per month (or about $770 US annually). If this ceiling is granted, the government contribution out of general revenue would have to be enormous.

**Provider payment – methods and rates**

Another essential step to implementing the NSHIF is deciding on provider payment methods and rates. The payment system has serious implications for the first year cost of the insurance program, and is even more important for giving incentives to control expenditure growth and provide high quality care thereafter. The government has considered the advantages and disadvantages of many payment systems, but it seems all methods are still on the table. They note that fee-for-service payment can encourage excess use, and has high administrative costs for claims checking. Per-case payments (per visit, admission, bed day, DRG), are simpler to administer, but may not avoid all excess use. They also noted that budgets and capitation based systems are good for their ease of administering and forecasting costs, but that they might lead to under-provision. They conclude that “it is expected that the NSHIF would have an interest . . . in more comprehensive payment methods including payment per case, per bed-day or admission, or per diagnosis related group.”
Initially it might make sense to maintain their current fee-for-service payment system until cost accounting procedures improve. Then they might consider flat-rate remuneration for inpatient day, reducing rates after 7 or so days to discourage overuse. The government is counting on negotiating low provider payments to improve the financial viability of the fund, however doing so might exacerbate brain-drain.

CONCLUSION

The National Social Health Insurance Fund was passed by Kenya’s Parliament in June, 2004, but was not signed by the president because it does not seem financially sustainable without large new taxes or borrowing. The legislation was voted on only a month after the Bill was written, and passed in a record 30 minutes, so the stakeholders were not involved as much as they would have liked. Now that the Bill has been stalled they have been able to raise their voices and demand concessions – lower tax rates, contribution ceilings, refusal to give up the old benefit system, representation in the board, provider payment method and rates, and so on. Too many concessions will make the NSHIF even less sustainable.

Major implementation issues remain. The government needs to define who is poor and cannot afford to pay the premium, and plan to certify this population. Then they need to clearly outline how they plan to pay for the poor – will the government cover their contributions entirely? will they partially depend on cross-subsidies from the formal-sector contributions? Will they get a lesser benefit package? If they chose the second option, which seems financially necessary, they need to be upfront with this or else the employers and employees will think their contributions are being squandered. The other major concern has been preventing corruption. There has been much consideration of this issue in designing the NSHIF structure, but this will always be a challenge. If the public fears their money is being siphoned away by board members or administrators, voluntary compliance rates will fall and the fund will need to hire more enforcement officers, and never meet its 5% administrative cost target.
REFERENCES


Chapter 4: Ghana

Initiating Social Health Insurance

Sreekanth Ramachandra
William Hsiao
CASE STUDY: GHANA

BACKGROUND

Formed from the merger of the British colony of the Gold Coast and the Togoland trust territory, Ghana in 1957 became the first sub-Saharan country in colonial Africa to gain its independence. A long series of coups resulted in the suspension of the constitution in 1981 and a ban on political parties. A new constitution, restoring multiparty politics, was approved in 1992. Recently, Ghana has been praised as a democratic nation where a fair and orderly election was held in 2004 with John Kufuor winning a second term.

Ghana is located in Western Africa, bordering the Gulf of Guinea, between Cote d'Ivoire and Togo. The natural resources include gold, timber, industrial diamonds, bauxite, manganese, fish, rubber, hydropower, petroleum, silver, salt, limestone. Christianity is the main religion accounting for 63% of the population; Muslim 16% and indigenous beliefs 21%. The ethnic groups are divided as black African 98.5% (major tribes - Akan 44%, Moshi-Dagomba 16%, Ewe 13%, Ga 8%, Gurma 3%, Yoruba 1%), European and other 1.5% (1998). English is the official language with African languages including Akan, Moshi-Dagomba, Ewe, and Ga.

Population and Health

Ghana has a total population of over 21 Million with an annual population growth rate of 2.4% (2004, UNPD database). Table1 below gives a picture of Ghana’s demographic status with its health indicators.

---

Table 1. Population and health indicators

<table>
<thead>
<tr>
<th>Population and Health</th>
<th>1999</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population, total (million)</td>
<td>19.3</td>
<td>20.3</td>
<td>20.7</td>
</tr>
<tr>
<td>Population growth (annual %)</td>
<td>2</td>
<td>1.8</td>
<td>1.8</td>
</tr>
<tr>
<td>National poverty rate (% of population)</td>
<td>39.5</td>
<td>..</td>
<td>..</td>
</tr>
<tr>
<td>Life expectancy (years)</td>
<td>..</td>
<td>54.9</td>
<td>54.4</td>
</tr>
<tr>
<td>Fertility rate (births per woman)</td>
<td>..</td>
<td>4.4</td>
<td>4.4</td>
</tr>
<tr>
<td>Infant mortality rate (per 1,000 live births)</td>
<td>..</td>
<td>..</td>
<td>59</td>
</tr>
<tr>
<td>Under 5 mortality rate (per 1,000 children)</td>
<td>..</td>
<td>..</td>
<td>95</td>
</tr>
<tr>
<td>Births attended by skilled health staff (% of total)</td>
<td>..</td>
<td>..</td>
<td>..</td>
</tr>
<tr>
<td>Child malnutrition, weight for age (% of under 5)</td>
<td>24.9</td>
<td>..</td>
<td>22.1</td>
</tr>
<tr>
<td>Child immunization, measles (% of under 12 mos)</td>
<td>73</td>
<td>81</td>
<td>80</td>
</tr>
<tr>
<td>Prevalence of HIV, total (% of population aged 15-49)</td>
<td>..</td>
<td>..</td>
<td>3.1</td>
</tr>
</tbody>
</table>

Source: World Development Indicators database, April 2005

While Ghana’s health indicators compare favorably with sub Saharan Africa, they still lag behind the world average\(^{21}\). Any comparison with the developed North block would be unfair but the disparities show that Ghana has a long way to go. The Under 5 mortality rate (U5MR) is still high though there has been a steady decline over time. A cause for concern is the inequities between the urban and rural areas. In northern Ghana, the U5MR is three times as high (at 171 per 1000 live births) as in the capital region\(^{22}\). The figures for MMR are high too and the gaps in antenatal care, unsupervised deliveries and inadequate\(^{23}\) postnatal care are some of the important underlying causes of high levels of maternal deaths. Malnutrition among women, high fertility rates and harmful traditional practices also contribute to this high rate of maternal mortality. The 1998 DHS reported that antenatal care received from a trained health worker was 83%. A welcoming trend is that by 2001, uptake of antenatal care had increased to 96%\(^{24}\). However, antenatal care from a doctor was only around 30%.

The high prevalence of HIV/AIDS is a big problem. There are an estimated number of 350,000 people living with HIV/AIDS (end of 2003) with about 30,000 deaths during the year\(^ {25}\). Malaria remains a leading cause of death in Ghana, and is the largest cause of outpatient hospital visits. Little progress has been made in reversing its incidence. In 2003, Malaria was the cause of 45% of all outpatient cases and over a third of all inpatients in health facilities. Twenty-two percent of all deaths occurring in children under five years is due to malaria. Prevalence of fever reaches 34-38% in the impoverished Northern, Upper East and Volta Regions, compared to the national average of 27%\(^ {26}\). Although Ghana has received Global Fund grants to address HIV/AIDS, malaria, and tuberculosis, a severe shortage of doctors and nurses has dampened its success. It is estimated that two thirds of the doctors and nurses trained in Ghana have left the country for better eco-

---


\(^{22}\) Ghana - Millennium Development Report, 2003

\(^{23}\) Over 50% of mothers do not receive post natal care

\(^{24}\) Calculated based on first (one) antenatal visit


\(^{26}\) Ghana - Millennium Development Report, 2003
Economic prospects overseas. Rural areas are particularly hard hit and many Northern regions have no access to doctors at all.

**Economic Indicators**

GDP of Ghana experienced a 5.2% GDP growth in the year 2003 with an estimated per capita GDP of PPP $2200. This growth, combined with a high population growth rate has contributed to a low per capita growth of 1.7 percent.

Though, well endowed with natural resources, and with twice the per capita output of the poorer countries in West Africa, Ghana still remains heavily dependent on international financial and technical assistance. Gold, timber, and cocoa production are major sources of foreign exchange. The domestic economy continues to revolve around subsistence agriculture, which accounts for 35% of GDP and employs 60% of the work force, mainly small landholders.

With the current focus on how health status influences income which in turn facilitates health, the huge economic inequity (Gini Coeff of 41) and poverty in Ghana are reasons for worry. While in 2000, the richest 20% of the population earned 46.7% of the total income, the poorest 20% earned a mere 5.6%. While the overall poverty in Ghana declined from 51.7% in 1992 to 39.5% in 1999 and extreme poverty declined from 36.5% to 26.8% over the same period, it should be noted that the reduction was concentrated in Accra and rural and urban forest localities. In the urban savannah, the population defined as poor actually increased.

Ghana is ranked 131st in the 2004 Human Development Report, with an HDI value of 0.568. The HPI-1 value for Ghana of 26.0% ranks it 46th among 95 developing countries for which the Human Poverty Index has been calculated. Ghana ranks 104th on the Gender Development Index (GDI), with a value of 0.564.

**National Expenditure on health**

Total health care expenditure in Ghana was around 4.4 percent of GDP in 2003 (US$13.6 per capita). Spending in the public sector (as shown in Table 2 below) is about 2.4 percent of GDP, making Ghana one of the lowest spenders on health care in the world, although some other African countries spend less (World Health Organization 2002).

<table>
<thead>
<tr>
<th>Table 2. Total estimated health expenditure in Ghana in 2003 (public sector)</th>
</tr>
</thead>
</table>

---

27 http://www.oneworld.ca/guides/ghana/development
28 Source: World Development Indicators database, April 2005
30 Ghana Poverty Reduction Strategy, 2003 – A Report; Using a lower poverty line (extreme poverty) of 700,000 cedis/adult/year and an upper poverty line (overall poverty) of 900,000 cedis/adult/year. The poverty lines are based on what is needed to meet nutritional requirements of household members.
<table>
<thead>
<tr>
<th>Care financed by</th>
<th>Bill. Cedis</th>
<th>US$ (mil)</th>
<th>In % of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular budget</td>
<td>763.00</td>
<td>90.83</td>
<td>55.29%</td>
</tr>
<tr>
<td>External aid</td>
<td>389.00</td>
<td>46.31</td>
<td>28.19%</td>
</tr>
<tr>
<td>Copayments</td>
<td>228.00</td>
<td>27.14</td>
<td>16.52%</td>
</tr>
<tr>
<td>Total</td>
<td>1,380.00</td>
<td>164.29</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Key structural data**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP</td>
<td>58,500</td>
<td>6,964.29</td>
</tr>
<tr>
<td>Status quo health exp. % GDP</td>
<td>2.36%</td>
<td>2.36%</td>
</tr>
<tr>
<td>Estimated general revenues</td>
<td>13,250.00</td>
<td>1,577.38</td>
</tr>
<tr>
<td>Status quo gov. expen % gen. rev.</td>
<td>5.76%</td>
<td>5.76%</td>
</tr>
</tbody>
</table>


As can be seen from Table 2, there were three main sources of financing for health services provided in the public sector (Cichon, Norman et al. 2003): the regular budget of the Ministry of Health (55.3 percent of public sector spending), external aid (28.2 percent) and official “cash-and-carry” user charges (16.5 percent). In addition, 46.5 percent of total health care expenditure came from out-of-pocket spending in the private sector.

The regular budget of the Ministry of Health accounted for about 5.8 percent of general revenues (low public spending on health by international standards) of which 28.2 percent comes from donors (high donor dependence by international standards). The government has pledged to increase public spending (domestic and foreign aid) to 15 percent of general government revenues over the next few years. With the introduction of the new health insurance system, there is expected to be a formal mechanism for pooling revenues and spreading risks across population groups, from rich to poor and across the lifecycle.

**Public and Private Provision of services in the country**

Table 331 below gives the regional distribution of public and private provision of services in Ghana by hospitals and clinics. The regions in the table are arranged in descending order of economic development. A correlation seems to exist between the affluence of a region and the number of government run hospitals. Private and missionary hospitals also tend to operate in more affluent regions, such as in Ashanti and Brong Ahafo. While the lack of private hospitals in the poorer areas can be justified, the lack of government hospitals is a cause for concern.

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31 This table does not include two teaching hospitals at Accra and Ashanti respectively
Table 3. Distribution of providers across the country

<table>
<thead>
<tr>
<th>Hospitals by Ownership</th>
<th>Mission</th>
<th>Private</th>
<th>Government</th>
<th>Quasi-Government</th>
<th>Total government run</th>
<th>Total number of facilities</th>
<th>% of facilities financed by the government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Accra</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>11</td>
<td>11</td>
<td>100.0</td>
</tr>
<tr>
<td>Western</td>
<td>4</td>
<td>0</td>
<td>9</td>
<td>6</td>
<td>15</td>
<td>19</td>
<td>78.9</td>
</tr>
<tr>
<td>Ashanti</td>
<td>13</td>
<td>35</td>
<td>13</td>
<td>3</td>
<td>16</td>
<td>64</td>
<td>25.0</td>
</tr>
<tr>
<td>Volta</td>
<td>7</td>
<td>7</td>
<td>11</td>
<td>1</td>
<td>12</td>
<td>26</td>
<td>46.2</td>
</tr>
<tr>
<td>Brong Ahafo</td>
<td>10</td>
<td>7</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td>23</td>
<td>26.1</td>
</tr>
<tr>
<td>Eastern</td>
<td>5</td>
<td>7</td>
<td>10</td>
<td>3</td>
<td>13</td>
<td>25</td>
<td>52.0</td>
</tr>
<tr>
<td>Central</td>
<td>4</td>
<td>2</td>
<td>7</td>
<td>1</td>
<td>8</td>
<td>14</td>
<td>57.1</td>
</tr>
<tr>
<td>Northern</td>
<td>3</td>
<td>1</td>
<td>7</td>
<td>2</td>
<td>9</td>
<td>13</td>
<td>69.2</td>
</tr>
<tr>
<td>Upper West</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>50.0</td>
</tr>
<tr>
<td>Upper East</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>60.0</td>
</tr>
<tr>
<td>Total</td>
<td>49</td>
<td>60</td>
<td>72</td>
<td>23</td>
<td>95</td>
<td>204</td>
<td>46.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Centers/Clinics by Ownership</th>
<th>Mission</th>
<th>Private</th>
<th>Government</th>
<th>Quasi-Government</th>
<th>Total government run</th>
<th>Total number of facilities</th>
<th>% of facilities financed by the government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Accra</td>
<td>0</td>
<td>213</td>
<td>32</td>
<td>4</td>
<td>36</td>
<td>249</td>
<td>14.5</td>
</tr>
<tr>
<td>Western</td>
<td>15</td>
<td>45</td>
<td>92</td>
<td>28</td>
<td>120</td>
<td>180</td>
<td>66.7</td>
</tr>
<tr>
<td>Ashanti</td>
<td>35</td>
<td>87</td>
<td>102</td>
<td>2</td>
<td>104</td>
<td>226</td>
<td>46.0</td>
</tr>
<tr>
<td>Volta</td>
<td>14</td>
<td>49</td>
<td>386</td>
<td>1</td>
<td>387</td>
<td>450</td>
<td>86.0</td>
</tr>
<tr>
<td>Brong Ahafo</td>
<td>8</td>
<td>55</td>
<td>106</td>
<td>10</td>
<td>116</td>
<td>179</td>
<td>64.8</td>
</tr>
<tr>
<td>Eastern</td>
<td>9</td>
<td>53</td>
<td>62</td>
<td>4</td>
<td>66</td>
<td>128</td>
<td>51.6</td>
</tr>
<tr>
<td>Central</td>
<td>8</td>
<td>49</td>
<td>45</td>
<td>2</td>
<td>47</td>
<td>104</td>
<td>45.2</td>
</tr>
<tr>
<td>Northern</td>
<td>20</td>
<td>11</td>
<td>85</td>
<td>0</td>
<td>85</td>
<td>116</td>
<td>73.3</td>
</tr>
<tr>
<td>Upper West</td>
<td>16</td>
<td>2</td>
<td>33</td>
<td>0</td>
<td>33</td>
<td>51</td>
<td>64.7</td>
</tr>
<tr>
<td>Upper East</td>
<td>8</td>
<td>10</td>
<td>56</td>
<td>1</td>
<td>57</td>
<td>75</td>
<td>76.0</td>
</tr>
<tr>
<td>Total</td>
<td>133</td>
<td>574</td>
<td>999</td>
<td>52</td>
<td>1051</td>
<td>1758</td>
<td>59.8</td>
</tr>
</tbody>
</table>

*Total government-run includes both government and semi-government.

In the case of health centers and clinics, the situation seems slightly different with the government financing a greater percentage of facilities in the poorer areas. Also as is to be expected the number of private facilities decreases as we go down the affluence ladder while the number of government facilities increases. But in aggregate terms, the two most affluent regions have more than three times the number of facilities in the two poorest regions.
Table 4 below gives a chronological depiction of the development of health financing mechanisms in Ghana from a publicly financed National Health Service to the current National Health Insurance.

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
<th>Backdrop / Rationale</th>
<th>Features</th>
<th>Source of Finance</th>
<th>Result</th>
</tr>
</thead>
</table>
| 1957       | Introduction of a national health service (Modeled after the British NHS) | Driven by early economic performance, natural resources and strong export base (World Bank 2004) | • Everyone entitled to free healthcare  
• Healthcare delivery through network of publicly owned facilities | From general revenues                                                | Not sustainable. With the decline in economic performance, the scheme proved to be too expensive |
| 1985       | Co-payment introduced                                                  | To avoid a collapse in publicly funded services                                      | • Co-payment for services  
• Healthcare delivery through network of publicly owned facilities  
• Full cost recovery for drugs  
• Reduced fees for children and primary care facilities | From general revenues and user fees recovered.                               | Out-of-pocket user fees charged from partial to full cost recovery         |
| 1992       | ‘Cash and Carry’ system instituted                                     | • To increase funds for providers  
• To make fee recovery legal  
• Restrict needless usage | • Subsidization of the vulnerable by the better off  
• Social protection against the impoverishing cost of illness | Donors like DANIDA, USAID  
Commumity                                                | Reduced gap between covered and non-covered (Arhin-Tenkorang 1995),  
Paved the way for mushrooming of MHOs                      |
| Early 1990s | Voluntary Mutual Health Insurance Organization Movement               | • Heavy ‘Cash and Carry’ burden  
• Lack of social protection mechanisms  
• Lack of government oversight of informal sector | • Donors like DANIDA, USAID  
Commumity                                                | Donors like DANIDA, USAID  
Commumity                                                | Reduced gap between covered and non-covered (Arhin-Tenkorang 1995),  
Paved the way for mushrooming of MHOs                      |
<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early 2000s</td>
<td>Profusion of MHOs</td>
<td>• Trend in other African nations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Success of initial MHOs in Ghana</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Encouragement of MOH</td>
</tr>
<tr>
<td>2003</td>
<td>National Mandatory Health Insurance Reform</td>
<td>• Spread over 67 districts in 10 regions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diverse in management styles and benefits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Based on district or occupation or religion or gender</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Donors like DANIDA, USAID</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Community</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Financial protection and health services access for poor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A model to cover larger parts of the population</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Relative success of the MHOs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Agenda of the current ruling government (re-election platform)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Abolish cash-and-carry</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Mandatory health insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Expanded coverage through district wide MHOs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• HI levy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 2.5% of SSNIT(^{32}), state budget transfers,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ROIs made by NHIC,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Voluntary contributions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• National health Insurance Council set up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Interim administrative arrangements</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Move towards 90 DMHISs</td>
</tr>
</tbody>
</table>

**Mutual Health Insurance Organizations (MHOs)**

The voluntary mutual health insurance movement started in Ghana during the early 1990s with encouragement from the Ministry of Health and support from donors such as DANIDA and the U.S. Agency for International Development (USAID) (Atim 2000; Apoya and Maaweh 2001; Atim, Grey et al. 2002; Aiken 2003). Such community initiatives began to bridge the large gap in social protection between people covered by formal schemes and those with no protection against the cost of illness or who were exposed to the impoverishing effects of user charges (Arhin-Tenkorang 1995). The movement has recently taken off, increasing from 47 MHOs in 2001 to 159 in 2002 (Atim, Grey et al. 2002). These MHOs are spread over 67 districts in all 10 regions of the country. The MHOs show richness in variety and innovation of design and management styles. Some are District-wide\(^{34}\); others are based on different types of collective groups such as occupation\(^{35}\), religion\(^{36}\), and gender\(^{37}\).

Data from a survey conducted in November 2002 by PHRplus indicates that nearly 84 percent of membership is concentrated in three regions: Ashanti -38.7 percent; Brong

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\(^{32}\) 2.5% of the 17.5% Social Security and National Insurance Trust (SSNIT) contribution from employees

\(^{33}\) This is similar to the role of communities in health financing in other African countries (Musau 1999; Arhin-Tenkorang 2001; Huber, Holmman et al. 2003; Waelkens and Criel 2004) and elsewhere in the world (Bennett, Creese et al. 1998; Jakab and Krishnan 2001; Preker, Carrrin et al. 2001; Baeza, Montenegro et al. 2002).

\(^{34}\) Dodowa Community Health Insurance Scheme

\(^{35}\) Ashanti Region Civil Servants' Medical Insurance Scheme

\(^{36}\) Koforidua Diocese Mutual Health Scheme

\(^{37}\) Manhyia Susu Health Scheme
Ahafo - 20.1 percent; and Northern - 30.5 percent. 62 percent of group members were female, and 62 percent were farmers.

### Table 5. Distribution of membership

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Membership</th>
<th>Percent of total # of insured people</th>
<th>Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashanti Civil Servants Medical Refund Scheme</td>
<td>60,300</td>
<td>27</td>
<td>Functional</td>
</tr>
<tr>
<td>Nkoranza Community Health Insurance Scheme</td>
<td>44,000</td>
<td>20</td>
<td>Fully operational</td>
</tr>
<tr>
<td>Damongo Health Insurance Scheme</td>
<td>32,000</td>
<td>14</td>
<td>Fully functional</td>
</tr>
<tr>
<td>Tiyumtaabi Welfare Association</td>
<td>21,200</td>
<td>10</td>
<td>Fully functional</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>157,500</strong></td>
<td><strong>71</strong></td>
<td></td>
</tr>
</tbody>
</table>

The survey also reports that the existing MHO market is heavily concentrated. The four largest MHOs shown in Table 5, have 71 percent of total members. These figures also imply that only about 1.1 percent of the population is enrolled in some MHO, leaving the remaining to depend on the ‘cash and carry’ system.

Memberships to the schemes can range from 1000\(^{38}\) to about 60,000\(^{39}\). In case of some like the Koforidua Diocese Mutual Health Scheme enrollment is compulsory for all members of the church. But in others like the Dodowa Community Health Insurance Scheme (established in January 2001 by the Health Economics and Financing Programme of the MOH and the London School of Hygiene and Tropical Medicine) enrollment is voluntary and in the first year, the enrollment turned out to be barely 5% of the population.

Most schemes tend to be provider sponsored plans and are sponsored and managed by providers. For example in the St. Rose’s Secondary School Health Insurance Scheme in Akwatia, St. Dominic’s Hospital\(^{40}\) which is the initiator of the scheme, is also the service provider, i.e., the service provider owns the scheme. One of the largest schemes, Nkoranza Health Insurance Scheme started as a community based scheme with the service provider being St. Theresa’s Hospital, the only referral hospital in the district. But the scheme was housed in the hospital itself and finally ended up being run by the service provider.

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\(^{38}\) Tano Community Health Insurance Scheme

\(^{39}\) Ashanti Region Civil Servants’ Medical Insurance Scheme

\(^{40}\) A mission hospital and the largest district hospital in the area with specialist staff; initiated the scheme in January 2000.
The health benefits can generally be accessed one year after joining any scheme. In most cases, benefits are related to ailments requiring hospitalization for at least one day. For example in the Nkoranza Health Insurance Scheme, the benefits relate to admissions for medical, surgical, obstetric, and emergency care. Risk coverage is limited to hospital admission and deliveries are covered only when they are complicated. Self-induced abortions are not covered.

The schemes are typically financed by the premiums collected from the community under consideration. The premiums start from GH¢20,000/annum (US$2.2). The premium collected depends on the number of members the scheme can enroll and the services provided. Also the ability of the members to pay is taken into account and the poor are subsidized. For example, in the Koforidua Diocese Mutual Health Scheme, which commenced in 2000, many of the families in the scheme are the poor and/or unemployed. Even a premium of GH¢500 (US$ 0.05) per week is too expensive for most members. To encourage premium collections, the frequency of the standard church collections has been reduced, and, out of the daily church collections, 30 percent is set aside for the MHO. Thus premiums are based on a family’s church contribution and therefore vary.

**National health Insurance Scheme**

Ghana passed the National Health Insurance Act (NHIA) in 2003 and it was made operational in March 2004. The scheme is to be operated as a decentralized NHIS encompassing District Mutual Health Schemes in all of the country’s 110 districts, private mutual health insurance and private commercial insurance schemes in order to give all Ghanaians the opportunity to join a health insurance scheme of their choice. The central government sets the minimum benefit package, licenses and regulates the health insurance schemes, certifies the providers, collects a national NHI levy and uses it to subsidize the premium of the poor. It intends to be a mandatory insurance scheme which implies that all Ghanaians would be compulsorily enrolled somehow. In terms of some expected outcomes, the policy document speaks of achieving insurance coverage of 30-40% of the population within the next five years, and 50-60% within the next five to ten years.

The scheme follows the provisions laid out in the National Health Insurance Act (NHIA) of 2003 and the National Health Insurance Regulations of late 2004. The important provisions of the NHIA are (i) establishment and functions of a National Health Insurance Council; (ii) types, registration and licensing of health insurance schemes; (iii) establishment and operation of district mutual health insurance schemes; (iv) establishment of private health insurance scheme, comprising private commercial and private mutual; (v) general provisions applicable to operation of all health insurance schemes; (vi) establishment of a National Health Insurance Fund; (vii) imposition of national Health insurance levy; and (viii) administration and miscellaneous matters for the effective implementation of the provisions of the Bill.
**National health Insurance Council**

The National Health Insurance Council was set up to govern the insurance scheme and reports through the Minister of Health to the President. Its objectives are to secure implementation of a national health insurance policy that ensures access to basic health care for all residents. The council has 15 members from various interest groups of society, including a chairperson and an executive secretary. The council members will be appointed by the President of the Republic of Ghana in consultation with the Council of State. Although the council discharges its functions through a health insurance administration and committees as deemed appropriate, it is required to comply with health policy directives issued by the Minister of Health. Initial appointments to the council were made in May 2004.

As its responsibilities, the council is expected to: (a) register, license and regulate health insurance schemes; (b) supervise the operations of health insurance schemes; (c) grant accreditation to healthcare providers and monitor their performance; (d) ensure that healthcare services rendered to beneficiaries of schemes by accredited healthcare providers are of good quality; (e) determine in consultation with licensed district mutual health insurance schemes, contributions that should be made by their members; (f) approve health identity cards for members of schemes; (g) provide a mechanism for resolving complaints by schemes, members of schemes and healthcare providers; (h) make proposals to the Minister for the formulation of policies on health insurance; (i) undertake a sustained public education on health insurance; (j) devise a mechanism for ensuring that the basic healthcare needs of indigents are adequately provided for; (k) maintain a register of licensed health insurance schemes and accredited healthcare providers; manage the National Health Insurance Fund established under Part VI; (m) monitor compliance with this Act and Regulations made under it and pursue action to secure compliance; and (n) perform any other function conferred upon it under this Act or that are ancillary to the object of the Council.

**Types, registration and licensing of health insurance schemes**

Three types of health insurance schemes were established under the NHIA. These were:
- District mutual health insurance schemes (district based and state sponsored)
- Private commercial health insurance schemes (private for-profit schemes)
- Private mutual health insurance schemes (non-profit, community based schemes)

A District Mutual Health Insurance Scheme is to be established in every district.\(^{42}\) District Mutual will be responsible for establishing a district administration, enrolling and maintaining membership, collecting contributions from people who can pay, applying a means test to determine who is indigent, and administering subsidies received from the National Health Insurance Fund for the indigent. People have a choice of enrolling with a private commercial health insurance scheme or private mutual health insurance scheme instead of joining the local District Mutual Health Insurance Scheme. The private commercial health insurance schemes will be established under the Companies Code 1963

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\(^{42}\) District Assemblies in Ghana are either Metropolitan (population over 250,000), Municipal (one-town Assemblies with population over 95,000) or District (population 75,000 and over). There are three (3) Metropolitan Assemblies, four (4) Municipal Assemblies and one hundred and three (103) District Assemblies.
(Act 179) and required to comply with relevant provisions of the Insurance Law of 1989 (P.N.D.C.L. 227). They are also not eligible for a subsidy for the indigent under the National Health Insurance Fund.

The NHIA specifies the operating principles of registered health insurance schemes: establishment of a governing body, scheme management (including financial management, reporting requirements, audits), staffing, membership registration, identification and termination, and specification of benefit package. It also lays out procedures for hearing and settling complaints, accrediting health care providers, monitoring the quality of service providers, safeguards to prevent excessive use or abuse of benefits, a schedule for settling outstanding payment to providers, and inspection procedures. Each health insurance scheme is required to comply with directives from the Health Insurance Council and may be required to appoint an actuary if there are reasonable grounds to think that a particular scheme has contravened the provisions of the NHIA or related regulations made under the NHIA.

**National Health Insurance Fund**

The purpose of the National Health Insurance Fund (NHIF) is to provide a direct subsidy to the District Mutual Health Insurance Schemes that offer the minimum health care benefits stipulated by the NHIA, reinsure the district funds against random fluctuations, cover the cost of health care for indigents, and support programs that improve access to health services. The health insurance fund will be financed through a Health Insurance Levy of 2.5 percent on goods and services produced in Ghana or imported from the outside, 2.5 percentage points of the Social Security and Pensions Scheme funds, transfers from the state budget allocated to the Fund by Parliament, returns on investments made by the Council, and voluntary contributions to the Fund (grants, donations, gifts, and other sources of financing). The Council may, by regulation, modify these sources of funding to keep pace with developments in the health insurance industry. Monies for the Fund are held in bank accounts approved by the Accountant-General. Transfers from the Fund to the District Mutual Health Insurance Schemes are approved annually by Parliament. The Fund will be managed by the Council. This includes liquidity management, investing temporary surpluses, maintaining appropriate accounts, submitting annual reports, and conducting regular audits of its financial activities.

The NHIF Allocation Formula (2005) was laid in the House on 24th May 2005 and referred to the Committee on the Whole in accordance with the Constitution and Standing Orders of the House. The monies were allocated as €139.2billion (USD 15.5 Million) for 1.74 million indigents, €48billion (USD 5.33 Million) for 600,000 aged people (to

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43 Schedule I, Part I of the NHIA specifies goods and services that are exempt from the levy such as medical supplies and services, mosquito nets, goods used by the disabled, water, education, livestock, agricultural products, food, fishing equipment, land, buildings, construction, electricity, transport, postal services, certain machinery (agricultural, industry, mining, and railways/trams), crude oil, financial services, printed matter (books, newspapers), and transfers of going concerns.

44 The funds collected from the Social Security payments would also serve as the premiums to be paid by workers in the formal sector as they would be automatically covered by virtue of their contributions into the SSNIT.

45 Very poor people, as defined by the MOH, Ghana

46 70 years and above
cater for their hypertension, diabetes, cancers and heart disease ailments) and €60 billion (USD 6.66 Million) for 2,000,000 under-18 people. The others beneficiaries are 132 Financially Distressed Schemes specified under the law - €81 billion (USD 9 Million and Social Security and National Insurance Trust (SSNIT) contributors automatically covered under the law - €60 billion (USD 6.66 Million). The rest include National Health Insurance Council Secretariat - €20 billion (USD 2.22 Million) for its operations, Contingency - €40 billion (USD 4.44 Million), Service Providers’ Support - €60 billion (USD 6.66 Million) to facilitate the population in accessing basic health service, Administration/Logistics - €82.8 billion (USD 9.2 Million) to assist the scheme for an effective administration set-up; and Investments - 608.2 billion (USD 67.5 Million) to reinsure the National Health Insurance Scheme.

Minimum Benefit Package

According to the NHIA §64, every enrollee of any scheme is entitled to minimum health care benefits as the Minister of Health, on advice of Council, prescribes. The minimum benefits package provides a comprehensive coverage of services; the list includes certain out-patient services, including general and specialist care, requested investigations (e.g. x-rays and ultrasounds), medications listed on the National Health Insurance Scheme Drugs List (not yet available from the MOH), HIV/AIDS symptomatic treatment for opportunistic infections, simple surgeries, and physiotherapy. In-patient services (i.e. those requiring overnight hospitalizations) included on the minimum benefits list are similar to the out-patient services, with the addition of accommodation in a general ward, feeding (where available), and cervical and breast cancer treatment. Also included on the minimum benefits list are basic oral health services; eye care services, including cataract removal and eye-lid surgery, among others; and maternity care, including antenatal, postnatal, and delivery services. Finally, all emergencies, or situations involving a “crisis health situation that demands urgent intervention”, shall be covered at any health facility. For all other services, the first point of attendance must be a primary healthcare provider. This list can be expanded, subject to the payment of additional premium as agreed upon by the scheme and its members (Regulation 19(2)). DMHISs, however, cannot expand upon this list without the prior approval of the Council (Regulation 19(3)).

Apart from these, public health services are available free from the government to every Ghanaian, irrespective of whether s/he is currently a member to a scheme. These services include immunization; family planning; in- and out-patient treatment for mental illness; treatment for tuberculosis, onchocerciasis (river blindness), Buruli ulcer, and trachoma (a specific type of blindness); and confirmatory HIV tests for AIDS patients.

47 This is based on the National health Insurance Regulations passed in late 2004.
48 It is unclear what specific immunizations will be offered, or to what services “family planning” specifically refers. It is possible that the MOH will further elaborate on this list in the near future.
DESIGN ISSUES

There are quite a few issues in the scheme design that could be matters for concern. The administration structure which in this case would be a mixture of public, quasi-public and private, needs better articulation. The financing mechanism for the NHIF and the disbursement of funds needs to be streamlined with a focus on long term sustainability of the scheme. A minimum benefits package that is universal needs to be spelt out after a proper costing exercise. There should be a clear understanding of how this package interacts with the public health services provided free by the government. While the policy is supposed to be pro-poor it needs to show clearly who the beneficiaries of this subsidy are and whether everyone who needs a subsidy gets it (i.e. the definition of indigents needs to be evaluated). The purchasing mechanism from the providers needs to be spelt out, and with the supply side subsidies available to the public providers, the possibility of an unlevel playing field needs to be taken into account.

Administrative Structure

There are now three new additions to the bureaucratic setup, the National Health Insurance Council, the National Health Insurance Fund and the District Administrative Entities. The administrative structure though seems open to conjecture. There seems to be no consensus on who the final authority would be and what roles are assigned to whom. Fig 1 below shows a rough interaction structure based on the available data.

Figure 1. Interaction between administrative entities
It was initially argued that health insurance was the sole responsibility of local government based on the notion of the provider/purchaser split. After a year however, there seemed to be an attempt to bring together health providers and local government to initiate the process of establishing schemes. This leaves the GHS and the District Administration unsure who is in the driving seat. It is also very likely to affect community ownership and participation if care is not taken in spelling out clearly the roles and responsibilities of different parties.

Also, as in many low income countries, Ghana has a shortage of skilled managers and very few who have been trained in the management of social insurance systems. The rapid growth of MHOs in the past has far outstripped the growth of technology and skilled personnel. A decentralized insurance system such as the new Mutual Health Insurance Scheme in Ghana will be very resource intensive and require significant management development so that the District Mutuals as well as central administration has appropriately skilled staff.

**NHIF – Financing and disbursement issues**

The NHIF is to be financed through a health insurance levy (2.5 percent on goods and services produced in Ghana or imported from the outside), 2.5 percentage points of the Social Security and Pensions Scheme funds, transfers from the state budget allocated to the Fund by Parliament, returns on investments made by the Council, and voluntary contributions to the Fund (grants, donations, gifts, and other sources of financing). There is no explanation of where these numbers come from. There is no evidence of an estimation of the budget required, though the Ministry of Health claims that it will cost the government between 70 and 120 billion Cedis [over US$ 13 million] annually to replace the ‘cash-and-carry’ system and finance health care in public facilities.49

Another issue for concern is the allocation and disbursement of these funds. The NHIA does not specify mechanisms but simply delegates this responsibility to the NHIC. Section 77.1 of the NHIA sets out areas in which the fund can be used such as subsidies to DMOs, reinsurance of DMOs, monies for the health care costs of indigents, facilitating provision of or access to health services, investing in any other facilitating program to promote access to health services as may be determined by the (Health) Minister in consultation with the Council. A certain allocation of funds based on a formula has been recently approved by the parliament though there is no mention yet of how these funds are to be disbursed and how the allocation of these funds will be made to various DMHISs.

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49 ‘GHANA: National health insurance scheme launched’ A report, featured at IRINNews.org
Costing of the Minimum Benefit Package

Many questions are still unsettled concerning the scope of the mandatory package under NHI and the package favored by district health insurance for their members (in the mutual schemes there is a broad diversity). The options chosen will be of major importance for the evolution of providers. A very broad package covering almost all care except chronic diseases has been published for feedback. Such a package is too extensive to be sustainable over the long term, and there is no reason to give details for some activities and not for others. There is no evidence of costing of the package. This could lead to a potential danger of cost escalation especially with the expected over utilization of services. Given the traditional relations between the state and the public in most African countries, where government sponsored initiatives are often seen as fodder for the taking, this is a legitimate fear. Costs might also tend to be higher in the health sector because of the additional burden of the administrative overhang from handling insured patients.

In the case of MHOs, the packages were designed to suit the members of the scheme and were costed accordingly, whereas now the new packages might cost a lot more and this is bound to put the private schemes under pressure. One fear is that they would try to compensate by cutting corners in other ways. In an extreme case, cost pressure could even lead to a crowding out of private health insurance with only a financially burdened DMHIS left holding the baton. Another fear is that since the cost structures of private insurers and the DMHIS vary with the providers they use, this could lead to quality differentials in healthcare and also create different insurance systems for different socio-economic strata.

One other issue is that of Public Health Services that are provided free by the Government. There seems to be no effort to reconcile these with the new NHIS. In fact the MOH is yet to completely set out all the provisions that will be part of these services. It is important that these two are clearly delineated so that the costing of the NHIS by itself can be undertaken and the budgeting and allocation of funds can be done efficiently.

Actuarial Soundness of the DMHIS

There seems to be no actuarial costing done before the NHIA was enacted. The NHIA though, recognized actuarial expertise and suggests the employment of one actuary who should have access to data to do his/her work. Since the NHIA came into being, the SSNIT with the assistance of the ILO has undertaken an actuarial analysis. However Ghana lacks adequate and reliable data to prepare reasonable cost estimates.

The main result of the analysis undertaken seems to be that the public health sector will not likely face expenditure problems that cannot be mitigated by parametric adjustments

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50 Subsection 72
of the health care financing system (such as increasing the premiums to the district mutual
health insurance schemes and temporarily reducing investment in the health services
infrastructure). The key uncertainty in the projections remains the future increase of the
coverage rate in the informal sector. The analysis also assumes a growth in formal em-
ployment which is not reflected by current trends. Another issue to be considered is that
this model depends on the current definition of indigents, which is suspected to be vastly
underestimated as discussed in the next section.

Exemptions for Indigents

The NHIA exempts the poorest of the Ghanaians, (termed indigents) from having to pay
premiums. The NHIA §104 defines an indigent as “a person who has no visible or ade-
quate means of income or who has nobody to support him or her and by the means test
qualifies as an indigent.” The Minister of Health, on the advice of the Council, is sup-
posed to prescribe a means test\textsuperscript{51} for determining persons who are indigent. This is a very
stringent test\textsuperscript{52}, which only the poorest of the poor in Ghana will satisfy. Further, accord-
ing to Regulation 58(5), if the indigents list submitted by any DMHIS exceeds one-half
percent of the entire membership of the scheme, the Council shall verify the list by what-
ever means it determines. There is also a complaints mechanism for any member of a
scheme for the classification of any person as an indigent under that same scheme (Regu-
lation 58(6-7)).

Clearly, the number of “indigents” will be limited in each District. The issue here is that
this could severely limit the number of indigents while ignoring the poor and needy who
deserve a subsidy. The number of indigents estimated by the MOH is 1.74 million, which
is about 9\% of the population. This seems unreasonable in a country where 40\% are poor
and more than 25\% are extremely poor (see section on Economic indicators). There are
two issues here; firstly the state would find it difficult to collect the premiums it envis-
ages as there would be a lot of people unable to pay and secondly a lot of poor people
would be uninsured and would be denied access to care. Thus the scheme could end up
hurting the very people it was intended to benefit. On the other hand, if the definition of
indigents is relaxed to cover a larger number of people, the issue of mustering extra fi-
nancing crops up.

Purchasing of services and pricing issues

The current system of payment is based on government budget allocations and out-of-
pocket payments by patients. Salaries are paid to health workers to deliver services.

\textsuperscript{51} ‘Means test’ refers to a protocol administered to determine the ability of individuals or households to pay varying
levels of contributions to the scheme, ranging from the indigent in the community whose contributions shall be totally
borne by the government, to those who can afford part but not all the required contributions for the Scheme

\textsuperscript{52} According to Regulation 58, a person cannot be classified as an indigent unless she/he independently satisfies each of
the following four criteria: (1) are unemployed and have no visible source of income; (2) do not have a fixed place of
residence according to the scheme standards; (3) do not live with a person who is employed and who has a fixed place
of residence; and (4) do not have any identifiable consistent support from another person.
These salaries are not related to how much work is done by an individual or the volume of services delivered. With insurance, the payment to health care services will be done by capitation \(^{53}\) or fee-for-service \(^{54}\). The previous method of ‘cash and carry’ functioned on a fee-for-service basis and this seems to be the favored method of the Ghana MOH now also.

A traditional fee-for-service system, based on individual services and detailed invoices, has two major disadvantages for the insurer: (1) Assessing individual claims to verify whether all services claimed have been delivered (and were necessary) is difficult; (2) Full financial risk is placed on the insurer, because it allows providers to claim as much as they feel necessary.

On the other hand, a capitation system needs to be based on a mutual understanding of the probable cost of services for a given population. Without correct and detailed information on the cost to be expected (usually derived from historical data), capitation puts a high financial risk on the provider (who bears the full insurance risk for the services under capitation). If the capitation does not reflect the real cost, providers usually react by refusing services to members or to asking for additional (informal) payments. Also varying cost structures between schemes implies the need for differential capitation fees. Therefore, a capitation system (especially in the hospital sector) seems inappropriate at the start of the new district mutual health organization system.

**Unlevel playing field**

The design of the scheme could create an unlevel playing field in two ways. Firstly, the MOH provides a huge supply side subsidy to the public providers (GHS) and the costs of the public hospitals for either ambulatory care or for inpatient treatment are bound to be much lower than the private facilities which receive no subsidies. The health sector has no pricing policy for the services provided. The public, mission, and private facilities all provide services based on different price indices and input costing. This has the potential to lead to a two tiered healthcare system. The reputations of the private and the mission hospitals are good and their services are ostensibly more expensive than the public facilities. Also most private facilities (for profit) are concentrated in urban areas where people can afford to pay for their services.

The second instance of an inequity arises between the private insurers and the DMOs. The DMHIS receives a direct subsidy and subsidies to cater for indigents. The private insurers will need to depend on paying enrollees as 100% of their revenues will have to come from the premiums collected. Faith/community based schemes might still get aid from other sources (foreign, catholic church etc) but the private for-profit organizations stand the danger of being crowded out.

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53 A fixed rate of payment per person for services delivered over a fixed period negotiated with an accredited facility

54 Paying per visit or activity
From the discussion above, it might be justified to conclude that the private for-profit insurers would have to compete on the quality aspect by contracting with private hospitals and the private non-profit insurers can compete on the cost basis by contracting with public providers but in a more cost efficient manner than the state sponsored plans. So we could be looking at a situation where the rich and the able enroll into private, commercial plans, the not-so-rich but able-to-pay population joining the community based, private plans and the indigents being covered by the state sponsored plans.

**IMPLEMENTATION ISSUES**

In terms of implementation, the handling and integration of a number of plans could prove to be a major hurdle. Enforcing the scheme and ensuring premium collection is bound to be a huge problem. Other issues include strengthening of the public and private health infrastructure and ensuring the availability of health personnel and accreditation of public and private facilities.

**District MHIS, Community financing and Integration issues**

The number of MHOs has grown from 4 in 1999 to 47 in 2001 and 159 in 2002. The expansion is clearly driven by the acute nature of the 'cash and carry' burden facing individual families and increasing knowledge of the existence of MHO alternatives to user fees. Against this backdrop, the Government has chosen to place an emphasis on district insurance schemes, in contrast to the previous spontaneously developing and dynamic mix of all kinds of MHOs including district-wide schemes, sub-district, village and community schemes. Experience in Ghana and elsewhere shows that the percentage coverage of district schemes is usually quite poor. Sub-district community schemes and those based on professional solidarity tend to reach a much larger percentage of their target populations, in addition to their greater ability to implement more robust risk management techniques.55 Outside Accra and a few other large cities, the social structure in Ghana remains highly decentralized, concentrated around the household, ethnic, religious, and occupational groups. The rural populations (57 percent of the country’s population,56) and the poor, distrust central government-sponsored programs based on past difficulties in financing and managing public services.

The NHIA does recognize other schemes such as the private and commercial MHOs but does not support either of them through subsidies. This means that these schemes would need to be either profitable by themselves to survive or should be relentlessly funded by non-governmental organizations. These scenarios become tougher to realize if the government thruts down a universal minimum benefits package without doing a cost-benefit

55 In terms of coverage, the biggest scheme in Ghana, both in numbers and coverage, is not a district scheme, but the enterprise-based Ashanti Civil Servants Association, which has 72,000+, representing nearly 100% of the target group.
56 Ghana Statistical Service 2000
analysis. The existing community schemes could thus be compromised by the governments focus on district insurance schemes.

Another issue that needs to be raised is that of integration of the schemes. Assuming that the private and commercial schemes do take place along with the DMHIS, we would be looking at a huge number of plans run by different administrations as they see fit. How are these to be integrated into a National Health Insurance Scheme? This is bound to create problems as the current MHOs are independent of each other and have different premium rates with varying benefit packages. All these issues remain to be thrashed out.

**Enforcing the scheme and enrolling individuals in the informal sector**

Adult Ghanaians are to pay a monthly minimum subscription of 60000 (US $0.66). The government will subsidize the health treatment of the aged, the poor as well as children of parents who both subscribe to the scheme.

While the MOH has declared that this is to be a mandatory scheme, there is no mention of how enrollment into the scheme is to be enforced. Moreover as the NHIC has set targets for coverage over the next 5-10 years, a question needs to be asked about the compulsoriness of the scheme.

Rough estimates from Table 6 below show that approximately 15% of Ghanaian population may be employed in the formal sector. More than 80% are self employed farmers and workers in the informal sector. But only a small proportion of them would be considered indigent. Enrolling and collecting premium from the non-indigent farmers and informal sector workers would be a gargantuan task.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Wage employees</td>
<td>17.3</td>
<td>18.1</td>
<td>15.4</td>
<td>13.2</td>
</tr>
<tr>
<td>Government</td>
<td>8.0</td>
<td>7.9</td>
<td>7.8</td>
<td>5.9</td>
</tr>
<tr>
<td>State enterprise</td>
<td>1.9</td>
<td>2.3</td>
<td>1.2</td>
<td>0.6</td>
</tr>
<tr>
<td>Private</td>
<td>7.4</td>
<td>7.9</td>
<td>6.4</td>
<td>6.7</td>
</tr>
<tr>
<td>Farmer</td>
<td>58.7</td>
<td>54.6</td>
<td>56.7</td>
<td>55.7</td>
</tr>
<tr>
<td>Nonfarm Self-Employment</td>
<td>19.5</td>
<td>24.2</td>
<td>23.5</td>
<td>27.3</td>
</tr>
<tr>
<td>Unpaid Family and Unemployed</td>
<td>4.2</td>
<td>3.0</td>
<td>4.5</td>
<td>3.8</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Ghana Country Data and World Bank 2004

The issue of dependents is a different story altogether. From what the NHIA says, dependents of working people who contribute to the scheme will be covered, even if they
are not aged or children. This pool of dependants can end up being quite large per active contributor. The financial implications of such a move needs to be determined.

**Accreditation of public and private facilities as providers**

The NHIC Council has the authority to limit the services to be provided by a facility depending on the standards of equipment and service. The NHIA states that “A scheme shall not use the services of any healthcare provider or any health facility in the operation of the scheme unless the healthcare provider or the health facility has been approved and accredited to the scheme by the Council. Regulations may prescribe the qualifications, requirements and such other matters as the Council considers necessary in respect of healthcare providers and healthcare facilities that operate under the schemes”.

The current version of the legislative instrument does not distinguish between accreditation for the facilities or between modern health care professionals with high level formal training and community-level providers such as TBAs\(^5\), small-scale chemical sellers, and traditional medicine practitioners. With the heavy utilization of services provided by the last category, care should be taken so as not to deny access to those who use these services. While setting up a permanent accreditation scheme is bound to take time, a temporary one needs to be instituted at the earliest. The primary focus at the moment needs to be an accreditation procedure aimed at ensuring consumer safety and enabling financial access to services in previously under-serviced areas.

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**SUCCESSES & CHALLENGES**

**Successes**

After long deliberation, the National health Insurance Council was finally set up in 2004. Just the establishment of a National Health Insurance Scheme should be termed a success. Other than the protection provided to enrollees to the voluntary mutual health organizations, protection against financial risk of illness was previously achieved mainly through access provided to publicly financed health services. The new health insurance system will introduce a formal mechanism for pooling revenues and spreading risks across population groups, from rich to poor and across the lifecycle.

The Ghanaian Parliament on June 08, 2005 approved an allocation proposed by the Committee of the Whole to the National Health Insurance Fund (NHIF). The National Health Insurance Levy component and Social Security and National Insurance Trust (SSNIT) fund component are to represent 77% and 23% respectively. The collection of funds has started and according to Malik Alhassan Yakubu, the Chairman of the Commit-

\(^5\) Traditional Birth Attendant
tee of the Whole, the National Health Insurance Council has been able to mobilize over €700 billion (USD 77.74 Million) from various sources into the Fund which is being kept in an account at Bank of Ghana.

According to President Kufuor, 40.6 billion cedis - nearly US$ 5 million - from the Heavily Indebted Poor Countries Index (HIPC) has been used to fund the scheme at the district level. A similar amount has been set aside for health workers who agree to work in deprived areas in the country. Thus the current scheme is being subsidized by HIPC and with the recent announcement by the G8\textsuperscript{58} to cancel debts of the world’s poorest countries, Ghana is likely to have more such funds for health care.

According to the health ministry, over 90 districts and sub-metros are at various stages of implementation and twenty-two districts are just about to start the implementation process. The sooner the scheme can be made visible and operational in places, the better the chances of its catching on.

**Challenges**

*Increasing coverage and building up political support*

In the current context with the rival political parties accusing the government of indecent haste\textsuperscript{59} in instituting the scheme the challenge is to demonstrate small successes in the near future that can build up support. It would be important for the NHIS to be on track to reach its purported goal of covering 30-40% of the population within the next five years, and 50-60% within the next five to ten years. This would send out the right signals to the people and to external donors and build support for the scheme.

**Administrative Structure**

From an administrative standpoint, role definition would be crucial. The Ministry of Health, the National Health Insurance Council, and the Ghana Health Service are bound to become increasingly interdependent in the formulation and execution of health policy in Ghana. Now the MOH funds and manages public facilities. The challenge would for MOH to become the policymaker and regulator of healthcare as opposed to being the provider of services.

**Enforcing mandatory insurance**

Another big challenge lies in enforcing the mandatory insurance. There are no specific guidelines on how this is to be achieved. While universal coverage is a long way off and certain milestone achievements over time seem to have been targeted by the government, it is important to specify the groups or people that will be covered in the first phase.

\textsuperscript{58} BMJ 2005;330:1407 (18 June), doi:10.1136/bmj.330.7505.1407

\textsuperscript{59} From the words of NDC Presidential candidate and former Ghanaian Vice-President, Professor John Atta Mills in the report ‘GHANA: National health insurance scheme launched’ featured at IRINNews.org
the current concentration of healthcare infrastructure in the urban areas, higher percentage of people employed in the formal sector and from an ability-to-pay perspective, it would seem logical to assume that urban population would be the first to be covered. This defeats the entire purpose of making healthcare accessible to the poor and the rural populations and of risk pooling and subsidizing the poor against the well-off. The challenge lies in targeting needy groups and setting out a road map to ensure coverage over the next few years.

**Ensuring Financial Sustainability**

The issue of financial sustainability is one of the biggest challenges that needs to be confronted. There is an actuarial analysis done recently but it needs to be refined with the use of utilization data. The sooner this is done and a benefit package is decided on after instituting a proper costing exercise, the better it is for the scheme. The recent parliament statement saying that about $300 billion (USD 33 Million) is to come out of contributions by 850,000 people into the SSNIT implies that on an average a person employed in the formal sector would be paying out $350,000/annum (nearly 40 USD) which seems steep compared to the $72,000/annum (8 USD) paid by community residents who enroll into an MHO. As the SSNIT contributors would be covered by the scheme as a virtue of having paid, the premium needs to be collected from the remaining people a majority of whom are outside the formal sector. Also, the definition of indigent could end up affecting the coverage process. With about 40% of Ghanaians termed as poor under the GLSS, enrolling the ‘non-indigent’ among them into the scheme or collecting premium from them would be a major hurdle. The fact that large proportions live in rural areas and work in the informal sector adds to this difficulty. The high dependence on foreign aid is another matter for concern. It is important to find other sources of revenues to sustain the scheme in the long run. In this scenario, the challenge will be to plan for the future setting out a clear operating budget and definitive sources of funds to ensure sustainability of the scheme.

**Integration into a National Health Insurance Scheme**

Integration of the various schemes into one National Health Insurance could be a huge and onerous task as has been evidenced by other countries. Korea had its share of problems taking four years (1997 to 2001) to work out the integration process though it was helped by the fact that the government started with many funds, had a compulsory insurance scheme since as early as 1977 and there was a much better understanding of insurance and a much better coverage and access to providers. Also the amount of variation between schemes was relatively lower compared to Ghana. It would be a challenge to integrate schemes which are varied in terms of membership, benefits, premiums and types of providers.

60 Korea, Germany
Creating healthcare infrastructure

One other challenge is to build up health infrastructure and a provider network to cater to the increase in coverage. This places twin pressures on the system; the first being to ensure the availability of healthcare professionals throughout the country and second to undertake a quick accreditation process to certify them. The success/failure of the scheme depends on how it is perceived by the early enrollees and whether they are able to access care. As can be seen from Table 3, the preponderance of healthcare facilities (both government and private) in the urban areas is a cause for concern. In order to ensure access, the government needs to ramp up public facilities and also facilitate the setting up of private facilities in the rural and poorer areas. It also becomes important to recognize the role of traditional healers and how they can contribute to the health system. A related challenge would lie in setting out clear accreditation guidelines and setting a clear target for implementation.

Safeguarding against Crowding out or Adverse/Risk Selection

Competition between schemes could lead to crowding out of the disadvantaged schemes or lead to failures through risk/adverse selection. The issue of supply side subsidy to the GHS needs to be re-examined along with the issue of ‘indigent subsidy’ to the DMHISs. Private providers would be facing a higher cost structure and the private insurers would accept only the rich people who can afford to pay higher premiums leading to a case of risk selection. A related issue would be the adverse selection that could take place at the DMHISs with only the poor and the indigent enrolling in those schemes. The challenge would be to structure the subsidy in such a way as to level the playing field between the different kinds of insurers and to ensure that there is a proper cross-subsidization and pooling of risk between the rich and the poor.

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61 As a side note, the NHIA or the NHIC does not specify any penalties for a provider failing to supply the services that an enrollee is entitled to.
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Chapter 5: Philippines

Extending Coverage Beyond The Formal Sector

Matthew Jowett
William Hsiao
CASE STUDY: THE PHILIPPINES

The Philippines has a wealth of experience in the implementation of health insurance schemes, little of which is appreciated by the many countries currently in the process of establishing similar schemes around the world. A national health insurance program (NHIP), known as Medicare and modeled on the system in the USA, was initiated in the early 1970s and revamped in the mid 1990s. Local health insurance schemes, operated by both local government and non-governmental organizations, flourished in the 1980s and early 1990s to fill the gaps in coverage left by Medicare which focused almost exclusively on those in formal employment. The Philippines also has a vibrant private health insurance market, providing supplementary coverage for the middle classes.

A further interesting dimension of the Philippines is that health insurance has developed within a service delivery system characterized by a rich mix of public and private providers and, since 1991, a far-reaching process of decentralization in the management and financing of government health services. In this case study, the story of health insurance in the Philippines is described and analyzed in the context of a range of policy objectives. Several key design and implementation issues are examined in terms of their strategic importance. In concluding, an attempt is made to draw out some of the effects of the NHIP, which is currently managed by the Philippine Health Insurance Corporation (PHIC, but commonly known as PhilHealth), on the Philippine health system and the health of the Filipino people.

BACKGROUND

Classified as a lower-middle income country, the Republic of the Philippines comprises over 7,000 islands located between the Pacific Ocean and the South China Sea. There are currently around 85 million Filipinos, increasing at an annual rate of 2.2%, one of the highest growth rates in the region. Ninety percent of Filipinos are Christian (80% Roman Catholic) and comprise 60% of all Christians in Asia. The Philippines has a long history of colonization; Spain ruled (through Mexico) for over 350 years (1542-1899), followed immediately by the United States of America (USA) for a further fifty years (1899-1946). Independence came following liberation from the occupying Japanese forces at the end of World War II.

In the latest assessment of the Human Development Index (HDI), which uses data from 2002, the country scores 0.753 ranking it 83rd between Armenia and the Maldives; the score

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62 The most recent census was conducted in 2000.
has increased from 0.653 in 1975. The following sections look in more detail at the country’s economy and its health system.

**Economy**

In 2002, GNI per capita was estimated to be US$ 1,150 (World Bank 2005); the most recent GDP per capita, measured in Purchasing Power Parity Dollars (PPPS), is for 2002 and estimated to be PPP$ 4,450 per capita (World Bank 2002). From being one of the most developed countries in East Asia in the 1960s, average annual growth in GDP averaged only slightly over 1% between 1965-1990. The 1990s also saw limited growth, and in 1997-1998 the economy suffered both from the Asian financial crisis and negative effects of the El Niño phenomenon.

Despite this, economic growth increased to 6.1% in 2004, the highest rate in 15 years, underpinned by a positive international economic climate. Manufacturing was the biggest contributor, expanding by 5.0%, with agricultural and service sectors also registering improved performances. Despite improvements in growth, the economy suffers from high levels of debt, standing at 78.6% of GDP, second only to Argentina. Table 1 presents selected economic indicators.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP per capita (2002)</td>
<td>US$ 1,080 / PPP$ 4,170</td>
</tr>
<tr>
<td>Annual growth GDP (2004)</td>
<td>6.1%</td>
</tr>
<tr>
<td>Government consumption as % GDP (2003)</td>
<td>11.4%</td>
</tr>
<tr>
<td>Agriculture as % GDP (2004)</td>
<td>4.9%</td>
</tr>
<tr>
<td>Services as % GDP (2004)</td>
<td>49.0%</td>
</tr>
<tr>
<td>Remittances from overseas workers as %GDP (2003)</td>
<td>10.0%</td>
</tr>
<tr>
<td>Present value of debt / GDP (2003)</td>
<td>79.1%</td>
</tr>
<tr>
<td>Poverty (% population below poverty line) (2003)</td>
<td>37.0%</td>
</tr>
</tbody>
</table>

The Philippines exports more labor than any other country in the world apart from Mexico. Much attention is currently given to overseas Filipino workers (OFWs) who now send home remittances to the tune of 13.5% of GDP (Global Economic Prospects 2006). Presently, there is strong demand for qualified nursing staff in the USA and other OECD countries with rapidly ageing populations.

Poverty rates are high in the Philippines; 37% of the population was estimated to be living below the official poverty line in 2003. Income distribution is also highly unequal, with an estimated Gini coefficient of 0.466 in 2003. Unemployment in the Philippines is currently running at an estimated 10.9%.
Health status

Overall, the health of Filipinos has improved over the past 15 years, with the infant mortality rate (IMR) declining from 57 per 1,000 live births in 1990 to an estimated 29 in 2003. Under-five mortality also improved from 80 per 1,000 children under-five in 1990 to 40 in 2003. However, malnutrition among 0–5-year-old children has declined only slightly, from 34.5% of children underweight in 1990 to 32% in 1998. Maternal mortality has fallen substantially from 209 maternal deaths per 100,000 live births in 1990 to 172 in 1998. Only in terms of child health is the country on target to meet the Millennium Development Goals. Table 2 summarizes the latest data.

Table 2. Health indicators

<table>
<thead>
<tr>
<th>Indicator and year</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy</td>
<td>70 years</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>11 / 1,000</td>
</tr>
<tr>
<td>Under 5 mortality rate</td>
<td>36 / 1,000</td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>3.1</td>
</tr>
<tr>
<td>Two leading causes of mortality</td>
<td>1) Diseases of the heart 2) Diseases of the vascular system</td>
</tr>
</tbody>
</table>

Source: Department of Health (2005) and WHO (2005)

As with income, there are significant inequalities in the distribution of health status across the population. For example, it is estimated that the IMR amongst households in the poorest quintile is 2.3 times higher than amongst those in the richest quintile; similarly, the under-five mortality rate is 2.7 times higher in the poorest quintile than in the richest. Life expectancy amongst adults in the Autonomous Region in Muslim Mindanao (ARMM) in 2000 was estimated to be comparable to that reached at the national level in 1970, indicating that in this important measure of health outcomes, the ARMM is at least 30 years behind the rest of the country.

In a recent Discussion Brief prepared by the World Bank (2004), several structural problems in the health system were identified, including the following:

- excessively high prices of medicines leading to inadequate and irrational use
- insufficient effort expended on prevention of new diseases, particularly non-communicable disease
- excessive reliance on use of high-end hospital services rather than primary care and outpatient specialist care
- inefficient organization of the country’s hospital system
- insufficient quality assurance mechanisms to eliminate poor and wasteful medical practices

A major initiative to reform the health system, known as the Health Sector Reform Agenda (HSRA), was launched by the Department of Health in 1999, one pillar of which, health financing, stressed the important role of PhilHealth in driving reforms.

63 Unusually, injuries are the 4th leading cause of mortality, 67% of which are intentional (stabblings, shootings etc).
Expenditures on health

National Health Account (NHA) data are available for the Philippines for the period 1997-2002 (WHO 2005). The first publication covered the period 1991 to 1997, and thereafter estimates have been made annually. As of 2002, total health expenditures stood at 2.9% of GDP, one of the lowest levels in the region, or US$28 per capita (equivalent to PPP$ 153 per capita). Figure 2 presents trends since 1998, whilst Table 3 provides a summary of the NHA 2002 findings.

Figure 2. Trends in health expenditure, 1998-2002

Public expenditures overall (including SHI) decreased by eight percentage points across this period, principally as a result of falling general government expenditures (i.e. not SHI), both at national and local levels. In 2002, peso expenditures by government (excluding SHI) were down by 18.2% compared with 2001, reflecting the country’s growing fiscal crisis.

Table 3. National health accounts 2002

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total health expenditure as % GDP</td>
<td>2.9%</td>
</tr>
<tr>
<td>Total health expenditure per capita (US$)</td>
<td>28</td>
</tr>
<tr>
<td>Total health expenditure per capita (PPPS)</td>
<td>153</td>
</tr>
<tr>
<td>Government expenditure as % total</td>
<td>39%</td>
</tr>
<tr>
<td>Social health insurance as % government expenditure</td>
<td>23.5%</td>
</tr>
<tr>
<td>Private expenditures as % total</td>
<td>61%</td>
</tr>
<tr>
<td>Prepaid plans as % private health expenditures</td>
<td>17.9%</td>
</tr>
</tbody>
</table>

Since 2000, the share of financing from private sources has increased by eight percentage points, which also reflects a real increase; actual expenditures grew by 7.9% in 2002 over 2001. In 1995, out-of-pocket expenditures on health stood at 50.4% of total health expenditures, falling to 41.0% in 2000, and then increasing to 55.8% in 2001 and 61% in 2002. The current level is higher than in China (59.9%), the People’s Democratic Republic of Laos (49.1%), South Korea (47.1%), Thailand (30.3%), but slightly lower than in Vietnam (70.8%).
Figure 3 shows the changing composition of public and private expenditures since 1998. Overall, government spent only 39% of total health expenditures in 2002, 23.4% of which is channeled through SHI. The majority of expenditure is private, however, standing at 61%. Of these expenditures, it is estimated that 17.9% is channeled through some form of pre-paid plan (WHO March 2005)\textsuperscript{64}, with the balance paid out-of-pocket by the patient. The HSRA set a target for PhilHealth reimbursements to represent 25% of all health expenditures by 2004 – in 2002 it represented just over 9%. It has, however, become an increasingly important source of public funding, growing from only 8.9% in 1998 to 23.4% in 2002.

**Figure 3. Composition of public and private health expenditures 1998-2002**

A chronology of health insurance

The approval of the Philippines Medical Care Act (Republic Act No. 6111) on 4\textsuperscript{th} August 1969 signaled the first step on the road to a national social health insurance scheme. The Philippine Medical Care Commission, established to manage the program, was largely successful in implementing RA6111, which mandated the enrolment of workers in regular employment, in both public and private sectors. In terms of reaching out to the poor and to other workers in the informal economy, however, Medicare was far less successful.

\textsuperscript{64} There are a number of private insurance companies, twenty-one for-profit employer oriented Health Maintenance Organizations (HMO), as well as many community level health insurance initiatives.
Table 4. Milestones in the development of the NHIP

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHASE 1</strong></td>
<td><strong>Covering the formally employed sector</strong></td>
</tr>
<tr>
<td>4th August 1969</td>
<td>Philippines Medical Care Act (Republic Act No. 6111)</td>
</tr>
<tr>
<td>1972</td>
<td>Philippine Medicare Commission formed, beginning mandatory enrolment of formally employed sector</td>
</tr>
<tr>
<td><strong>PHASE 2</strong></td>
<td><strong>Shift towards universal coverage</strong></td>
</tr>
<tr>
<td>1995</td>
<td>Philippine Health Insurance Corporation created to implement Republic Act 7875</td>
</tr>
<tr>
<td>1999</td>
<td>Department of Health launches Health Sector Reform Agenda</td>
</tr>
<tr>
<td>October 1999</td>
<td>Launch of indigent program</td>
</tr>
<tr>
<td>December 1999</td>
<td>Equalization of benefits across member type – results in 32% increase in benefits for government employees</td>
</tr>
<tr>
<td>July 2000</td>
<td>Launch of Outpatient Consultation and Diagnostic Package</td>
</tr>
<tr>
<td>December 2001</td>
<td>Plan 500 (enrolment of poor households)</td>
</tr>
<tr>
<td>February 2002</td>
<td>Implementation of Relative Value Scale 2001</td>
</tr>
<tr>
<td>April 2003</td>
<td>Launch of TB Dots Package</td>
</tr>
<tr>
<td>May 2003</td>
<td>Launch of Maternity Package and SARS Package</td>
</tr>
<tr>
<td>July 2003</td>
<td>Launch of Partnership with Organized Groups initiative to enroll the informal sector</td>
</tr>
<tr>
<td></td>
<td>Accreditation of Ambulatory Surgical Clinics</td>
</tr>
<tr>
<td>February 2004</td>
<td>Launch of the Plan 5/25 – mass enrolment of indigent households</td>
</tr>
</tbody>
</table>

Source: PhilHealth (2004)

Difficulties in the extension of Medicare to those without formal employer-employee relationships (i.e. the informal sector) led to growing popular concern over the lack of coverage for this group. In response, the late 1980s and early 1990s, saw a growth in the number of smaller-scale local health insurance schemes (GTZ 2003).

Republic Act 7875 (RA 7875), passed into law in 1995, represented a further legislative landmark for SHI in the Philippines, embodying a clear mandate of reaching out to all Filipinos, in order to achieve universal coverage. A new government-owned and operated corporation (GOCC), PhilHealth, was established to take this new agenda forward in place of the Philippine Medical Care Commission. The new legislation also represented a philosophical shift away from the ex-post reimbursement of hospital costs, towards the more proactive promotion of health, for example through the extension of benefits to outpatient services. As noted in section 2.3, however, there is still considerable room for PhilHealth to move further in this direction, in order to become a driving force for good health in the country, rather than a purchaser of clinical services.

Insurance coverage has grown steadily since 1972 (see Figure 8 in section 4.2). However, only since the establishment of PhilHealth has some progress been made in extending coverage to the poor and informal sector workers. For PhilHealth, as well as many other countries, achieving universal coverage depends on the success of strategies to enroll
these two groups. An equally challenging task is to ensure that any extension in coverage is sustainable. PhilHealth has a target of 2010 to reach universal coverage.

**DELIVERY OF HEALTH SERVICES**

The Philippines has a vibrant public and private mix in the delivery of health services. Supply is regulated through licensing by the Department of Health (DoH), whilst PhilHealth operates a separate process of facility accreditation. Whilst there are more licensed beds in government than private facilities, there are considerably more PhilHealth accredited beds in the private sector.

**DoH facility licensing**

Table 5 summarizes the number of hospital facilities in the Philippines licensed by the DoH. Almost two-thirds are in the private sector, and one half are first level facilities (i.e. relatively small primary hospitals). When the number of licensed beds is analyzed, rather than simply the number of facilities, the dominance of the private sector disappears, with over 53% of licensed beds in government facilities (see Table 6). Over half (53%) of beds in government facilities are found in third level referral hospitals. Similarly, of all licensed beds in private facilities, 54% are in third level referral facilities. Over one-third of all licensed beds in government facilities are located in the national capital region, compared with 27% of private beds.

<table>
<thead>
<tr>
<th>DoH licensed hospital facilities (2003)</th>
<th>First level</th>
<th>Second level</th>
<th>Third level</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>327</td>
<td>250</td>
<td>82</td>
<td>659</td>
<td>39.6%</td>
</tr>
<tr>
<td>Private</td>
<td>465</td>
<td>377</td>
<td>164</td>
<td>1,006</td>
<td>60.4%</td>
</tr>
<tr>
<td>Total</td>
<td>792</td>
<td>627</td>
<td>246</td>
<td>1,665</td>
<td>47.6% 37.7% 14.8%</td>
</tr>
</tbody>
</table>

Public health services at the primary level are delivered through Rural Health Units (RHU). Again, the DoH licenses these facilities, and in an effort to improve service quality introduced a *Sentrong Sigla* seal of quality, effectively a form of accreditation.

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65 Based on official data taken from the DoH website.
Table 6. Hospital bed distribution by ownership and level

<table>
<thead>
<tr>
<th>Ownership</th>
<th>First level</th>
<th>Second level</th>
<th>Third level</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>6,775</td>
<td>14,261</td>
<td>24,242</td>
<td>45,258</td>
<td>53.2%</td>
</tr>
<tr>
<td>Private</td>
<td>6,428</td>
<td>11,328</td>
<td>21,293</td>
<td>39,049</td>
<td>46.8%</td>
</tr>
<tr>
<td>Total</td>
<td>13,183</td>
<td>25,589</td>
<td>45,535</td>
<td>84,307</td>
<td></td>
</tr>
</tbody>
</table>

Following the introduction of the Local Government Code in 1991, ownership of RHUs was transferred to local chief executives, as part of a process of deep decentralization.

**PhilHealth facility accreditation**

A separate, independent, facility accreditation process is conducted by PhilHealth. Hospitals are categorized into primary, secondary or tertiary hospitals. Summary data are shown in Table 7, and also in graphical form in Figure 4. In terms of accredited facilities, the figures are almost identical to DoH licensing data (there are 107 fewer PhilHealth accredited facilities).

Table 7. PhilHealth accredited hospital facilities by ownership and level (2005)

<table>
<thead>
<tr>
<th>Ownership</th>
<th>Primary</th>
<th>Secondary</th>
<th>Tertiary</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>291</td>
<td>231</td>
<td>80</td>
<td>602</td>
<td>38.6%</td>
</tr>
<tr>
<td>Private</td>
<td>389</td>
<td>389</td>
<td>178</td>
<td>956</td>
<td>61.4%</td>
</tr>
<tr>
<td>Total</td>
<td>680</td>
<td>620</td>
<td>258</td>
<td>1,558</td>
<td></td>
</tr>
</tbody>
</table>

From a look at the data, the system appears too heavy in terms of secondary hospitals, principally due to the large number of accredited private facilities. Indeed, it should be noted that PhilHealth does not currently use the accreditation process as a tool to control supply; PhilHealth accredits any facility meeting its basic criteria— the facility can then begin to make claims from PhilHealth for the treatment of members. Table 8 and Figure 5 detail the number of PhilHealth accredited beds, by hospital facility level, and ownership type.

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66 Health care institutions must have been operating for at least three years prior to their initial application for accreditation and must have the human resources, equipment, physical structure and other requirements in conformity with the standards of the relevant facility, as defined by PhilHealth.
Figure 4. PhilHealth accredited facilities by ownership and level

![Bar chart showing PhilHealth accredited facilities by ownership and level.]

Table 8. PhilHealth accredited bed capacity (2005)

<table>
<thead>
<tr>
<th>PhilHealth accredited beds</th>
<th>Primary</th>
<th>Secondary</th>
<th>Tertiary</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>4,213</td>
<td>10,160</td>
<td>17,782</td>
<td>32,155</td>
<td>44.9%</td>
</tr>
<tr>
<td>Private</td>
<td>4,055</td>
<td>10,753</td>
<td>21,801</td>
<td>36,609</td>
<td>55.1%</td>
</tr>
<tr>
<td>Total</td>
<td>8,268</td>
<td>20,913</td>
<td>39,583</td>
<td>68,764</td>
<td>57.6%</td>
</tr>
</tbody>
</table>

Compared with the number of facilities, however, there is greater divergence between DoH and PhilHealth in terms of accredited beds. Whereas 53.2% of DoH licensed beds are in government facilities, only 44.9% of total PhilHealth accredited beds are in such facilities. In addition, PhilHealth accredits 18 teaching hospitals, and a number of Ambulatory Surgical Clinics, which perform day surgery.

Figure 5. PhilHealth accredited beds by facility type and ownership

![Bar chart showing PhilHealth accredited beds by facility type and ownership.]

Since introducing the Outpatient Consultation and Diagnostic Package (OCDP), which is currently restricted to members of its indigent or sponsored program, PhilHealth now accredits Rural Health Units (RHU). For each indigent enrolled by a Local Government Unit (LGU), PhilHealth makes a capitation payment of Pesos 300 to the LGU, for the provision of this package. No private providers at the primary level are accredited. By the end of 2004, 749 RHUs were accredited by PhilHealth nationally to provide this benefit package.
Additional benefit packages have been introduced by PhilHealth in recent years, in particular the maternity package (for normal spontaneous delivery), and the TB-DOTs package. Facilities must go through a separate accreditation process to qualify for the delivery of these new service packages to PhilHealth members. This evolution in the design of benefits represents a strategic shift in PhilHealth’s thinking, away from simply paying retrospectively for inpatient care, and towards a more progressive approach with the aim of keeping members healthier i.e. treating problems before they require expensive inpatient care. On the positive side, this approach has stimulated a supply-side response; Table 9 summarizes the current status of facility accreditation nationally. On the downside, however, it has created an overlap with the public and primary health functions of the DoH, whose funding of health services was over three times greater than total PhilHealth reimbursements in 2002.

Table 9. Facility accreditation for new PhilHealth benefit packages

<table>
<thead>
<tr>
<th>Indicator (December 2004)</th>
<th>Applied</th>
<th>Approved</th>
<th>Deferred</th>
<th>Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity Care Clinics</td>
<td>76</td>
<td>74</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Anti TB / DOTS Centres</td>
<td>31</td>
<td>29</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Free Standing Dialysis Clin.</td>
<td>19</td>
<td>8</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

For the first time in ten years, PhilHealth revoked the accreditation of three hospitals in 2005 for being “…guilty of filing claims for non-admitted patients, extending the period of confinement of these alleged patients and padding the claim amounts.” Typically, the initial analysis of a facility is strict, with a simple pass or fail outcome. However, when an accredited facility is being re-assessed for renewal, if it does not meet the standards e.g. non-functioning equipment, a provisional accreditation may be issued by PhilHealth, allowing the facility to continue claiming. If insufficient qualified staff is the reason for failure, a facility may be re-accredited but with a lower accredited bed capacity, reducing the volume of claims it can make, and the level of benefits for members.

Registered health professionals

The DoH registers medical professionals, a summary of which is provided in Table 10. Despite the image of the Philippines as a country losing all its health professionals to richer countries, and indeed there is currently a huge exodus of health human resources, the ratio of health professionals to population is high, at least relative to other countries in the region.

Table 10. Registered health professionals

<table>
<thead>
<tr>
<th>Registered health professionals (2004)</th>
<th>Ratio per 100,000 population</th>
<th>Ratio per 100,000 (Sri Lanka)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>116</td>
<td>43</td>
</tr>
<tr>
<td>Nurses</td>
<td>442</td>
<td>79</td>
</tr>
<tr>
<td>Midwives</td>
<td>179</td>
<td>42</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>60</td>
<td>5</td>
</tr>
<tr>
<td>Laboratory Technologists</td>
<td>51</td>
<td>-</td>
</tr>
</tbody>
</table>
As noted earlier, the primary demand from richer countries is for qualified nursing staff. Despite this, however, there is a ratio of 442 nurses per 100,000 nurses in the Philippines, higher than any other country in the region. Data for Sri Lanka is juxtaposed for illustrative purposes. While many existing staff are leaving for nursing jobs overseas, there is also a strong pull factor, with many school leavers training as nurses and workers from other sectors of the economy retraining as nurses. The Philippines is also well-off in terms of the other major categories of health professionals.

**DESIGN & IMPLEMENTATION ISSUES**

At the onset of the NHIP in 1972, the Philippine Medical Care Commission (Medicare) acted principally as a policy-making body, an accreditor of health facilities, and an arbiter for claims appeals. The main functions of enrolment, collecting contributions, and processing claims were retained by GSIS, the Government Service Insurance System, which managed government employee members, and SSS, the Social Security System, which managed private sector employee members. The creation of PhilHealth merged these functions into one organization.

Whilst the Chairman of the PhilHealth Board is the Secretary of the Department of Health, an Executive Committee of PhilHealth has considerable autonomy over how it organizes and manages itself on a day-to-day basis. PhilHealth is, however, still subject to Executive and Administrative Orders issued by the Office of the President, but not the Department of Health. PhilHealth can set its own salary scales, although there are natural limits built into the system; a maximum of 12% of income through premium contributions can be spent on total administrative expenses (including salaries), and the salary of the President and CEO of PhilHealth must be approved by the Office of the President, setting a natural limit on the salary scale of the entire organization. The official vision and mission statements of PhilHealth are stated below, followed by several sections detailing key aspects of the national health insurance program:

“A premiere government corporation that ensures sustainable, affordable, and progressive social health insurance which endeavours to influence the delivery of accessible quality health care for all Filipinos.” (Vision)

“As a financial intermediary, PhilHealth shall continuously evolve a sustainable NHIP that shall; lead towards universal coverage; ensure better benefits for its members at affordable premiums; establish close coordination with its clients through a strong partner-

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67 This issue requires more detailed analysis, as it is not clear whether the figures include those nurses who were trained in the Philippines, but have since moved overseas to work. Furthermore, the average hides an unequal distribution within the Philippines.

68 Equivalent to the Minister of Health.

69 For example, Administrative Order 103, issued in 2004, imposed limits on expenditures on training, travel, and other line items, as a measure to stem growing levels of public debt.
ship with all stakeholders; and, provide effective internal information and management systems to influence the delivery of quality health care services.” (Mission)

Financial position

Overall financial situation
PhilHealth is currently in a healthy financial position, as portrayed in Figure 6. Whilst legally PhilHealth is authorized to maintain a maximum of two years of projected annual benefit payments in reserve, in practice it maintained the equivalent of 4.08 years in 2004\(^{70}\). To some extent this picture reflects the limited risk that PhilHealth accepts in terms of benefit payments. The graph shows that both contributions and benefit payments have been increasing steadily since the establishment of PhilHealth.

![Figure 6. PhilHealth’s financial position 1997-2004](image)

A justification frequently offered by PhilHealth for exceeding the two years reserve rule, is the growing risk they face related to the non-paying program. It is estimated that 25% of benefit payments are made to beneficiaries over the age of 60 years, with a further 25% paid out to those under the age of 20 years. However, no detailed financial analysis, in terms of projected income and expenditures, are publicly available. The fee-for-service approach to provider payment currently used for the bulk of PhilHealth payments is likely to be creating problems of supplier-induced demand. This issue is discussed further later in this report.

Table 11 summarizes PhilHealth’s assets as of 31\(^{st}\) March 2005, the majority of which are invested in long-term Treasury Bonds. PhilHealth is subject to fairly stringent rules in

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\(^{70}\) This is likely to be a slight overestimate as no value of projected benefit payments was available, and hence the current year was used.

\(^{71}\) There were allegations of misuse of funds during the transfer of funds from SSS to PhilHealth in 1998, when Pesos 4.9 billion were shifted, for a period of time, from a bank account bearing 16% to one bearing 4%. Whilst a Congressional Investigation was expected, this never took place.
terms of how it can invest; it is not allowed to invest in health facilities, given its exclusive role as a purchaser of health services, and as a rule it focuses on low-risk investments. Whilst there have been many allegations, no PhilHealth official has ever been convicted of misuse, or misinvestment of funds.

Table 11. PhilHealth financial statement (31st March 2005)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-term investments</td>
<td>11.8 billion</td>
<td>11.7 billion</td>
</tr>
<tr>
<td>Treasury Bills</td>
<td>6.6 billion</td>
<td>10.2 billion</td>
</tr>
<tr>
<td>Special Savings Deposits</td>
<td>5.3 billion</td>
<td>1.5 billion</td>
</tr>
<tr>
<td>Property, Plant and Equipment</td>
<td>0.6 billion</td>
<td>1.1 billion</td>
</tr>
<tr>
<td>Land</td>
<td>0.5 billion</td>
<td>0.9 billion</td>
</tr>
<tr>
<td>Long-term investments</td>
<td>30.9 billion</td>
<td>36.9 billion</td>
</tr>
<tr>
<td>Treasury Bonds</td>
<td>30.3 billion</td>
<td>36.8 billion</td>
</tr>
</tbody>
</table>

Revenue issues

PhilHealth makes estimates of collection efficiency, based on expected versus actual premium contributions by membership category. In the public sector, government employer contributions, allotted by the Department of Budget Management, have remained at the 2002 level despite changes approved by PhilHealth (see explanation in following section). So for example, those government employees earning Pesos 20,000 and above per month are paying Pesos 250 as their 50% share of premium contributions to PhilHealth, whilst their employer is contributing only Pesos 62.50, the 2002 level. Clearly, this represents a significant loss of revenue to PhilHealth.

Figure 7. Government employer contributions

Amongst employees of private firms, the situation is less clear, although it is frequently suggested that employers find ways of evading making contributions on behalf of their employees. In the IPP, it has been estimated that only one-third of those registered under the scheme are paying on a regular basis, a problem which is being tackled by the
strengthening of group enrolment (see discussion at end of section 4.2). Enrolment in the indigent program varies from year to year, depending on the availability, and prioritization, of public budgets, but has been boosted by considerable political support in recent years (see next section).

**Enrolment and coverage rates**

Membership in the NHIP has increased steadily since Medicare began operations in 1972 (see Figure 8). The total population of the country is represented through a straight line, to allow a visual approximation of the NHIP coverage rate. The white area below this line roughly equates to that portion of the population that is uninsured. Figure 8 shows that employees in the private sector have formed the bedrock of the program. The sudden drop in membership between 1986 and 1987 results from a reduction in private employed enrollees from 23.6 million to 16.2 million. Discussions with officials who were working with Medicare at the time, suggest that the popular uprising of 1986 against the military junta which resulted in a change of political leadership, also led to changes in the management of SSS. As a result, SSS conducted a review of the membership database, followed by a ‘cleaning’ process to deal with what was considered a bloated membership listing.

PhilHealth membership is segregated into four categories, each of which is discussed in detail next.

**Figure 8. Enrolment into the national health insurance program (1972-2005)**
**Employed program**

Section XIV of the Implementing Rules and Regulations (IRR) of RA 7875 states that “All government and private sector employees, including household help and sea-based OFWs, are compulsory members of the NHIP”. Contributions are currently set at 2.5% of the employee’s salary, shared equally between employer and employee. A salary cap is set at Pesos 25,000 per month i.e. absolute contributions do not increase above this level. The salary cap has increased considerably in recent years and will continue to do so in the future. By bringing contributions more in line with ability to pay, financing is becoming more equitable or ‘fair’.

Monthly contributions are deducted and withheld automatically by the employer and then remitted to PhilHealth. Compliance, or evasion, is reportedly a major issue, particularly amongst small shops and businesses. Whilst there are no accurate estimates of the extent of the problem, the Office of the Actuary estimates that ‘collection efficiency’ is as low as 30% i.e. 70% of those who should be contributing are not. Further details and discussion are provided in a later section.

**Indigent / sponsored program**

The enrolment of indigents into PhilHealth is initiated by LGUs, (defined as either a City or a Municipality), which are responsible for their identification. The LGU then pays their share of the annual premium of Pesos 1,200 which varies according to their class, and which changes over time (see Table 12). For a Municipality which is 4th, 5th or 6th class, they contribute only 10% of the premium in the first two years – the remainder of the premium, in this case 90%, is paid by the central Department of Budget Management to PhilHealth.

Indigent enrolment was a major issue during the national elections of 2004. President Gloria Macapagal Arroyo, running for re-election, launched the “Plan 5/25” which aimed to enroll five million families, or 25 million beneficiaries, into PhilHealth. To do so, funds were earmarked from the Philippine Charity Sweepstakes Office (PCSO), which paid the premium in full i.e. without any LGU contribution. Whilst controversial, the program was successful in boosting numbers, and was positive in that enrolling indigents was considered a vote-winning strategy, and at the top of the political agenda.

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72 The increase has been as follows: P5,500 (2000), P7,500 (2001), P10,000 (2002), P15,000 (2003), P15,000 (2004), P20,000 (2005).

73 The class of an LGU depends on their total income, rather than the degree of poverty.
Table 12. Indigent member premium contribution sharing schedule

<table>
<thead>
<tr>
<th>Year</th>
<th>City 1st-6th Class</th>
<th>Municipality 1st-3rd Class</th>
<th>4th-6th Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td></td>
<td>90/10</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>90/10</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>85/15</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>80/20</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>75/25</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>70/30</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>65/35</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>60/40</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>55/45</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>50/50</td>
<td></td>
</tr>
</tbody>
</table>

However, there was a downside to the “Plan 5/25” initiative. Technical difficulties resulted from the creation of a second category of indigent; when local government premium sharing is in place, the indigent member is eligible for PhilHealth’s additional OCDP, and the LGU receive a capitation payment of Pesos 300 per member in return; in contrast, those indigents funded under “Plan 5/25” were not eligible for the OCDP, as there was no LGU sharing. Furthermore, a ‘gaming’ problem has arisen, with some LGUs not making their contributions, in expectation that central government (or PCSO) will continue to pay the full amount.

The issue of sustaining this rapid increase in indigent members is, not surprisingly, now a major issue. Whilst there has been some success in maintaining funding, through earmarking a portion of the recently introduced sin tax, numbers are expected to fall in 2005. To a large extent, the initiative was closely associated with the incumbent President, who was also running as an election candidate, and as such was subject to accusations of electioneering. As a result the program runs some risk of being undermined in the future.

One alternative approach, which PhilHealth has discussed, is the possibility of deducting premium contributions from internal revenue allotments to LGUs, in the same way that contributions are deducted from salaries at source. However, this is not considered politically feasible. A more positive development is new legislation which earmarks 4% of recently increased VAT receipts to fund indigent PhilHealth premiums. More specifically, these funds will be used to cover that portion of the indigent premium which local government should pay. It is estimated that this new source of funding will amount to Pesos 2 billion per annum, but PhilHealth will only receive these funds from 2008 onwards. A further positive development is the earmarking of a portion of the additional revenue resulting from the recent increase in sin taxes. The 2.5% of incremental receipts is estimated to be worth just over Pesos 100 million per annum to PhilHealth, and will be used to cover the central government counterpart for indigent premiums. However, this arrangement is only valid for 2005 the period 2010.

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74 PhilHealth officials estimate the figure will reduce from five million families (25 million beneficiaries) to two million (10 million beneficiaries).
Both these developments are positive and are a further indication that, following the use of charity sweepstakes funds in 2004, the funding of indigent premiums is being slowly centralized. This in turn reflects growing resignation that local governments will not adequately prioritize PhilHealth enrolment for their poor constituents.

**Individual Paying Program**

Those eligible neither for the employed program, nor the indigent program, can join the NHIP voluntarily through PhilHealth’s Individual Paying Program (IPP). Broadly speaking, this program targets non-indigent informal sector workers, and the annual premium is currently the same as that for the indigent program of Pesos 1,200. The International Labour Organization estimates that 50% of the working population in the Philippines is in the informal sector.

There is a major problem in terms of regularity of payments amongst this group; most members of the IPP pay on a quarterly basis i.e. Pesos 300 every three months. In around two-thirds of cases, members are not paying the required amount on a regular basis. For example, a member may join and pay an initial quarterly payment, miss the next quarterly payment, but pay the following contribution, and so on. This target group, which is categorized by uncertain and variable income through the year, is particularly susceptible to this problem, leading to instability in finances, intermittent financial protection, and administrative complications for providers when verifying eligibility.

PhilHealth is currently considering a proposal to segment those currently eligible for the IPP into several groups, and to vary the premium for each. The aim of this proposal is to bring premium contributions more in line with ability to pay, given that the IPP targets a heterogeneous group, ranging from relatively wealthy professionals to relatively poor farmers.

**Non-Paying Program**

PhilHealth’s non-paying program targets those who have reached the age of retirement, as provided for by law, and have paid at least 120 monthly premium contributions to PhilHealth i.e. ten years. No contributions are made for this increasingly high-risk group, either by themselves, or by government on their behalf. It thus represents a growing risk for PhilHealth from a financial perspective.

**Estimates of coverage**

Figure 9 shows the breakdown of NHIP membership between the five membership categories (once the employed are separated by government and private). The rapid increase in the indigent program in 2004 is clear, increasing from 16% to 48% of the total. At the end of 2004, PhilHealth estimated national coverage to be 81%; at the end of September 2004, the official figure is 63 due, almost entirely, to a fall in the enrolment rate of indigents %. Preliminary author estimates of coverage rates by member sector are presented in Figure 10, based on both membership data, and target group size calculations using
employment structure data from the National Statistics Coordination Board. In summary, the greatest gap in coverage is amongst non-poor informal sector workers, followed by indigents, and private sector employers.

**Figure 9. Changes in membership composition from 2003 to 2005**

![Graph showing changes in membership composition from 2003 to 2005.]

**Figure 10. Estimated coverage rates by member sector 2004**

![Graph showing estimated coverage rates by member sector 2004.]

**Strategic issue – group enrolment in the informal sector**

Voluntary enrollment of individual households leads to the predictable problem of adverse selection, commonly observed in insurance markets, of which there is some evidence in PhilHealth terms of claims rate trends. PhilHealth is currently testing a new initiative, designed to limit problems of adverse selection and irregular premium contributions. The essence of the strategy is to offer an incentive to groups such as micro-finance and cooperative organizations if they deliver a minimum of 70% of their eligible members into PhilHealth’s IPP. It is hoped that the intervention represents a triple-win situation as described below:

**PhilHealth:** Moving away from individual and towards group enrolment should limit adverse selection and reduce dropouts, helping PhilHealth to move towards universal coverage in a more sustainable way. If the minimum threshold is not met, no group premium rate is applied, and the partner organization re-
receives no income. If after time, individuals who joined the scheme start to drop out, and enrolment levels fall below the 70% threshold, again no discount is applied and the group will receive no income. This approach gives a clear incentive to the group both to enroll a large percentage of their members into the IPP, and to prevent dropouts. By only entering into partnerships with groups having at least 1,000 eligible members, PhilHealth will also achieve gains in terms of administrative efficiency.

Organized group: The partnership will allow the groups to offer a new product to their clients, serving their needs more effectively. In most cases, the organization is expected to continue charging the full premium to their members, but remit the discounted group premium amount to PhilHealth, keeping the difference as income, in order to cover administrative costs, or use at its discretion. For example, any surplus might be returned to members in terms of dividends, additional health benefits, or reinvested in other ways. No conditions are set by PhilHealth on how the organization uses these funds, although ideas, advice, and technical support is made available. In addition, research shows that a major proportion of bad loans, or ‘delinquency’, amongst microfinance organizations results from their members falling ill and facing high hospital bills and expenditure on medicines; understandably paying the health bills takes priority over loan repayment. It is thus hoped that the strategy will, in many cases, contribute to the financial stability of the partner organization.

Member: Research has shown that for informal sector workers, more important than the premium level of Pesos 1,200 is the issue of flexibility in payment; as such the success of the strategy will depend on the extent to which the organization is innovative in terms of introducing flexible payment methods for its members (e.g. weekly collections), and in assisting members when they face problems making payments (e.g. through savings schemes). PhilHealth is thus targeting organizations that are well-managed, and have extensive and effective loan collection systems. If the managers of the organized group decide to pass on some of the discount, the member may also obtain cheaper access to PhilHealth through this initiative.

Member benefits

Benefits under the NHIP are principally inpatient-related. Under PhilHealth’s IRRs the scope of benefits are defined as follows:

a. In-patient hospital care
   1. Room and board charges
   2. Fees of health care professionals
   3. Diagnostic, laboratory, and other medical examination charges
   4. Charges for use of surgical or medical equipment and facilities
   5. Prescription drugs
b. Out-patient care
   1. Fees of health care professionals
2. Diagnostic, laboratory, and other medical examination charges
3. Diagnostic, laboratory, and other medical examination charges
4. Personal preventive services
5. Prescription drugs
c. Health education packages;
d. Emergency and transfer services; and
e. Such other health care services that the Corporation determines to be appropriate and cost-effective.

PhilHealth excludes the following services from its benefit package:
a. Fifth and subsequent normal obstetrical deliveries;
b. Non-prescription drugs and devices;
c. Alcohol abuse or dependency treatment;
d. Cosmetic surgery;
e. Optometric services; and
f. Cost-ineffective procedures as defined by the Corporation.

Benefits are portable nationwide (i.e. can be accessed at any PhilHealth accredited hospital facility in the country), and defined in terms of a series of ceilings, related to the various items listed above (e.g. room charges, professional fees). These are summarized in Table 14. In principle, PhilHealth Regional Offices (PRO) can vary the benefit package to their local area, provided that the overall value to the patient does not change.

PhilHealth has introduced several new packages in recent years, including the Maternity Care Package for Normal Spontaneous Delivery in 2003. A case rate of Pesos 4,500 is paid to accredited health care providers, regardless of length of hospital stay. Pesos 2,000 is allocated to the health professional and Pesos 2,500 for the health facility, which is expected to cover costs related to room and board, drugs and medicines, diagnostic procedures, operating room expenses, and all other medically necessary care.

Also in 2003, an Outpatient Anti-Tuberculosis/ Directly Observed Treatment Short-Course (DOTS) benefit package was introduced, under which a flat payment of Pesos 4,000 per case is paid to an accredited DOTS facility. With this amount, the provider is expected to cover diagnostic and consultation services, as well as anti-TB drugs. A first payment of Pesos 2,500 is made after the accredited DOTS facility has completed the intensive phase of DOTS treatment, and a final payment of Pesos is made at the end of the maintenance phase. PhilHealth extended the reimbursement of dialysis services to freestanding dialysis centers in 2003, and launched a SARS package in response to the recent regional crisis, under which a maximum of Pesos 50,000 per case is paid. Table 13 summarizes these additional packages.

<table>
<thead>
<tr>
<th>Benefit package</th>
<th>Basis</th>
<th>Pesos</th>
</tr>
</thead>
<tbody>
<tr>
<td>OCDP</td>
<td>Per LGU-enrolled indigent member</td>
<td>300</td>
</tr>
<tr>
<td>Maternity</td>
<td>Per case / birth</td>
<td>4,500</td>
</tr>
<tr>
<td>TB DOTS</td>
<td>Per case</td>
<td>4,000</td>
</tr>
<tr>
<td>SARS Package</td>
<td>Per case</td>
<td>50,000</td>
</tr>
</tbody>
</table>
Strategic issue – financial protection

It was envisaged that PhilHealth, with its legal mandate to “provide all citizens of the Philippines with the mechanism to gain financial access to health services,” would cover approximately 70% of the total hospital costs of patients compared with the estimated 30-45% at the time, which has been further clarified as 70% of ward rates. In practice, the situation is highly variable and uncertain; a review of the HSRA in 2002 noted: “While periodic increases in benefit expenditure ceilings are expected to increase the value of NHIP benefits, PHIC has been unable to present a clear estimate of the support value of benefit.” (Solon et al 2002). The problem of assessing the actual support value provided by PhilHealth results from two aspects of the NHIP’s design:

a) The design of PhilHealth benefits as “first-peso coverage”, and
b) Providers being allowed to charge what they want (or what the market will bear)

As a result, there is a high degree of uncertainty for the patient about what the cost of care will be, how much will be covered by PhilHealth, and how much they must pay out-of-pocket themselves. It is very difficult to generalize about the support value offered by PhilHealth; in many cases (for example public hospitals in rural areas), PhilHealth benefits will be enough to cover 100% of the cost of treatment. However, for treatment received in private hospitals in large cities, PhilHealth may only cover a very small percentage of the hospital bill, leaving the patient to shoulder the balance. A recent internal analysis conducted by PhilHealth calculates that the average support value of PhilHealth benefits nationwide is 62%, ranging from an average of almost 88% in government hospitals, but only just over 53% in private hospitals. However, further studies are required to validate these findings.

Low benefits, or rather low financial protection diminishes the value of joining PhilHealth, and can exacerbate adverse selection, with the danger that lower risk individuals will elect not to join the program. Understandably, there is pressure on PhilHealth to translate its considerable reserves into greater benefits. However, without changing the design of the benefit package, and the way that PhilHealth pays providers, such a move may simpler benefit providers rather than members, as discussed in the following section.

Strategic issue - benefit package design and provider payment

One research study conducted in 1991, which analyzed survey data collected from randomly sampled patients in 132 hospitals across the country, demonstrates how unregulated private providers increase their prices in order to capture benefit payments by PhilHealth (Gertler and Solon 2000). The study estimated that private hospitals mark-up prices to insured patients by 23.4%, with private patients charged a 60% mark-up. Overall, they calculate that hospitals extract 86% of PhilHealth benefit payments through price discrimination (i.e. profit or rent), with only 14% financing patient care.

Commentators suggest that the ideal rate of co-payment is between 15-25% of the total cost of care, to simultaneously meet objectives of efficiency and financial protection.

The survey was conducted by the Philippine Institute of Development Studies, on behalf of the Philippine Department of Health (PIDSDOH) in 1991.
The study illustrates how, when PhilHealth increases the caps in its benefit package, private providers simply increase their prices in response. Without some ex-ante certainty over the final price charged for the care delivered, the decision by PhilHealth to increase benefit payments will not necessarily result in great financial protection to members.

Under the ‘first-peso’ approach to benefits, PhilHealth limits financial risk to itself, pushing it onto the patients, who end up absorbing any charges over and above the benefit ceiling. Designing benefits in this way allows PhilHealth to manage the risk to its finances, but without exerting its power over providers, exposes its members to potentially poverty-inducing medical expenses. One option would be to reverse the design of the benefit package, with the patient making an initial deductible payment, and PhilHealth covering the ‘second-peso’ i.e. capping the amount paid by the member. However, without negotiation over the final price, the same problem may continue, with the possibility that a ‘third-peso’ will fall onto the patient.

In terms of provider payment, PhilHealth makes most reimbursements to hospitals on a fee-for-service basis. Health facilities are accredited and the cost of treatment reimbursed up to a certain ceiling, or cap, depending on the type of care provided (ordinary, intensive, catastrophic), and in which type of hospital (primary, secondary, tertiary). Table 14 summarizes the current schedule. Special agreements with non-accredited providers exist for emergency care. Recent years have seen some positive developments, however. PhilHealth now uses capitation payments to fund the OCDP, with fixed case-payments used for the recently introduced TB Dots and Maternity packages, as described earlier in this section.

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77 In Vietnam, for example, social insurance fixes provider fee schedules, and covers 80% of the total cost of care, leaving the patient with a 20% co-payment. However, once a patient has paid the equivalent of half the minimum annual salary, the patient is not expected to make any more payments out-of-pocket.

Table 14: PhilHealth member benefits\textsuperscript{79}
For all Members and Dependents under the National Health Insurance Program

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>PRIMARY</th>
<th>SECONDARY</th>
<th>TERTIARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROOM AND BOARD</td>
<td>200</td>
<td>300</td>
<td>400</td>
</tr>
<tr>
<td>Not exceeding 45 days for each member &amp; another 45 days to be shared by his dependents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DRUGS &amp; MEDICINES</td>
<td>1,500</td>
<td>1,700</td>
<td>3,000</td>
</tr>
<tr>
<td>Per single period of confinement</td>
<td>2,500</td>
<td>4,000</td>
<td>9,000</td>
</tr>
<tr>
<td>a. Ordinary</td>
<td>0</td>
<td>8,000</td>
<td>16,000</td>
</tr>
<tr>
<td>b. Intensive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Catastrophic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-RAY, LAB, ETC.</td>
<td>350</td>
<td>850</td>
<td>1,700</td>
</tr>
<tr>
<td>Per single period of confinement</td>
<td>700</td>
<td>2,000</td>
<td>4,000</td>
</tr>
<tr>
<td>a. Ordinary</td>
<td>0</td>
<td>4,000</td>
<td>14,000</td>
</tr>
<tr>
<td>b. Intensive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Catastrophic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROFESSIONAL FEES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per single period of confinement shall not exceed:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Ordinary</td>
<td>600</td>
<td>600</td>
<td>600</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
</tr>
<tr>
<td>Specialist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Intensive</td>
<td>900</td>
<td>900</td>
<td>900</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>1,500</td>
<td>1,500</td>
<td>1,500</td>
</tr>
<tr>
<td>Specialist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Catastrophic</td>
<td>900</td>
<td>900</td>
<td>900</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>1,500</td>
<td>1,500</td>
<td>2,500</td>
</tr>
<tr>
<td>Specialist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHERS</td>
<td>385</td>
<td>670</td>
<td>1,060</td>
</tr>
<tr>
<td>Operating Room</td>
<td>0</td>
<td>1,140</td>
<td>1,350</td>
</tr>
<tr>
<td>a. RVU of 30 and below</td>
<td>0</td>
<td>2,160</td>
<td>3,490</td>
</tr>
<tr>
<td>b. RVU of 31 to 80</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. RVU of 81 and above</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anaesthesiologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compensable Outpatient Services:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ambulatory surgeries and procedures including dialysis, radiotherapy and chemotherapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• TB DOTS</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{79} Reproduced from the PhilHealth website (http://www.philhealth.gov.ph/benefits.htm)
Cross-subsidization and sustainability

Figure 11 summarizes data on revenues through contributions, and expenditure through reimbursements, disaggregated by membership category. Whilst there are some missing data, the picture shows that private employees are the major net contributors to the NHIP, whilst non-paying members, and members of the IPP, are the main net recipients. Clearly, poor households are also major net recipients given that the premium is paid on their behalf by government. Government employees receive, through claims payments, almost exactly what they put in through premium contributions. Overall, the scheme plays the role of cross-subsidization, with those in regular employment subsidizing the less well-off.

Figure 11. Cross-subsidization across member categories 2004

In terms of the longer-term sustainability of the NHIP, fraud poses a problem, principally in terms of claims made for treatment never provided to a member, and in terms of inflated prices. PhilHealth considers the problem as serious, which tends to be exacerbated when providers are reimbursed on a fee-for-service basis. PhilHealth has a Standing Committee on Fraud, and the Office of the Chief Actuary estimates that somewhere between 10-20% of claims are fraudulent.80

Figures 12 plots recent trends in the claims rates, and Figure 13 the average value of claims, in both cases disaggregated by member category. The main point of note in figure 12 is the rapid increase in claims by non-paying members, who are by definition a higher-need category of over-60 year olds. Whilst this group represents a small percentage of total membership, the trend is extremely worrying and potentially financially damaging for the NHIP. The claims rate for other member categories is generally stable, although for the IPP the rate has more than doubled since 2002.

80 The Chief Actuary of an international private health insurance company, operating in the Philippines, also estimates that fraudulent claims are at least 10%.
In terms of the average value of a claim, there is a clear upward trend across all member categories since 2002 (see Figure 13). Most worrying, once again, is the trend amongst non-paying members, which has shown an increase of almost 50% since 2002. The average claim value made by indigent members is also increasing rapidly, although remains substantially lower than those made by other members.
These two trends combined suggest that at the current premium level, and given the underpayment of contributions by other government departments, the scheme is not sustainable in the medium to long-term. Again, the principle approach taken in other countries is to innovate with provider payment mechanisms, such as the use of global budgets.

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**THE IMPACT OF SHI**

Attributing changes in health status or poverty levels to the introduction of the national health insurance program is difficult. However, it can be argued (and debated) that the NHIP has had the following effects:

- **Raising health as a political priority** - through its indigent program, PhilHealth has raised the issue of access to health services up the political agenda, both at local and central government levels. This in turn has helped to secure greater funding for health insurance coverage for the poor.

- **Stable funding for the health sector** - with its own earmarked source of funding through premium contributions, PhilHealth is not dependent on annual government budget allocations, which are currently facing severe cutbacks in response to high levels of public debt. Whilst premium contributions increase and fall with the performance of the economy, nevertheless, the establishment of the NHIP has led to a more reliable, stable, and sustainable source of funding for the continued reimbursement of claims for health services provided, relative to a system funded out of regular government budgets.

- **Better health information** – although limited to those individuals enrolled into the NHIP, PhilHealth collects detailed information on disease patterns and other health-related problems through its claims processing information system. Despite limitations, the database has the advantage of being up-to-date, compared with data generated through the facility-based routine data collection, and sample surveys, which are often several years out-of-date.

- **A dynamic public sector organization** - the establishment of PhilHealth as a separate, independently managed organization has created a relatively dynamic public sector institution open to new ideas and prepared to test them. Whilst there remains an urgent need for further improvements in many policy areas, PhilHealth is well positioned both financially and in terms of its legal framework, to drive reforms throughout the health sector, given the right leadership and management team.
- **Improvements in access to services and financial protection for the poor** - the extension of health insurance to a large number of poorer households, through both indigent and individual paying membership programs, has led to greater access and financial protection for poorer sectors of society. The extent of this effect, however, has been limited given the persistence of relatively low service utilization rates amongst those groups. This in turn reflects the fact that for the poor, indirect costs, such as those incurred for transport, and out-of-pocket payments required over and above PhilHealth benefits, remains a deterrent to seeking care.

- **Greater equity in access to health care** - the policy decision made in 1999 to equalize benefit packages across member categories, strengthened equity in access to health care. Again, however, the impact of this decision has been limited given the lower levels of utilization amongst poorer households.

- **Quality of healthy services** – whilst difficult to measure, the establishment of a separate accreditation process under PhilHealth has probably led to some improvements in the quality of health services over and above the licensing process conducted by the Department of Health. In the future, however, there is considerable potential for PhilHealth to use its influence as a purchaser to further drive up the quality of health services.
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Chapter 6: Colombia

SHI with Managed Competition to Improve Health Care Delivery

Diana Pinto
William Hsiao
CASE STUDY: COLOMBIA

The National Health Insurance scheme in Colombia came into existence with the Health Reforms of 1993. The reforms paved the way for transformation of the healthcare delivery system and brought in a model of ‘Managed Competition’. With the Health insurance scheme now being in vogue for more than ten years, its analysis provides valuable insights for design and implementation of universal health insurance scheme in other countries. This case study discusses the rationale behind the National health Insurance Scheme, the institution of regulatory bodies, the setting up of a health insurance fund, the design and implementation of the Insurance Scheme and its provisions. The case focuses more on the implementation side and looks at the successes and setbacks over the last decade and spells out challenges for the future.

BACKGROUND

Colombia is a lower middle income country located in Northern South America, bordering the Caribbean Sea between Panama and Venezuela, and bordering the North Pacific Ocean between Ecuador and Panama. It is the fourth largest country of the continent.

The country is divided into 32 administrative states, called departments, which in turn are divided into smaller units called municipalities, of which there are 1092. There are also four districts which correspond to major capital cities. Although 70% of municipalities are rural and have less than 20,000 inhabitants, more than 60% of the population lives in the six largest, urban municipalities.

Economic Indicators

Colombia had one of the most stable economies in Latin America, experiencing economic growth until the mid 90’s. However, after 1996 the country entered a period of economic recession, hitting the nadir in 1999 with negative economic growth rates. Although the economy recovered, the impact of the recession on poverty, employment and social public expenditure was huge as evidenced below (Lasso 2004):

- Poverty increased from 53.2% in 1995 to 58.2% in 1999
- Urban unemployment rate increased from 10% in 1996 to 20.1% in 2001
- Social public expenditure as percent of GDP had increased substantially between 1990 and 1997(from 6.8% to 15.3%) but subsequently decreased to 13.6% of GDP in the period 2000-2001.
Table 1. Selected macroeconomic indicators 2004

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP per capita USD Colombia (2004) a</td>
<td>2,099</td>
</tr>
<tr>
<td>GDP per capita USD Latin America (2004)</td>
<td>2,835</td>
</tr>
<tr>
<td>GDP per capita PPP USD (2004) a</td>
<td>6,370</td>
</tr>
<tr>
<td>Annual GDP growth rate (2004) b</td>
<td>4.3%</td>
</tr>
<tr>
<td>Health development index ranking a</td>
<td>73</td>
</tr>
<tr>
<td>% Population under line of poverty b</td>
<td>50%</td>
</tr>
<tr>
<td>National unemployment rate 2004 c</td>
<td>14%</td>
</tr>
</tbody>
</table>


Health Indicators and demographics

Colombia currently has moderate birth, mortality and fertility rates. The key demographic indicators are shown in Table 2.

Table 2. Colombian demographic profile

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Colombia</th>
<th>Latin American region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population (2005) a</td>
<td>46,000,000</td>
<td>-</td>
</tr>
<tr>
<td>Life expectancy at birth (2003) b</td>
<td>72</td>
<td>71</td>
</tr>
<tr>
<td>Under 5 mortality rate (2003) b</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Infant mortality rate (2003) b</td>
<td>21</td>
<td>33</td>
</tr>
<tr>
<td>Total fertility rate (2000-05) c</td>
<td>2.6</td>
<td>2.5</td>
</tr>
</tbody>
</table>


The country’s health profile fits into what has been described as the double burden of disease, which is characterized by an increasing incidence of chronic and degenerative diseases typical of developed countries and persistence or resurgence of infectious and parasitic diseases such as malaria and tuberculosis.

Colombia ranks fourth among Latin American countries with respect to the total number of reported cases of HIV/AIDS. Estimates of the current total number of people living with AIDS in the country vary immensely, between 82,000 and 160,000. The observed trends for this condition between 1990 and 1998 are decreasing rates of AIDS cases and mortality, and rising rates of asymptomatic HIV infections (ONUSIDA 2005)
National Health Expenditure

Graph 1 summarizes the distribution and trend of health expenditures as percentages of GDP for 1993–2002. Total health expenditures as % of GDP have grown from 6.2% in 1993 to 8.1% in 2002, much of which is due to an increase in public expenditure (1.4% in 1993 to 3.7% in 2002). Social security expenditures grew until 1999 to 4.5% and then decreased to 4% in 2002. Total private expenditures remained around 3% from 1993 to 1997 and then decreased to 1.3% in 2002. Direct out of pocket expenditures (OOP) have also decreased over the period.

Graph 1. Health expenditures as % of GDP, by source 1993-2002

Note: According to NHA methodology, total expenditure includes direct public expenditures and public expenditures on insurance (subsidized regime), social insurance expenditures which are essentially contributory regime expenditures, and private expenditures (including both voluntary private insurance and families’ out of pocket expenditures).


Public and Private Providers of Healthcare

In the 70’s, as part of initiatives to extend coverage of basic services to all nationals, the former Colombian Ministry of Health invested in the creation of a wide network of public providers, which was set up as three levels based on a progressive scale of complexity of services and catchment area.

81 First level care includes health posts, centers and hospitals that provide general medicine, second level care includes hospitals that provide basic specialty medical and surgical services that may require intermediate complexity hospitalization and third level care includes institutions that provide specialty and subspecialty care and high complexity hospitalization.
form also required public institutions to transform their management and budgeting structure so it can compete with the private sector institutions.

As of December 2003 54,778 health care providers were registered in the Ministry’s provider certification database. Of these 41,000 are individual physicians, and the remaining are healthcare institutions of different levels of complexity. Thirty two percent of the registered health care institutions were public providers comprising of primary care providers (80%), secondary care providers (17%) and tertiary care providers (3%). 60% of public hospital beds belonged in the secondary and tertiary centre level.

Since 2002 all health services providers must meet a set of minimum quality, financial and administrative standards defined by the MPS in order to operate. To obtain a three-year certification providers register at the local health authority (Secretaría de Salud) which then verifies that the requisites are met through an inspection visit.

HEALTH CARE REFORM, 1993

Historical Base – Three tiered system

Prior to 1993 Colombia had a three tiered health care system, consisting of public provision of health care for about 65% of the population, a mandated social insurance plan which financed and operated its own facilities for workers of the formal sector, and private insurance and health care provision for those able to pay out of pocket. This system resulted in limited access to even basic health services for a large proportion of the population, operational inefficiencies at all levels of care, and poor quality of services. All these contributed to low use and acceptance of the network of public providers.

1993 Reform and its Strategy

The problems inherent in the three tiered system motivated a major reform, enacted by Ley 100 (Law 100) in 1993. The law transformed the organization, financing and delivery of Colombia's health care system seeking to improve access, efficiency and quality of services, and equity. It mandated the creation of a new system for the financing and delivery of health care, allocating public subsidies directly to individuals instead of institutions. The reform introduced four main elements to reach the poor (Escobar, 2005): i) a proxy-means testing index to target the allocation of public subsidies in health (SISBEN—Selection System of Beneficiaries for Social Programs); ii) transformation of the

82 Decreto 2309 de 2002
83 The original SISBEN instrument consists of 62 variables related to aspects of housing, public services, family structure, labor participation, education, affiliation to insurance, and recreational activities amongst others. Each household is assigned a score and classified into one of six levels. The instrument was modified in 2003 to improve its sensitivity and specificity.
traditional supply-side subsidies, which finance the public health care network, into individual insurance premiums for the poor subsidized by the system; iii) an equity fund with financial flows allowing for payroll contributions and Treasury resources to cross subsidize the insurance premium for the poor; and, iv) contracting health service delivery from both the public and private sectors. The strategy used to improve access and equity was based on the concept of ‘Managed Competition’ and Decentralization.

**Managed Competition:**
To improve efficiency and quality NHI was organized as a two-market managed competition model, illustrated in Figure 2.1. At a first level is an insurance market, where consumers have freedom of choice to enroll among a set of public or private health insurance plans. These plans offer services included in the benefits package in return for a risk adjusted premium (denominated the Unidad de Pago por Capitación or premium) fixed at the national level. In a second level, the provider market, health plans act as group purchasers for their enrollees by arranging a selected network of providers based on the best price and quality. Since the premium is fixed, health plans compete for enrollees through the service and quality features of the package. In this model, the government has the role of facilitating competition between plans by creating a level playing field. This is done by providing information about price and quality, and by formulating, monitoring and enforcing regulations concerning benefits, premium value, quality, enrollment rules and operations standards for health plans.

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**Figure 1 Colombia’s Managed Competition Model for NHI**

**Decentralization**
Implementation of the reform required new roles for local governments and the existing public provider network. The stage for this was partly set up at the time Law 100 was enacted, since in the late 1980s, Colombia’s health sector began to take part of a nationwide process of fiscal, political and institutional decentralization which sought to reassign government functions and responsibilities between the national, departmental and municipal
levels. Under the decentralization framework the central government’s role concentrated on policy design, regulation and public finance; departmental governments assumed regional planning, management and finance, articulation of policy at the local and national levels and provision of health care services at a regional level; municipal governments took on policy implementation and provision of health care services at the primary level (Bossert 2000). From 1990 to 1993 legislative mandates defined territorial functions and responsibilities, new sources of financing for health service provision and their respective allocation formulae. Administrative procedures to certify local governments as “decentralized” were established and on the basis of these, authority, responsibility and budgetary control of resources were to be shifted to departmental and municipal levels.

Law 100 also established the legal basis for institutional decentralization of public hospital facilities, through provisions mandating separation of hospitals from administrative dependency on local governments. The law facilitated conversion of these facilities to semi-public entities referred to as Empresas Sociales del Estado (ESEs), thus granting them the financial and managerial autonomy necessary to prepare for competition with the private sector under the new health insurance scheme.

---

**DESIGN**

**Administrative Structure**

The reforms demanded a reorganization of the administrative structure with the addition of new units (see Figure 2.2). The former Ministry of Health, now called the Ministry of Social Protection-MPS, assumed the role of formulating national policies and regulations and monitoring their progress and results. The monitoring, inspection and sanctioning functions of health plans were entrusted to a regulatory body called the Superintendencia Nacional de Salud (SNS). A National Health Insurance Fund denominated the Fondo de Seguridad y Garantía (FOSYGA), was created to pool the system’s revenues and distribute them among regimes. The National Council of Social Security in Health (Consejo Nacional de Seguridad Social en Salud -CNSSS), was formed as a policy making body with regulatory and policy making authority over benefit packages, premium payments, copayments and measures to avoid adverse selection, tariffs, operation rules of the SR and management of the FOSYGA. The CNSSS is chaired by the Minister of Social Protection and includes the Minister of Finance as a member. The other members are various stakeholders such as employers and worker’s representatives (who pay the premiums), the public and private health plans (who act as intermediaries) and the providers (both public and private).

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84 Ley 10 de 1990; Constitución Política de 1991; Ley 60 de 1993 (Competencias y recursos) and Decreto reglamentario 1757; Ley 100 de 1993.
85 The Ministry of Social Protection was created in 2003 by integrating the former Ministries of Health and Labor.
Target population (Contributory and Subsidized)

With the objective of reaching universal insurance coverage for all the population, but given resource constraints, it became necessary to design two separate insurance schemes that targeted different populations. One scheme, in which members contribute to a national health fund according to ability to pay is denominated the Contributory Regime (CR). The CR included all formal sector employees or independent workers with ability to pay who were already enrolled in some form of either private or public insurance, and extended coverage to their families.

The other scheme, denominated the Subsidized Regime (SR), targeted the poor and indigent population by providing subsidies to the insurance premium from specific public resources and contributions from the CR. As resources became available, expansion in insurance coverage for the population eligible for subsidies would be accompanied by gradual additions to the benefits package. Both regimes were expected to become equal in terms of benefits coverage in 2000, so that a single universal health insurance system could be implemented throughout the nation.

Benefit design

The regimes mentioned above required the design of a benefits package within the resource constraints of each scheme.
CR enrollees are entitled to a very comprehensive, standard benefits package called the *Plan Obligatorio de Salud* (POS). This package does not include amenities, such as semi-private room service in hospitals, and some services such as expensive imaging are excluded. However the law allows private insurers to supplement the packages with such services. Any individual wishing to purchase the supplementary package in addition to the basic package may do so. The benefits package of the SR enrollees, called the *Plan Obligatorio de Salud Subsidiado* (POSS), is limited in coverage compared to the CR’s plan. The POSS focuses on primary care interventions, some basic surgery and hospitalizations and catastrophic events.

According to Law 100 adjustments to the benefits packages are to be made based on changes in the epidemiologic and demographic profile of the population. Specifically for the POSS, addition of services is also limited to resource availability. The value of the premium each package is fixed at the national level on an annual basis, and is to be based on estimates of the costs of providing the respective benefits package. If deemed required, the value of the premium can also include risk adjustment.

**Financing**

The 1993 legislation introduced the following new sources of funding to the health sector:

*Contributory regime*

Payroll taxes were increased from 8% to 12% of income. Formally employed individuals would now pay a contribution equivalent to 12% of salary, of which 4% was to be paid by the employee and 8% by the employer. Independent workers would pay the full 12% starting from a floor of 2 minimum wages.

*Subsidized regime*

Of the 12% payroll contribution rate, a full one percentage point (or roughly one-tenth of the total) was to be channeled to the SR. Tax revenues from several sources and social investment transfers to municipalities were to be earmarked for health. Among these were new resources from oil revenues and matching funds for the solidarity point coming from the central government. Resources used for supply side subsidy were to be transformed to demand subsidies.

These new sources were intended to finance the expansion of insurance coverage that would eventually embrace the entire populace. This is illustrated by Figure 2.3. The left hand panel represents the uninsured population, by ability to pay. The right hand side depicts the amount of resources available for insurance, from the main sources of financing. Under the macroeconomic and employment growth assumptions for 1993, payroll tax contributions and affiliation to the CR would increase and so would funds for the SR coming from the solidarity percentage point. Additionally, increases in national and local tax revenues earmarked for health, coupled with the gradual transformation of the re-
sources allocated to finance the supply of health services into demand subsidies would
ensure funds to provide insurance subsidies to cover the poor population

Figure 3 Towards universal health coverage 1993-2001

Administration and flow of funds
As already mentioned, FOSYGA is the institution that pools the system’s revenues and
distributes these among regimes. The flow of funds takes place in the following manner
(see Figure 2.4):

FOSYGA receives total wage contributions from health plans
Of the 12% payroll contributions, a full 1% is transferred to the solidarity fund, to finance
the subsidized regime
0.41% of total revenues are transferred to a promotion and prevention fund which fi-
nances health promotion and prevention activities by health plans
0.25% of total revenues are set aside for sickness leave payments
0.25% of total revenues are set aside for maternity leave payments

The remaining revenues are used for payment of premiums to CR health plans and for
payment of claims filed by health plans to FOSYGA for medications and procedures not
included in the benefits package. Surpluses are invested in government bonds and re-
served for future contingencies. See figure on next page.

86 Law 344 of 1996 established a conversion plan for 1997-2000, by which of 15, 25, 35 and 60% of supply subsidies
were to be transformed into demand subsidies
**IMPLEMENTATION**

**Expansion of Population Coverage**

Colombia’s health care reform has been successful in expanding insurance coverage from 20% to 70% of the total population in the last ten years. Growth of enrollment in each regime is shown in Graph 2. From 1992 to 2004 coverage by national health insurance grew from 27% to 63% of total population. The growth in enrollment is notable in the subsidized regime, reaching 30% of the total population at the end of this period.
The SR has played a key role in increasing coverage for the poorest population, particularly in rural areas, where insurance coverage increased from 7 to 52% of the population as can be seen in Graphs 3 and 4.

Insurance coverage has reached the most vulnerable population. Estimates of the proportion of insured individuals by income quintile in 1992 and 2003 show an increase of 37 percentage points or a variation of 444% for the first quintile (9% in 1992 to 48% in 2003), whereas in the fifth quintile the increase was 21 percentage points (60% in 1992 to 81% in 2003) as seen in Graph 5.
Estimates from a national household survey in 2003 indicate the total population eligible for subsidies (SISBEN I-III population not enrolled in the CR) could be around 22 million, out of which 12 million are SISBEN I-I, and 10 million SISBEN III. Foreseeing no additional funds for the SR will become available, consider the following scenarios as of December 2004 (Table 3.1).

Under Scenario 1, all the population eligible for subsidies is offered insurance with available demand resources. The SR premium would have to be reduced and so would the benefits plan. The main drawback of this scenario would be that reduction of benefits would be a politically undesirable measure. Under Scenario 2 the SISBEN I and II population is offered insurance at the current SR premium and benefits, using available demand resources and a contribution to the premium is required for SISBEN III population. This contribution would be equivalent to about 18% of annual family income of this population, assuming the family head earns one minimum wage per month. Not only is it likely that few families would be willing or able to afford such a contribution, but also it would be very difficult to collect. Scenarios 3 and 4 are the same as 1 and 2, but assume an aggressive transformation of 60% of supply subsidies.
Table 3 Scenarios for expansion of coverage, subsidized regime (Colombian pesos)

<table>
<thead>
<tr>
<th>Assumptions</th>
<th>Scenario 1</th>
<th>Scenario 2</th>
<th>Scenario 3</th>
<th>Scenario 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demand resources: 2,773,000,000,000</td>
<td>Cover everyone eligible for subsidy with available resources</td>
<td>Cover only SISBEN I&amp;II populations with available resources &amp; require contribution from SISBEN III</td>
<td>Transform 60% of supply resources and cover all eligible for subsidy</td>
<td>Transform 60% of supply resources and cover only SISBEN I &amp; II, require contribution from SISBEN III</td>
</tr>
<tr>
<td>Supply resources: 1,800,000,000,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total resources SR: 4,573,000,000,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value of SR premium 2004: 193,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population eligible for subsidy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SISBEN I-II: 12,184,143</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SISBEN III: 10,228,873</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total: 22,413,016</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value of SR premium</td>
<td>123,723</td>
<td>193,000</td>
<td>159,908</td>
<td>193,000</td>
</tr>
<tr>
<td>Individual annual premium</td>
<td>0</td>
<td>151,797</td>
<td>0</td>
<td>72,508</td>
</tr>
<tr>
<td>Individual contrib., as % income</td>
<td>0</td>
<td>18%</td>
<td>0</td>
<td>8%</td>
</tr>
<tr>
<td>Supply subsidy per capita</td>
<td>80,310</td>
<td>80,310</td>
<td>44,125</td>
<td>44,125</td>
</tr>
<tr>
<td>Total expenditure per capita</td>
<td>204,033</td>
<td>204,033</td>
<td>204,033</td>
<td>204,033</td>
</tr>
</tbody>
</table>


Given the political infeasibility of reducing the SR benefits package or of accelerating the transformation of subsidies, the government used as an alternative -- the creation of a third insurance scheme, which was implemented since 2004\(^\text{87}\). The rationale behind the scheme is to expand coverage of the urban SISBEN 2 and 3 populations who have not been enrolled in the SR due to lack of funds to provide full subsidies. The program is financed through a mix of government subsidies and departmental and municipal resources\(^\text{88}\). Health plans already operating in the SR may participate in the program, providing a package which is a reduced cluster of interventions included in the POSS, and receive a premium which is about 40% of the current SR premium.

**Benefits plan of the three regimes**

Table 3.2 summarizes the main features of the Contributory and Subsidized regimes packages. As can be seen, the CR package (POS) covers almost all health interventions whereas the SR package (POSS) covers only essential clinical services, a few surgeries and the treatment of catastrophic diseases. The major difference between the two packages can be seen in the provision of services in the secondary and tertiary level of care. The partial subsidy package is a subset of the POSS, covering catastrophic care, orthopedic services, maternal and child care and medications.

\(^{87}\) Acuerdo CNSSS.

\(^{88}\) Local governments must guarantee resource availability to cofinance the program until 2008.
Table 4. Comparison of features of the Contributory and Subsidized Regime benefits packages

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Contributory regime POS</th>
<th>Subsidized regime POSS</th>
<th>Subsidized regime, partial subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheme nature</td>
<td>Compulsory</td>
<td>Social welfare</td>
<td>Social welfare</td>
</tr>
<tr>
<td>Model</td>
<td>Public/private managed competition model</td>
<td>Public/private managed competition model</td>
<td>Public/private managed competition model</td>
</tr>
<tr>
<td>Population coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target population</td>
<td>Individuals and families with ability to pay—Formal workers, informal workers who earn more than 2 minimum wages,</td>
<td>Individuals and families eligible for subsidies (SISBEN I and II)</td>
<td>Individuals and families eligible for partial subsidies (urban, uninsured SISBEN II-III)</td>
</tr>
<tr>
<td>Number of enrollees as of December 2004</td>
<td>14,857,250</td>
<td>13,765,405</td>
<td>1,788,069</td>
</tr>
<tr>
<td>% Coverage of total population</td>
<td>33%</td>
<td>30%</td>
<td>4%</td>
</tr>
<tr>
<td>Characteristics</td>
<td>Contributory regime POS</td>
<td>Subsidized regime POSS</td>
<td>Subsidized regime, partial subsidy</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------------------------</td>
<td>------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td><strong>Contents of Benefit Package</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family coverage</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Public health education and outreach</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Preventive care, individual and family</td>
<td>All which can be provided with services included in POS</td>
<td>All which can be provided with services included in POS-S</td>
<td>NO</td>
</tr>
<tr>
<td>Outpatient services (consultations, treatment, diagnostic tests, rehabilitation)</td>
<td>All</td>
<td>All obstetric services</td>
<td>All obstetric services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All pediatric services for children under 1 year of age</td>
<td>All pediatric services for children under 1 year of age</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low complexity outpatient services (consultations, diagnostic tests), minor trauma, glasses for children and the aged, family planning</td>
<td></td>
</tr>
<tr>
<td>Dental care</td>
<td>Basic dental care (i.e. fluoridation, prophylaxis, cavity occlusion)</td>
<td>Basic dental care (i.e. fluoridation, prophylaxis, cavity occlusion)</td>
<td>NO</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>All</td>
<td>Hospitalization for low complexity care (i.e. Pneumonia)</td>
<td>All obstetric services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All obstetric services</td>
<td>All obstetric services for children under 1 year of age</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All pediatric services for children under 1 year of age</td>
<td>All pediatric services for children under 1 year of age</td>
</tr>
<tr>
<td></td>
<td></td>
<td>General surgery (herniorraphy, appendectomy, cholecystectomy, histerectomy)</td>
<td>All obstetric services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cataract surgery, correction of strabismus</td>
<td>All orthopedic care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All orthopedic care</td>
<td>All orthopedic care</td>
</tr>
<tr>
<td>Characteristics</td>
<td>Contributory regime POS</td>
<td>Subsidized regime POSS</td>
<td>Subsidized regime, partial subsidy</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------------------------------------------------------------------------------</td>
<td>---------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Contents of benefit package</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td>All medications in national listing</td>
<td>Same as POS</td>
<td>All medications within POS listing required for treatment of covered conditions and primary level care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Same as POS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catastrophic care</td>
<td>Treatment with radiotherapy and chemotherapy for cancer, dialysis and organ transplant for renal failure, Surgical treatment of heart, cerebrovascular, neurological and congenital conditions, treatment of major trauma, intensive care unit, hip and knee replacement, major burns, treatment for AIDS</td>
<td>Same as POS</td>
<td>Same as POS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td>For referrals, catastrophic care cases</td>
<td>Same as POS</td>
<td>NO</td>
</tr>
<tr>
<td>Excluded conditions</td>
<td>Aesthetic surgery</td>
<td>All conditions not listed above</td>
<td>All conditions not listed above</td>
</tr>
<tr>
<td></td>
<td>Infertility treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Treatment for sleep disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Organ transplants (except renal, heart, chornea and bone marrow) Psychotherapy and psychoanalysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Treatments for end stage disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Characteristics</td>
<td>Contributory regime POS</td>
<td>Subsidized regime POSS</td>
<td>Subsidized regime, partial subsidy</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td><strong>Enrollment rules</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions against adverse</td>
<td>Minimum weeks of enrollment required before full coverage of higher complexity care takes place; Minimum period of 2 years of enrollment before switching plans</td>
<td>Minimum period of 2 years of enrollment before switching plans</td>
<td>None</td>
</tr>
<tr>
<td>and risk selection</td>
<td>No denial of coverage or pre-exclusions of conditions</td>
<td>No denial of coverage if eligibility criteria are met or pre-exclusions of conditions</td>
<td>No denial of coverage if eligibility criteria are met or pre-exclusions of conditions</td>
</tr>
<tr>
<td></td>
<td>Risk adjustment of premium by age and sex</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Cost sharing</strong></td>
<td>Sliding scale copayments for ambulatory care and hospitalization, preventive services and conditions of public health interest excluded (i.e. Hypertension, diabetes care)</td>
<td>No copayments</td>
<td>No copayments</td>
</tr>
<tr>
<td><strong>Choice of insurer</strong></td>
<td>Free choice within set of plans available in geographic work setting</td>
<td>Free choice within set of SR plans operating in municipality</td>
<td>Free choice within set of SR plans operating in municipality and offering partial benefit product</td>
</tr>
<tr>
<td><strong>Choice of provider</strong></td>
<td>Free choice within plan network, use of gatekeepers</td>
<td>Free choice within plan network, restricted to public network in low complexity care, use of gatekeepers</td>
<td>Free choice within plan network, restricted to public network in low complexity care</td>
</tr>
</tbody>
</table>
Health Plans

Health plans serving the Contributory Regime (CR) are known as Entidades Promotoras de Salud (EPS). These plans can be private (for profit or non-profit) or public. Before the reform, health insurance to employees was provided almost exclusively by public insurers, the largest being Instituto de Seguros Sociales (ISS). Between 1993 and 2000, competition by private health plans has reduced the public sector’s market shares. Between 1995 and 1998 the market share of private health plans increased from 11% to 30% of the population in the CR, a net increase of 261.1%. As of December 2004 there were 40 health plans operating in the CR, out of which private health plans have 72% of market share. In the CR, health plans are free to structure their network of providers. First levels of care are contracted mainly with private providers, and recently there has been a trend towards vertical integration (ownership of first level providers by insurance plans, like HMOs in the U.S.

Health plans serving the Subsidized Regime (SR) are generically known as Administradoras del Régimen Subsidiado (ARS). These can be public, private (for profit or non-profit), or community-based non-profit organizations. The insurance market for the SR developed quickly: ARSs were authorized to operate in 1995, and as of December 1999 there were 239 ARS in the market, with a total of 9 million enrollees, or 22% of the total population (Cardona. 1999). The large number of ARS did not permit adequate risk pooling, and generated large inefficiencies, especially due to large transaction costs. This motivated the government to issue Decree 1804, that required ARS to have a minimum of 200,000 enrollees, and led to a wave of mergers that reduced the total number of ARS to 43 as of December 2004. Forty five percent of these are private, 42% community based, 6% public and the remainder health plans for indigenous populations.

Analyses of market structure at the municipal level indicate that although there are several health plans in most municipalities, the market is characterized by a dominant health plan with more than 73% of enrollees. Only in major cities does the market appear to be competitive (Restrepo 2001). Also, while there were efforts to unify the insurance schemes existing in 1993, exceptions were made for the military and police forces, the education sector and workers of the Colombian oil company (Empresa Colombiana de Petróleos -ECOPETROL), allowing these groups to be autonomous in the organization and provision of health benefits. About 4% of Colombia’s population is affiliated to these independent schemes.

Minimum quality, financial and administrative standards for health plan operations have been defined by the MPS and health plans are required to demonstrate fulfilment of these requirements through a certification process. However, implementation of this process has been slow, in part due to political pressure from public health plans which might not meet the standards.
Contracting and Payment of Providers

For more complex levels, health plans contract both with public and private institutions. Capitation payment is increasingly being used by health plans for preventive services and the primary level, but most specialist care and hospital care is paid on a fee for service basis as shown in Table 3.3

<table>
<thead>
<tr>
<th>Level of care</th>
<th>Proportion of sampled firms that use payment method</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Capitation only</td>
</tr>
<tr>
<td>Preventive care</td>
<td>55%</td>
</tr>
<tr>
<td>Primary care</td>
<td>45%</td>
</tr>
<tr>
<td>Secondary care</td>
<td>27%</td>
</tr>
<tr>
<td>Tertiary care</td>
<td>9%</td>
</tr>
<tr>
<td>High complexity, specialized care</td>
<td>0%</td>
</tr>
</tbody>
</table>


Although ARS are required by law to contract at least 40% of their network with public providers, they are free to structure the rest of their network. Otherwise, contracting and health care management strategies are essentially the same as those described for EPS in the CR.

In the CR health plans can control demand by charging co-payments both for ambulatory care and hospital services. The maximum value of co-payments per service is set by the government at the national level, on a sliding scale by income level. Co-payments for preventive services and services for certain conditions of public health interest such as hypertension and diabetes are not permitted. The main administrative strategies used by health plans to control demand are the use of gatekeepers, and utilization management for specialist, hospital and diagnostic care.

Financial Conditions

At the time of the reform it was assumed that sustainability of the CR would be guaranteed through wage contributions, and by additional resources for health plans generated by enrollee co-payments and the sale of supplemental insurance. This also implied that the value of the premium would be enough to cover health plan costs. Until 1999 the compensation fund maintained positive balances, which yielded important financial returns. However, by 2000, premium payments to health plans increased at a faster rate than revenues from wage contributions and by 2001 the compensation fund reached a negative balance, leading to the need to use surpluses from previous years. Table 3.4 shows FOSGYGA balances from 1998-2002. The total number of enrollees in the CR has grown mainly by expansion of family coverage, as seen by a faster growth rate of beneficiaries compared to contributors. Average salaries expressed in minimum wages have been decreasing and family density increasing. The effect of the composition of enrollees and labor market conditions has translated in less revenues and greater expenditures.
Table 8. FOSYGA BALANCE, 1998-2002

<table>
<thead>
<tr>
<th>Characteristics of enrollees</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>Variation 98-02</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributors (# of people)</td>
<td>5,089,574</td>
<td>5,293,294</td>
<td>5,235,106</td>
<td>5,204,702</td>
<td>5,282,773</td>
<td>0,9%</td>
</tr>
<tr>
<td>Beneficiaries (# of people)</td>
<td>6,481,049</td>
<td>7,734,498</td>
<td>7,692,801</td>
<td>7,732,990</td>
<td>7,976,987</td>
<td>5,3%</td>
</tr>
<tr>
<td>Total enrollees</td>
<td>11,570,623</td>
<td>13,027,792</td>
<td>12,927,907</td>
<td>12,937,692</td>
<td>13,259,760</td>
<td>3,5%</td>
</tr>
<tr>
<td>Family density</td>
<td>2,27</td>
<td>2,46</td>
<td>2,47</td>
<td>2,49</td>
<td>2,51</td>
<td></td>
</tr>
<tr>
<td>Average salary (# minimum wages)</td>
<td>2,18</td>
<td>2,09</td>
<td>2,07</td>
<td>2,1</td>
<td>2,0</td>
<td></td>
</tr>
</tbody>
</table>

Revenues (millions of col pesos)

| Contributions                  | 3,256,567 | 3,766,973 | 4,058,810 | 4,501,359 | 4,701,245 | 1,4%            |
| Financial returns              | 57,998    | 74,641    | 38,099    | 37,923    | 40,198    |                 |
| Total                          | 3,314,565 | 3,841,614 | 4,096,909 | 4,539,282 | 4,741,443 | 1,1%            |

Expenditures (millions of col pesos)

| Premium (Pesos)                | 207,362   | 241,577   | 265,734   | 289,119   | 300,684   | 1,5%            |
| Total premium payments         | 2,399,308 | 3,147,215 | 3,435,384 | 3,740,533 | 3,986,998 | 5,0%            |
| Sick and maternity leave payments | 135,690   | 156,957   | 169,117   | 187,557   | 176,297   | -1,3%           |
| Transfers to solidarity        | 310,108   | 384,052   | 386,317   | 382,092   | 368,346   | -3,5%           |
| Transfers to prevention fund   | 135,690   | 156,957   | 169,117   | 187,557   | 62,683    |                 |
| Total                          | 2,980,795 | 3,845,181 | 4,159,935 | 4,497,739 | 4,594,324 | 3,0%            |
| Balance                        | 333,770   | (3,567)   | (63,026)  | 41,543    | 147,119   |                 |

Source: Acosta, Ramírez and Cañon, 2004
The experience for the SR was similar to that of the CR. Between 1995 and 2002, resources for the SR increased from 63 to 1.84 billion (0.75 to 0.91% GDP). Initially, the main source of financing was the solidarity contribution, but it has gradually been replaced by resources from the national budget, which reached 66% in 2002. Other resources of funding grew moderately in importance (Table 5.2). The amount of funds available for the SR is not enough to provide full coverage for the eligible uninsured at the current value of the SR premium.

Table 9. Total resources and sources of funding for the Subsidized Regime, 1995-2002
(Colombian pesos)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total resources ($1,000,000,000,000 pesos)</td>
<td>0.63</td>
<td>0.71</td>
<td>0.80</td>
<td>1.12</td>
<td>1.25</td>
<td>1.24</td>
<td>1.71</td>
<td>1.84</td>
</tr>
<tr>
<td>Total resources (% GDP)</td>
<td>0.75%</td>
<td>0.70%</td>
<td>0.66%</td>
<td>0.79%</td>
<td>0.84%</td>
<td>0.73%</td>
<td>0.91%</td>
<td>0.91%</td>
</tr>
</tbody>
</table>

Sources of funds (% of total resources)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Solidarity fund</td>
<td>85.7%</td>
<td>63.1%</td>
<td>46.7%</td>
<td>51.3%</td>
<td>38.0%</td>
<td>34.6%</td>
<td>36.0%</td>
<td>31.0%</td>
</tr>
<tr>
<td>National budget</td>
<td>14.3%</td>
<td>36.9%</td>
<td>44.0%</td>
<td>37.2%</td>
<td>50.0%</td>
<td>51.9%</td>
<td>51.0%</td>
<td>66.2%</td>
</tr>
<tr>
<td>Own resources (municipal taxes)</td>
<td>no data</td>
<td>no data</td>
<td>3.8%</td>
<td>4.5%</td>
<td>3.9%</td>
<td>5.1%</td>
<td>3.0%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Earmarked municipal taxes</td>
<td>no data</td>
<td>no data</td>
<td>1.8%</td>
<td>2.2%</td>
<td>3.4%</td>
<td>2.1%</td>
<td>9.0%</td>
<td>no data</td>
</tr>
<tr>
<td>Transfers from employment funds (Cajas)</td>
<td>no data</td>
<td>no data</td>
<td>3.7%</td>
<td>4.8%</td>
<td>4.8%</td>
<td>6.2%</td>
<td>2.0%</td>
<td>2.1%</td>
</tr>
</tbody>
</table>


**ACHIEVEMENTS**

**Access to health care services**

There is evidence of a decrease in financial barriers to health care as shown in Graph 6. According to a household survey in 1992, the main reason for non-use of health care in the lowest quintiles of the population was the cost of services. Tabulation of the responses to this same question in another household survey carried out in 1997 show a reduction in the percentage of people reporting non-use of health care services for this reason, regardless of income level.
Graph 6. Reasons for non-use of health care, % of respondents by income quintile 1992 & 1997


Being insured seems to be positively related to having access to a doctor. Graph 7 presents a comparison of treatment rates (the percent of the populations who had a health problem and were seen by a doctor) between 2000 and 2003. In that period, both in urban and rural areas, not only are treatment rates higher for the insured compared to the non insured, but they also increased more.

Graph 7. Percentage of respondents who had a health problem who were seen by a doctor, by enrollment status and area 2000 & 2003

Source: MPS calc., Encuesta de Hogares (EH) 1992 and Encuesta Nacional de Calidad de Vida (ECV) 2003

Financial protection

Colombia’s insurance schemes seem to provide financial protection, in particular for the poor. For example, a risk pooling study carried out during 2005 compared the percent of the population that falls below the poverty line due to a health shock requiring ambulatory care or a hospitalization, by insurance status. The study finds that 5% and 14% of the non insured fall below the line of poverty as a result of an ambulatory and a hospital shock respectively, in contrast to 4% of the SR population that falls below the line of poverty as a result of either shock (see Table 4.1).
Table 10. Financial protection provided by insurance

<table>
<thead>
<tr>
<th>Type of health care</th>
<th>% of population that falls below poverty line</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Contribute</td>
</tr>
<tr>
<td>Ambulatory care</td>
<td>1</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: Bitran et al. 2004

C H A L L E N G E S

Expansion of Coverage

Several factors negatively influenced the growth and availability of resources for health insurance expansion, among which the most important are:

*Economic recession*

Availability of resources for health insurance declined due to reduction of wage contributions and fiscal resources. This was largely a result of unemployment and of decreases in family income (about 25% since 1997). Additionally, fiscal pressure coupled with lack of political commitment led the central government to fail in its obligation of providing solidarity matching funds for the SR and directing oil revenues to the health sector.

*Labor market characteristics*

Colombia’s labor market characteristics pose challenges to insurance expansion and to increases in revenues from wage contributions. More than half of Colombia’s labor force is in the informal sector as seen in Table 5.1

Table 11. Non agricultural employment distribution, 2000

<table>
<thead>
<tr>
<th>Informal sector</th>
<th>Total</th>
<th>Independent workers</th>
<th>Domestic servants</th>
<th>Small business</th>
<th>Formal sector</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>55.6</td>
<td>32.2</td>
<td>5.3</td>
<td>18.1</td>
<td>Public</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>44.4</td>
</tr>
</tbody>
</table>


A study carried out in 2001 (Bitrán 2002) found that about 31% of informal workers fell into SISBEN categories 1-2, and thus, were eligible for the SR. Out of the remaining informal workers about 84% did not have the ability to pay the full CR premium. Informal workers without ability to pay were estimated to be around 10 million, which is about 25% of Colombia’s population, and half of these were uninsured. There is evidence that this segment of the population has been growing.

The main difficulties in expanding insurance coverage in this segment of the population in the CR are:

1. This population’s ability to pay is limited, unpredictable, and unreliable
2. The potential for adverse selection is high
3. Administrative costs to enroll, monitor and collect contributions from this population can be very high

Lack of incentives to enroll, since people can still use services in the public sector, many times at a minimal cost due to lack of capacity of institutions to collect user fees.

Evasion

Empirical evidence has shown that evasion of wage contributions and underreporting of income are factors that have affected the balance of FOSYGA (Bitrán 2002). Estimates for 2000 indicated that only 65% of potential contributors were actually paying their obligations, and furthermore, those who did contribute paid much less than they should. The combined effect of evasion and elusion could be decreasing revenues of the CR by 35%. In the absence of this problem in 2000, positive balances would have been achieved and resources to enroll an additional 1.5 million people to the SR would be obtained.

Among the factors related to evasion in Colombia’s NHI are the characteristics of Colombia’s labor market, incentives for health plans to promote underreporting of income and lack of an information system that allows detection of evaders. As a first strategy to reduce evasion, cross links between the pension system data and health insurance contribution data have been established.

Incentives for competition

Managed competition is based on the premise that given mechanisms to guarantee equitable access to health care services and regulations to address failures inherent to health care markets, competition can be used to improve efficiency and quality. The design of the Colombian health care system should lead to a focus in quality. However, after ten years of reform necessary conditions for quality competition have not emerged in Colombia.

For example, a variety of barriers may be preventing consumer choice from being the driving force behind competition. In order to generate more sensitive demand for quality, finding effective ways to provide information to consumers about how the system functions, their rights and obligations, and aspects of quality of care relevant to consumer choice is a priority. Toward this end, the government is currently working on the design of consumer information systems that are feasible for Colombia. An alternative is to identify potential sponsors as originally envisioned by the Enthoven model of managed competition. By pooling a large number of enrollees, sponsors might be more effective in generating the incentives for quality competition. On an informal basis, it seems that employers in the CR and local governments in the SR are exercising this role. Therefore, the government may want to consider improving the capacity of these institutions to direct enrollees towards high quality health plans through the provision of information about
quality. Surveys and focus groups of consumers, employers, and local health authorities that seek to identify who is making health care choices and how these choices are made could be useful to inform these policies.

Other problems in implementation of the reform that represent obstacles for quality competition were the absence of a quality assurance system and weak institutional capacity to conduct quality oversight also need to be considered. In 2003 quality regulations such as minimum standards and accreditation procedures were issued and it is still to be seen whether there will be sufficient capacity to monitor and enforce these provisions.

On the other hand, there are areas of the country where the size of the risk pools makes it simply not feasible for more than one health plan to operate or to have a choice of providers. Competitive bidding and performance based contracts might be alternatives to induce quality improvement in these scenarios.

**Transforming supply subsidy into demand subsidy**

Implementation of rules governing the transformation of supply subsidies into demand subsidies was slow. Transformation of subsidies only began in 1997, and by 2000 only 50% of what had initially been estimated had been transformed. Most public hospitals are still financed by national resources allocated through historic budgets. Public hospital spending has increased more than their income, reaching 2.8% of GDP in 2000 (Graph 8).

![Graph 8. Public hospital income and expenditure](image)

Source: MPS calculations based on hospital budgeting data (Ejecuciones presupuestales)

An evaluation of the public network found that between 1994 and 2000, the income of public hospitals increased more than 100% (Contraloría General de la República, 2002). This was more pronounced for first level hospitals, despite the fact that the occupancy rate at this level was reduced. Personnel costs increased 40% in real terms since 1995 and total hospital expenditures increased almost 1 percentage point of GDP between 1996 and 2000.
During 2003 the main source of patient revenue for first level hospitals was provision of services for the SR, and supply subsidies for second and third level hospitals (see Table 5.2). For all levels of care, sale of services for the CR represents a small share of total revenue from sale of services. First level hospitals generate 40% of total sales revenues, and second and third level hospitals 36% and 24%, respectively.

Table 12. Sources of public hospital’s sales revenues as % of total sales revenue, by level of care, 2003

<table>
<thead>
<tr>
<th>Source of sales revenue</th>
<th>Level I</th>
<th>Level II</th>
<th>Level III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsidized regime</td>
<td>42%</td>
<td>20%</td>
<td>17%</td>
</tr>
<tr>
<td>Contributive regime</td>
<td>5%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Uninsured care</td>
<td>30%</td>
<td>47%</td>
<td>44%</td>
</tr>
<tr>
<td>SOAT- ECAT</td>
<td>0%</td>
<td>2%</td>
<td>5%</td>
</tr>
<tr>
<td>Public health package</td>
<td>4%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>6%</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

% share of total sales revenue 40% 36% 24%

Source: Author’s calculations with public hospital accounting data, Dirección General de Calidad, MPS 2003

Amongst the most important obstacles for hospital transformation have been the application of bail out policies, political pressure from interest groups, in particular strong unions, scant development of managerial capacity and legal restrictions to autonomous management of resources (personnel, in particular). Also, the persistence of uninsured population and the design of the subsidized benefits package (which envisages the public network satisfying the demand for a large portion of second and third level care), has been used as a justification to continue financing via supply subsidies (Sáenz 2001; Giedion, Lopez, Marulanda 2000; Giedion, Morales, Acosta 2000).

Lack of clarity and flaws in rationing policies

If a Colombian citizen demands a health service or medication that is not covered by the benefits package, he/she has the option of filing a lawsuit against the health plan or the public provider basing the claim on the constitutional right to life. This if granted by the courts, will require payment of the medication or service by FOSYGA. Also in the specific case of medications, there is a mechanism established in FOSYGA that reimburses health plans a fraction of the cost of drugs not covered in the package if they are able to demonstrate medical need. Use of these options has been increasing in the last years, and the costs to the system are not negligible. If the total value of these claims is converted to premiums one can see it would have been possible to pay for insurance for approximately 199 thousand CR enrollees in 2002 and 327 thousand in 2003 (Table 5.3). Similarly, claims corresponding to the SR are equivalent to enrollment of 27,000 persons in 2002 and 43,000 in 2003.
Table 12. Total value of claims filed to FOSYGA for services and medications not covered in the benefits packages, 2002-2003

<table>
<thead>
<tr>
<th>Regime and year</th>
<th>Total value of claims to FOSYGA expressed as number of premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contributory regime</strong></td>
<td></td>
</tr>
<tr>
<td>2002 (premium=304,153 col pesos)</td>
<td>198,709</td>
</tr>
<tr>
<td>2003 (premium=323,316 col pesos)</td>
<td>327,130</td>
</tr>
<tr>
<td><strong>Subsidized regime</strong></td>
<td></td>
</tr>
<tr>
<td>2002 (premium=168,022 col pesos)</td>
<td>26,656</td>
</tr>
<tr>
<td>2003 (premium=180,622 col pesos)</td>
<td>43,394</td>
</tr>
</tbody>
</table>

Source: Pinto and Castellanos 2004

For example, the costliest claims have been related to a brand medication for Gaucher’s disease, a rare metabolic lifetime disorder. In one year, the value paid by FOSYGA for the treatment of 3 persons with this disease could be equivalent to enrollment of about one thousand persons in the CR and twice as many in the SR. Solutions to this problem will require development and promotion of policies around evidence based medicine and technology assessment and an explicit debate around rationing that incorporates both the stakeholders of the health care system and the courts.

**Administrative Inefficiency**

Due to the complexity of the system, the administrative costs of health plans can be large and highly variable, ranging from 4 to 60% of the value of the premium (Cendex 2000, DNP 2001). More than 50% of the administrative costs are spent on support activities for daily operation (financial, personnel and information management) and enrollment processes; very little is spent on risk management and quality assurance (Cendex 2000).

Delays in the flow of funds from the government to health plans and health plans to providers are a critical problem. Calculations have showed that 230 days could pass before resources coming from FOSYGA reach a provider. All the actors contribute to the problem: providers are slow in their capacity to charge health plans, health plans spend a lot of time in claims auditing and local governments delay payment to health plans to obtain interest from insurance funds (Jaramillo 2002). This constrains provider capacity to invest in technology and infrastructure, and in general, increases the risk of operation. Measures have been taken to simplify the administrative processes in the flow of funds.

**Information gaps**

Colombia’s health system has not developed mechanisms for adjustment and monitoring of the value of the premium and the contents of the benefits package. The parameter that has guided the decisions regarding the premium has been the annual increments to the minimum wage, summed to considerations regarding FOSYGA’S balance at the end of the fiscal year. After 10 years of the reform there have been no actuarial studies of the
real cost of providing the benefits packages, mainly due to lack of representative and reliable information needed for these calculations.

As seen in Table 5.4 below, 2003 and 2004 estimates of health plan’s ratio of Total health expenditures/Total income from premiums suggest that the value of the premium is enough to cover health plans’ health expenditures and could leave a margin for administrative expenses and utilities. However, the reliability and validity of these estimates is questionable, since they are based on financial reports from accounting data, which do not have standardized reporting systems and are difficult to verify. If truly the premiums are set above costs, the system would be wasting resources. If premiums are set below true costs, consumers will suffer as health plans will have incentives to cut quality and access.

Table 13. Ratio of total health expenditures/Total income from premiums 2003-2004

<table>
<thead>
<tr>
<th>Regime</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributory</td>
<td>78-83</td>
<td>80-86</td>
</tr>
<tr>
<td>Subsidized</td>
<td>87-95</td>
<td>74-94</td>
</tr>
</tbody>
</table>

Sources: Author’s calculations based on MPS health plan financial data (Estados financieros reportados a la SNS)

Regarding the POS/POSS the MPS does not have systematic mechanisms to revise and adjust their contents. Very few modifications have been made to the packages, and decisions to include medical interventions have been a response to requests of interest groups. Epidemiological information has not been updated since 1995. Thus, little is known about the appropriateness of the benefits package to address the changing health priorities of the country.

Risk selection

Despite the existing regulations to prevent adverse and risk selection, there is evidence of selection problems in the Colombian NHI. For example, results from a 2002 study of the distribution of cases related to catastrophic care in the CR showed important positive deviations from the national average for conditions such as Chronic Renal Disease (CRD) and HIV-AIDS for several health plans, the ISS in particular (MPS 2002). While the national average number of cases in the CR for CRD and HIV-AIDS was 41 and 19 per 100,000 respectively, the ISS’ average was 137 and 44.

The situation motivated the government to adopt two measures which were expected to be one-time solutions to the problem. In one measure the “outlier” health plans were reimbursed retrospectively the value above the expected costs of these two conditions for one year. This was done by transferring this amount from the premium of health plans below the national average of cases. In a second measure, a “redistribution” of cases was

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89 Compulsory enrollment, standard benefits, age and sex risk adjustment payment, non-denial of enrollment, prohibition of exclusions and minimum enrollment periods – Law 100
90 Acuerdos 217, 242 and 245 del CNSSS.
mandated, by legally requiring a randomly selected number of patients in excess of the national average to switch to other health plans. Enforcement of this second measure was extremely cumbersome. Many of the selected patients could not be found due to information inconsistencies in the databases that were collected for this purpose, a large number of individuals refused to switch, and lawsuits against the measure were filed. In consequence, the measure was dropped in 2004. As an alternative, the MPS is studying the alternative of including risk adjustment for these conditions in the premium. However, the challenge for the success of this strategy is going to lie in developing reliable diagnostic and cost information.

Equity and convergence of the two regimes

The fact that both regimes have not converged, and will not do so in the near future raises serious equity and efficiency concerns for Colombia’s NHI. Because of the gaps in coverage of services the SR population is more likely to experience discontinuities in care that have the potential of reducing effectiveness of treatments.\(^9^1\) Also, since this population would be accessing services both from health plans (covered services) as well as local governments and public hospitals, the monitoring of access, quality and efficiency becomes very difficult.

Introduction of partial subsidies contributes to further increase the inequities generated by the differences in coverage of the CR and SR. The policy ignores the potential for this segment of the population to pay even a small percentage of the premium for the SR and perpetuates the need for supply subsidies. It also concentrates activities on curative care.

At this point there are no clear answers as to alternatives to equalize benefits between the CR and SR. A first step is to evaluate the contents of these packages in the light of updated information on burden of disease, utilization of services, cost effectiveness of interventions, available resources and patient preferences. This could initiate a process towards re-design of both packages starting from a common basis.

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\(^9^1\) For example, a woman with a positive PAP smear for cervical cancer, which is covered by the POSS, has to pay out of pocket to have the diagnosis confirmed by a colposcopy, which is not covered.


Chapter 7

Thailand

Achieving Universal Coverage with SHI

Piya Hanvoravongchai
William Hsiao
CASE STUDY: THAILAND

Thailand is a middle-income developing country with interesting history of health financing development. For 5 decades since the first unsuccessful effort to introduce social health insurance law in 1950s, the country has learned from its experiment with various types of financing mechanisms. It recently became one of very few developing countries that have achieved universal coverage of health insurance. This case study starts with background information about country’s sociopolitical characteristics and health systems and health financing development. The experience of how Thailand achieved universal coverage through mobilization of political and technical supports is then discussed. The case concludes with lessons and challenges from Thailand’s unfinished health financing reform.

BACKGROUND

Thailand is a lower-middle income country in South East Asia covering a tropical land area about the size of France (514 thousand square kilometers). It has a population of 63 million with relatively young demographic structure - a quarter of them are under 15 years old and only 6 percent are 65 years old and above. The kingdom has 76 provinces with around 800 districts. One third of the population lives in urban areas. Almost 95 percent of Thais are Buddhists and a little less than 5 percent Muslims. Thais are generally known to be friendly and optimistic which give rise to the nickname of the country, ‘The land of smiles’.

Thailand is one of the few countries in Pacific Asia that have never been colonized. Its political system is a constitutional monarchy with a King as Head of State and the Prime Minister, elected by the parliament, as the head of administration. The political reform initiated in 1995 after the fall of military government led to a new constitution, the “Constitution of the Kingdom of Thailand, B.E. 2540”, which was promulgated in 1997. This Constitution is frequently referred to as the ‘People’s Constitution’ because it set new standards in judicial, executive and legislative systems. It strengthens political party systems and civil society. The first election under this new Constitution in 2001 resulted in the Thai Rak Thai Party gaining majority of parliament seats. Its leader, Thaksin Shinawatra, became the Prime Minister and the universal health care coverage program, one of the Party’s main political campaigns, began to be rapidly implemented.

Over the past 30 years, the Thai economy has developed from mainly agrarian-based to largely industrial-based. Thailand was one of the world's fastest-growing economies over
the period of 1985-95 with real average annual growth of 8.4 percent. Until the economic crisis in 1997, the steady growth had allowed the country to achieve a much higher per capita income and a significant drop in the number of the poor from 45 percent in 1988 to 17 percent in 1996 (Figure 1).

![Figure 1. Poverty trend](image)

The 1997 South-East Asia economic crisis led Thailand into a period of abrupt economic slowdown with over 50 percent devaluation of local currency and negative 10 percent GDP growth rate. It was accompanied by a fall in demand for labor and reduction in wages, increase in prices of key commodities, reduction in government spending on social services and erosion of social capital. The number of poor also increased. Nevertheless, the economy started to get back on track in 2001 and the growth rate has reached over 6 percent per annum in 2003 and 2004. The GDP per capita in 2004 is at 98,164 Baht (2,450 USD or 7,010 I$).

In regard to human development, Thailand ranks number 76 in the UNDP’s Human Development Report 2004 with the Human Development Index score of 0.768 and ranks number 61 for the Gender-related development index (GDI) of 0.766. The life expectancy at birth is 69.1 (F 73.4, M 65.2) and literacy rate of 93 percent (F 90.5, M 94.9). The gross primary, secondary, and tertiary school enrollment is at 73 percent (F 72, M 74).

**Health status**

During the past three decades, the population health status has improved considerably as shown by a significant reduction of IMR (Infant mortality rate) to 24 per 1,000 live births, under-five mortality rate to 28 per 1,000 live births, and maternal mortality ratio to 44 per 100,000. Life expectancy at birth increased to 70 years and immunization coverage against preventable diseases stays high at 90 percent. Rate of child malnutrition and anemia in pregnant women have also steadily declined.
Despite successful prevention programs and declining prevalence (currently less than 2 percent), HIV/AIDS is still the leading cause of death especially among the working age population. It accounts for 21 percent of total years of life lost in 1998 followed closely by road traffic accidents (20 percent). Other leading causes of death include heart disease, cancer, and lower respiratory tract infection.

Thailand is also going through an epidemiological transition with increasing health problems from degenerative and behavioral related diseases. The increasing life expectancy and the drop in fertility rate resulted in increasing numbers of elderly and a further increase in disease burden from non-communicable diseases. It is expected that the proportion of elderly (over the age of 65) will increase from the current level of 6 percent to 10 percent in 2020. The prevalence of chronic illnesses such as diabetes and hypertension will also increase faster than current trends. The cancer prevalence rate rose from 53.8 to 60.4 per 100,000 population in the decade between 1987 - 1997.

**Health service provision**

The health service system in Thailand involves both public and private institutions. Table 1 shows the share of public and private health facilities and utilization rates in 2003. The Ministry of Public Health (MoPH) is the major health service provider with its extensive network of hospitals and health centers. Of the total 136,201 hospital beds in 2003, sixty-four percent were MoPH facilities additional 14 percent were public agencies.

| Table 1. Public and private health facilities and medical care utilization in 2003 |
|-----------------------------------|--------|--------|--------|--------|--------|
|                                   | MOPH   | Other Public | Private | Total  |
| No. of Hospitals.                | 868    | 94      | 331    | 1,293  |
| Beds                             | 87,752 | 19,088  | 29,361 | 136,201|
| Outpatient cases                 | 22,872 | 2,442   | 4,144  | 29,459 |
| Inpatient cases                  | 5,804  | 634     | 1,487  | 7,926  |
| Inpatient days                   | 26,473 | 4,671   | 4,338  | 35,483 |
| Bed Occupancy                    | 82.7   | 67.1    | 40.5   | 71.4   |

Every province has at least one MoPH general hospital and every district has one MoPH district hospital (altogether 720 MoPH hospitals nationwide). General and district hospitals provide outpatient and inpatient medical services including diagnostic, medical treatments and surgical services. At the subdistrict level there are over 10,000 community health centers equipped with trained personnel (2-years of training after high school) who provide primary health care including health promotion and prevention programs. In addition, each village has one or two village health volunteers who participate in health promotion and prevention activities.

The private sector participates in health care service delivery but private facilities are mainly concentrated in Bangkok and big cities, particularly in the Central Region. The economic boom in the late 1980s and early 1990s promoted rapid private health sector investment and growth. This has been significantly slower since the 1997 economic crisis.
as shrinking consumer demand and oversupply of hospital beds forced 80 private hospitals out of business, while the remaining private hospitals had to reduce their bed capacity and scope of service.

In 2000, the doctor to population ratio was at 1:3,400 (total 18,025 doctors in 2000). About two-thirds of them are in public sector with over half working for MoPH. Public sector physicians are paid mainly on salary basis with additional income from on call duty work. A significant proportion of public sector physicians also work in the private sector during non-office hours (in the evening and weekends) for extra income. Physicians in private hospitals receive consultation fees that are charged directly to patients. Doctors in private clinics earn most of their income from user charges and profits from drug dispensing. The number of private clinics has doubled from around 7,000 clinics nationwide in 1984.

There were over 13,000 drugstores and pharmacies in 2001; almost all are privately owned and operated. Half of these pharmacies are classified as modern pharmacies where there are full-time practicing pharmacists. The remaining are drug stores that sell pre-packed non-dangerous drugs. Traditional medicine drugstores also exist but their share has declined to less than 15 percent of all drugstores and pharmacies in 2001. Apart from drugstores and pharmacies, local grocery stores are major suppliers of drugs for common and minor ailments for rural villagers in several areas. In some places, prescription drugs such as steroids, antibiotics, or certain injections may be sold at village grocery stores despite being illegal.

Before the Universal Coverage (UC) implementation, medical care services at public hospitals and health centers were not free of charge. Patients had to pay out-of-pocket for both services and drugs unless they had health insurance or were covered by public welfare systems and be eligible for free care. Nevertheless, public medical services were generally priced lower than the prices at private facilities as there were subsidies from the government through staff salaries and capital investments. Public hospitals are allowed to keep revenues from user fees for their use, which are frequently spent on drugs, medical supplies, and labor costs not already supported by the government.

The National Health Accounts studies and earlier estimates from Thailand National Economic and Social Development Board (NESDB) shows a continuous rising trend of health spending from 1980 to 1997 when it reached almost 4 percent of GDP. Private share of health spending, mostly from out-of-pocket health payments, accounted around half of total health spending. After the 1997 economic crisis the trend changed as health spending level and its share of national income decreased in both 1998 and 1999. The level of spending did increase again in 2000 but the share of health spending from out-of-pocket continued to decline to 44 percent in 2001. Figures 2 to 4 summarize the findings from National Health Accounts studies from 1994 to 2001.
Figure 2. A. Level of national health spending, 1994 to 2001

Source: National Health Accounts

Figure 2. B. Health expenditure as % GDP, 1994 to 2001

Source: National Health Accounts

Figure 3. Share of national health spending by sources in 2001

Source: National Health Accounts
Figure 4. Share of national health spending by spending category in 2001

Health Financing Development (before Universal Coverage)

Before the implementation of Universal Coverage policy in 2001, the Thai health care financing systems were very complex with multiple financing schemes. Each financing scheme has its own rules, regulation and benefit packages for specific beneficiary groups. Approximately 70 percent of the population were covered by four public health insurance schemes while private health insurance had almost no role. The remaining 30 percent, over 15 million people, had no health insurance and paid out-of-pocket for health services and medicines.

Thailand’s health insurance system development has been a long process (Figure 5). The first Social Security bill was proposed in 1954 but was never considered in the parliament. The first medical welfare program started in 1975 when the government decided to provide medical services in public hospitals and health facilities free-of-charge to the poor. This program subsequently expanded to cover the elderly, children, and other underprivileged groups.

Following the Medical Welfare Scheme (MWS) were health insurance schemes for formal sector employees. The medical benefit scheme for civil servants, public employees, and their family (Civil Servant Medical Benefit Scheme – CSMBS) was established in 1980. The Social Security Scheme (SSS) for private employees was first introduced in 1990. Efforts to expand coverage to informal sector workers have been tried with community financing schemes in 1983 and voluntary health card scheme (VHCS) in 1991. However, both programs were not successful. It was not until 2002 that universal coverage of health insurance was accomplished. The details of each health insurance program are presented below.
The Medical Welfare Scheme (MWS)

The government medical welfare scheme started in 1975 when free medical care was offered to low-income individuals who passed a means test based on cash income of less than 1,000 baht per month. In 1981 the program was transformed into the Low-Income Card Scheme when a free-care card was offered to eligible individuals (23 percent of the then population). The program further expanded to cover the elderly (over 60 years old) and all children less than 12 years old, the disabled, monks and religious leaders, and war veterans.

MWS beneficiaries were entitled to free medical care: outpatient, inpatient, diagnostics, and medicine from public facilities. The government paid public hospitals and health centers based on capitation and service utilization rates but at a price much lower than cost recovery level due to its limited budget. Hospitals therefore had to shoulder the costs and had no incentive to provide quality services to this group of patients resulting in long waiting lists and low responsiveness. Health care providers cross-subsidized the scheme by charging other insurance scheme’s patients higher.

Despite its rapid expansion to cover 30 percent of population in 1999, the MWS had limited effectiveness in its means testing system to define eligible beneficiaries. Several studies showed that a significant proportion of MWS members should not have been entitled to the benefits as they had higher income than the eligible level. Moreover, some of those who were really poor and should have been included could not enter the scheme. The weakness of the means testing system resulted from difficulty in income estimation for informal sector. Involvement of community leaders in proposing who should be included was helpful in some communities but it also created nepotism in some other areas. The MWS was finally merged into the UC scheme when the Universal Coverage was implemented in 2001.
Civil Servant Medical Benefit Scheme (CSMBS)

The CSMBS is the government medical benefit program for government employees, state enterprise employees, state pensioners and family members which includes their children and parents. The CSMBS is considered the most generous insurance scheme in the country because it provides comprehensive health benefits including inpatient and outpatient services in public hospitals and emergency services in public and private hospitals. Beneficiaries are not required to pay any premiums as the Government covers all the scheme costs. Health providers also like the scheme with its generous fee-for-service reimbursement system.

Until 1998, CSMBS fully reimbursed all costs of treatment and prescription drugs on fee-for-service basis without any patient’s cost-sharing. For outpatient services, the patients paid up front and reimbursed back from the scheme. For inpatient, hospitals submitted full charges directly to the scheme and received full reimbursement. The flexibility of the CSMBS made it a major source of income for many public hospitals who cross-subsidized the loss from serving MWS patients using profits from this scheme. Statistics shows that the CSMBS admission rate per beneficiary was higher than other scheme and the length of stay was much longer. Some health providers also overcharged the scheme by over-prescribing diagnostic services for maximum income generation. The CSMBS expenditure per capita was therefore the highest among all health insurance programs and it had been increasing at 20 percent per annum in nominal terms during the period 1988-97 despite low medical inflation rate.

With the pressure to control cost, especially after the onset of economic crisis, the Ministry of Finance, who is in charge of the CSMBS scheme, has slowly implemented several cost-cutting measures since 1998 including reducing benefits and reforming the payment system. The private inpatient care benefit was discontinued and drug benefits were reduced to those listed in the National Essential Drug List unless determined necessary by a doctor. In 2003, the scheme changed its provider payment system for inpatient care from full reimbursement to Diagnostic-Related Group (DRG) reimbursement.

Social Security Scheme (SSS)

The Thai Social Security Act was promulgated in September 1990. It was compulsory for all private enterprises with at least 20 employees to participate in the Social Security Scheme (SSS). Later the Scheme expanded to cover all enterprises with at least 10 employees in 1994 and to all-size enterprises in 2002. Six million Thais (10 percent of population) are covered by this scheme which is regulated by the Ministry of Labor (MoL) and managed by the Social Security Office (SSO).

The SSS provides a comprehensive benefit package including sickness, disability, maternity and death benefits. Contributions to the social security fund come from employers, employees, and the government at the rate of 1.5 percent of payroll each (4.5 percent al-
Public and private hospitals are contracted (frequently called ‘main contractors’) to provide inpatient and outpatient services to the beneficiaries. Each beneficiary has an option to select one contractor of his or her choice and s/he can get health services only from the network of main contractor they selected with no co-payment. The SSO then pays each hospital on a capitation basis i.e. based on the number of beneficiaries registered with that hospital. The capitation payment is all inclusive at 1,505 baht per capita (2002 rate) and is intended to cover medical fees, outpatient and inpatient care, and drug expenses. With this capitation payment contract system, the provider has a big incentive to keep costs at the minimum. There is no financial reason to deliver unnecessary services or over-prescribe, so the cost to the scheme is easily controlled.

On the other hand, the capitation payment system also raised several problems such as cost-shifting, cream skimming and dumping (risk selection), and poor provider’s responsiveness. There was an initial concern on quality of care as the quality control system was initially weak and the information system was incomplete. However, several mechanisms have been introduced to improve the scheme including quality reviews, hospital accreditation, and provider payment adjustment. The SSO also recently introduced extra payments for high cost services such as emergency and accident injury, renal dialysis and provides supplementary payment based on utilization rankings and number of beneficiaries with chronic cases to adjust for provider’s risk.

**Voluntary Health Card Scheme (VHCS)**

The VHCS evolved from a community financing pilot initiative in 1983 that aimed to cover informal sector workers through community financing concepts. At the time, health cards were sold in each community to finance the Village Mother and Child Health Development Fund. The card entitled minimal benefits for its purchaser including maternal and child health services, vaccinations, and simple treatments. The Funds functioned as revolving funds, to be lent to members for toilet construction and other public health activities. Due to limited participation and unclear government policy and support, the initiative was subsequently phased down.

In 1991 the program was transformed into a voluntary health insurance scheme under management of the MoPH and implemented nationwide in 1994. Its financing came from premiums collected from selling the cards with matching funds from the government. The health card for a family of up to five members was priced at 500 Baht and the government contributed an additional 500 Baht (1,000 Baht later in the program). Health Card benefits included outpatient care for illness and injuries, inpatient care, and mother and child health services at local public providers. Drug benefits included medicines in National Essential Drug List with no copayment.

With extensive mass media advertisement and government support, VHCS was quite popular in several areas of the country with up to 12 percent of Thais as their beneficiaries at one point. The funds from card sales and government matching contributions for
each province were collectively managed at the local provincial health office. Most health care providers received a global budget allocated from the local Health Card fund according to the number of cards they sold. However, this amount was inadequate considering actual medical care expenses the hospital provided and low cost recovery. For example, in 2000 the average expense per card was 2,700 Baht while the income per card was only 1,000 – 1,500 baht.

One main reason for low cost recovery is due to the voluntary nature of VHCS which subjected the scheme to adverse selection and system abuse. Utilization statistics reveal that VHCS beneficiaries used medical services more often than general population for outpatient and inpatient services. Self selection was evident as it was common to see pregnant women or patients with chronic diseases purchasing health cards once diagnosed. Low cost recovery and questionable financial sustainability led to the government’s decision in 2001 to end the program.

**Figure 6. Trends of population coverage of Health Insurance Schemes**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>uninsured</td>
<td>80%</td>
<td>60%</td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td>UC</td>
<td>10%</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Private &amp; Others</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>VHCS</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>MWS</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>SSS</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>CSMBS</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
</tbody>
</table>

**Table 2. Insurance Payment Mechanism and Utilisation of Services, 1996**

<table>
<thead>
<tr>
<th>Insurance program</th>
<th>Payment mechanism</th>
<th>OP visits / Capita</th>
<th>Admission rate / capita</th>
<th>ALOS (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSMBS</td>
<td>Fee-for-Service</td>
<td>5.5</td>
<td>13.6</td>
<td>11.9</td>
</tr>
<tr>
<td>SSS</td>
<td>Capitation</td>
<td>1.4</td>
<td>2.6</td>
<td>5.6</td>
</tr>
<tr>
<td>VHCS</td>
<td>Capitation</td>
<td>1.7</td>
<td>5.8</td>
<td>4.3</td>
</tr>
<tr>
<td>MWS</td>
<td>Global Budget</td>
<td>0.7</td>
<td>3</td>
<td>5.1</td>
</tr>
<tr>
<td>Out of pocket</td>
<td>Fee-for-Service</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
</tbody>
</table>

Sources: Donaldson et al 1999

In summary, in the period before the introduction of UC system Thailand had several health financing schemes under various management organizations with different payment mechanisms and funding methods. There were differences in budget subsidies, benefit packages, quality of service provisions, and rates of utilization (Table 2). Inefficiencies were prominent in almost all schemes from various reasons including adverse
selection, moral hazard, and allocative inefficiency. Despite the effort to increase coverage through the expansion of social security scheme to formal sector employees, the extension of the public welfare system to cover more underprivileged groups, and the introduction of voluntary health insurance to capture informal sector workers, a significant portion of Thais (30 percent) were still uninsured (Figure 6). With a big proportion of population working in informal sector, there was a consensus that relying on voluntary insurance would not be a realistic approach to achieve universal coverage.

The introduction of the Universal Coverage scheme in 2001 was a big political decision accompanied by a major health financing reform to improve accessibility, equity, and efficiency of Thailand health financing system. The UC scheme merged two existing public financed programs, the MWS and VHCS, together with a big change in funding and payment mechanisms. Coverage also expanded to include all Thais who were not already covered by CSMBS or SSS. The movement towards the UC scheme, the scheme characteristics and its implementation are described in the next section.

**Achieving Universal Coverage**

Before the UC implementation in 2001, how to achieve universal coverage (UC) had been regularly debated and discussed since the early 1990s. It was clear to policy makers and technocrats that relying on existing schemes to expand their coverage to the uninsured population, especially those in the informal sector, was unlikely to be successful.

Several meetings and workshops had been organized to discuss possible pathways towards UC. For example, in 1993 a workshop on health financing in Thailand was organized by the National Economic and Social Development Board, the Ministry of Public Health, and the World Bank on expanding health insurance. However, there was no consensus on how to achieve UC. In 1996 a draft of the National Health Insurance and Standard Medical Care Bill was prepared by the Ministry of Public Health and the Standing Committee on Health of the House of Representatives to set up a compulsory health insurance scheme for those not already covered by other schemes. The new scheme would be funded from premium collections and the government would subsidize the premiums for the poor. Nevertheless, the parliament was dissolved before the bill was considered.

The promulgation of the Constitution of the Kingdom of Thailand B.E. 2540 in 1997 built up a conducive environment to universal coverage development. The Constitution provides a strong foundation on the concept of people’s right to health. In its article 52, every Thai has “an equal right to receive standard public health services and the indigent shall have the right to receive free medical treatment from public health facilities of the state”. The article 82 of the Constitution also states that the State “shall thoroughly provide and promote standard and efficient public health services.” Universal coverage of health insurance was seen as an important element of people’s right to health.
In the spirit of the 1997 Constitution, a Working Committee on Universal Coverage was formed in 2000 under the support of the Health Systems Research Institute to study potential alternatives towards UC. The financial feasibility of achieving universal coverage was studied and confirmed by the Committee to be affordable, conditioned upon having an efficient health insurance system. A total amount of 100 billion baht per year was the expected level of funding required for universal coverage. This was not much higher than the 76 billion baht per year spent through various health insurance programs and public health budgets at that time (only an extra 24 billion baht would be required). However, it implied a major financing reform that would reroute funds from many different sources into a single payer system. In addition, the Working Committee proposed a focus on strengthening cost-effective primary medical care and a split between health care purchasers and providers. Three alternative approaches to achieve universal coverage were proposed: an expansion of the existing financing system; an introduction of a single national health insurance system; and an introduction of dual system of public & private health insurance systems.

In parallel to the work of the academic Working Committee, there were movements from civil society groups who in 2000 drafted a version of National Health Security Bill based on the MoPH Bill prepared in 1996. The primary interest of the civil society groups was to increase consumer protection and consumer participation in health system management. The proposed bill would establish a single national fund to implement universal coverage based on tax financed mechanism instead of compulsory insurance with beneficiaries’ contribution as in the MoPH Bill.

In addition to academic and civil society movements, the media also played an influential role. They were active in keeping the public informed about various UC debates and developments, resulting in heightened awareness of the UC policy.

The universal coverage policy only became a major national agenda when the Thai Rak Thai Party (TRTP) - a new political party established by Thailand’s richest business tycoon Thaksin Shinawatra – embraced the plan to achieve UC as a key component of its political campaigns for the 2001 election. The party leaders adopted this policy as they had envisioned the popularity of the program and had learned about financial feasibility and technical achievability from existing studies and evidence. With a landslide victory in the election (it won 243 of 400 seats in the parliament), Mr. Shinawatra became the Prime Minister and the universal coverage policy was incorporated into the government policy. A workshop on universal coverage implementation was organized soon after with the Prime Minister himself as the chair. A Taskforce to implement the UC program was established and the MoPH was assigned to be in charge of the program implementation.

With several members of the Working Committee on Universal Coverage in the workshop and the taskforce to implement the UC project, the implementation plan was laid out similarly to the ways recommended earlier by the Working Committee. There was a major reform of the MoPH health facility payment system (from historical budget system to capitation). UC beneficiary cards were first distributed to previous MWS and VHCS members and the uninsured in April 2001. The program started in 6 pilot provinces and
expanded to cover the whole nation in April 2002. Along with the CSMBS and SSS, Thailand has achieved universal coverage with three health financing schemes.

The UC card holders are eligible to receive comprehensive health care at the provider they registered to with very minimal co-payment per outpatient visit (30 baht or 0.75 USD). Existing government budgets for MWS and VHCS were merged together with the MoPH budget for health care delivery to create a common budget line for UC coverage. Health care providers received capitation payment based on the number of Gold card holders registered with them. A contingency fund was set up to provide temporary alleviation to health care providers whose capitation budget was then significantly lower than previous historical budgets that were based on number of staff and hospital’s capacity.

Concurrent to the implementation of government UC policy, The National Health Security Bill was drafted by the Ministry of Public Health in April 2001 to set up a National Health Security Office (NHSO) and the National Health Security Fund as formal mechanisms to manage and finance universal coverage. The Fund would be financed by general tax revenue to cover health service for beneficiaries not enrolled by CSMBS or SSS. It is also envisioned in the Bill that this Fund will perform as the single health care purchaser in the future when CSMBS and SSS will transfer health services purchasing functions to the Fund.

The enactment of this National Health Security Bill was not without opposition. It easily passed through the Council of Ministers on July 2001 but faced a strong lobbying pressure from various interest groups in the parliament. The medical profession supported the Bill on universal coverage but they were against the medical liability clause provided in the bill and voiced their concern over the power of the single health care purchaser to be created. The labor unions were afraid of the diversion of funds from Social Security Fund to the UC scheme and saw the single purchaser plan as the merging of funds. They perceived UC benefits to be inferior to what they already had. Several street protests were also organized to voice their concerns against the merging of the SSS into the UC. Technocrats in Ministry of Finance also expressed worries over potential long-run budget implications from the tax-financed program as it may increase public debt that was already high. The private health care sector also exerted pressure to ensure the Bill would allow private sector participation in this new scheme so that monies from UC fund would also be available to them.

With minor revisions of the text to accommodate requests and strong control of the parliament under TRTP, The National Health Security Bill was passed and the National Health Security Act was promulgated in August 2002. The National Health Security Office (NHSO) was then set up as a quasi-public organization with Ministry of Public Health as the chair of the executive board. Operation and fund management of UC program was transferred from MoPH to NHSO who became the health care purchaser for UC beneficiaries. Several committees have been set up to improve the UC system and to prepare for future merging of health purchasing activities.
LESSONS LEARNED FROM UC

Thailand has achieved universal coverage through a long process of health financing development. The country has learned from its successes and failures of several financing schemes that have been implemented. The UC was achieved with technical knowledge, powerful public support, and strong political commitment.

The implementation of the UC program, albeit rapid and fairly prepared, experienced several technical hurdles. The first problem was how to identify those who were uninsured (not already covered by SSS and CSMBS) given that no database of the CSMBS beneficiaries exists. A comprehensive information system was therefore invented and rapidly developed using government registration database to avoid duplication of health insurance benefits. This was not an easy task considering over 50 million records of beneficiaries that need to be created.

The second bigger problem is related to provider payment reform that accompanied the UC implementation. Even with the clear decision to use capitation as the UC payment mechanism, there were several detailed policy options that required careful planning and implementation. First, an appropriate level of capitation payment was a subject of major debates at the time of implementation. Based on prior costing studies in the country, setting a suitable capitation rate would provide cost recovery and good incentives for providers to participate in delivering quality health services. At the same time, it should not incur overly high budget to the government. However, with different assumptions used in costing exercises a range of capitation rates could be used. The lowest choice was initially chosen by the Government so as to incur lowest budget implication of the program but it also created public outcry from health providers who were not satisfied with the level.

The accompanying provider payment system reform also included salary costs in the capitation rate which means, for public hospitals, no fixed salary payments from central government. Public health facilities therefore face higher risks of operating in loss as wage and salary are generally a major share of their operating budget. Inclusion of salary in capitation rate gives big hospitals with many staff in low population density areas (and low total budget from capitation) a much smaller total budget than from the period prior to UC. With very limited authority in firing or moving staff, the fixed cost of staff wages became a big burden and there were protests from big public providers. With strong political pressure, the UC program finally allowed MoPH to separate salary payments from the total MoPH capitation budget at the central level and allocate the remaining proportion (only non-salary budget) to providers by capitation.

How to contract providers efficiently and effectively is another issue of major concern and technical difficulties. The UC program learned from the experience of the SSS, which has general and provincial hospitals as the main contractors. Smaller hospitals and clinics can participate as subcontractors in the network of these main contractors. This is to ensure adequate risk pooling among beneficiaries especially for the inpatient medical
care costs that could be high. Recently there was a proposal to use clinics as main contractors for outpatient (OP) services to promote primary care and systems efficiency. In 2004, OP service contracting with clinics started in urban settings where private clinics are allowed to be main contractors and receive capitation payment for outpatient and prevention and promotion services.

### Table 3. The composition of UC scheme capitation rate and payment methods

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
<th>Percentage</th>
<th>Payment Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient care</td>
<td>488.18</td>
<td>37%</td>
<td>Capitation</td>
</tr>
<tr>
<td>Inpatient care</td>
<td>418.36</td>
<td>32%</td>
<td>Capitation</td>
</tr>
<tr>
<td>Prevention &amp; Promotion</td>
<td>206.00</td>
<td>16%</td>
<td>Capitation</td>
</tr>
<tr>
<td>High cost care</td>
<td>66.30</td>
<td>5%</td>
<td>Capitation</td>
</tr>
<tr>
<td>Accident and Emergency care</td>
<td>19.70</td>
<td>2%</td>
<td>DRG payments</td>
</tr>
<tr>
<td>Emergency medical services</td>
<td>10.00</td>
<td>1%</td>
<td>Point systems</td>
</tr>
<tr>
<td>Remote Areas</td>
<td>10.00</td>
<td>1%</td>
<td>Add to capitation</td>
</tr>
<tr>
<td>Capital replacement</td>
<td>85.00</td>
<td>6%</td>
<td>Add to capitation</td>
</tr>
<tr>
<td>No fault liability</td>
<td>5.00</td>
<td>0%</td>
<td>Claim based pay-</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ments</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,308.54</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Source: NHSO 2004

In 2004, three quarters of all contracted facilities were MoPH hospitals. Over 90 percent of UC beneficiaries registered with MOPH facilities while only 5 percent registered with private providers. The payment system has also evolved from all inclusive capitation to main contractors to a more complex system of contracting payments. Of 1,309 baht per capita for UC scheme budget, 85 percent was paid for medical care such as outpatient, inpatient care and prevention and promotion activities by capitation to main contractors (1,112.74 Baht per head in 2004). The remaining 15 percent (195.80 Baht per head) was retained at the NHSO, which spent the funds on high cost care, accident and emergency care, and no-fault liability payments using Diagnosis-related Group (DRG) payments, point systems, or claim based payments.

Several changes have been introduced for efficiency and equity improvement. The decision to keep budgets for high cost care and emergency care at the central level is to help risk-pooling across contractors. The NHSO also introduced age-structure adjustment in the capitation rate calculation for provider payments to compensate for any difference in risk faced by these contractors. NHSO also pays bonus for priority programs or treatments such as extra per case payment of 1,000 baht for cataract operation; 100,000 baht per open heart surgery case. It also allocated 115 million to Department of Health for strengthening control and prevention of cervical cancer.

Note that the payment system for MoPH contractors is more complex. With political interest to retain some financing power at the central MoPH level, the Ministry successfully negotiated to get total capitation budget to central MoPH level instead of allowing NHSO to make direct capitation payments to MoPH main contractors. One argument is to smoothing the transition phase and to allow MoPH to deduct a proportion of the funds for salary payments before allocating the remaining proportion to main contractors. This system clearly reduced pressure to big hospitals with large number of staff as their salaries
are guaranteed to be paid. However, it is detrimental to hospitals that currently have low staff level and need to expand to cover big beneficiary base.

Despite all problems in implementation, the UC scheme is considered the most popular government policy and received high public satisfaction ratings in all public polls. The scheme brought a new perspective of having a ‘right to health’ to the population which is in contrast to their previous ‘welfare-recipient’ status. With capitation payments, there is a link between consumers and service purchasers as money follows patients. The utilization statistics show an increase in outpatient visits at health centers and district hospitals and a decrease in outpatient use at general hospitals – reflecting an effective gate-keeping system that emphasizes primary medical care.

**CHALLENGES**

In spite of its success, the UC scheme still faces several challenges. The first one is concerning its long term funding. Currently NHSO receives funds from general tax revenue, which requires annual negotiation on the capitation budget between the NHSO and the Ministry of Finance. From the past few years, there was a clear tendency towards approving lower budget per capita than what would be adequate for cost-recovery. In addition, the Fund does not have any endowments so it is not prepared for long term expenses. With changes in health care technology and an increase in population aging, it is expected that the cost of the program will continue to increase and financial sustainability of the scheme will be at risk. Therefore, alternative long term funding mechanisms are necessary. Several studies are currently exploring the possibilities of getting funds from other sources such as a sin tax (from tobacco or alcohol tax) or premium collection.

The second major challenge is on the merging of existing funds, namely the UC scheme, CSMBS, and SSS together. As described earlier (see also Appendix II), there are inequities in the systems as the three schemes received different levels of funding per person, have different payment mechanisms, and cover different benefits. The National Health Security Act provides in its article 9 that the UC scheme will eventually be the only health insurance scheme as CSMBS and SSS will purchase health services from NHSO for their beneficiaries. However, the merging process is not easy as the differences between schemes are still enormous.

To facilitate the future merging process, a Coordination Committee on health insurance development was set up in January 2004. It has a duty to coordinate development and monitor “progress on benefit package, duplication of eligibility, payment method, standard of care, health facilities, and portability of eligibility; share info on claims, financial reports, claim audit, and medical audit” of the three schemes. For successful merging, three main areas of work are required namely (1) the development of information infrastructure and management information system; (2) the set up of common benefit package and quality & standard of care; and (3) the development of payment methods and claim
processing. As of October 2005, the three schemes started to synchronize their provider payment administration by merging the claim processing activities to be carried out through NHSO.

CONCLUSION

The development of social health insurance and health financing system in Thailand has been a long process. The plan to establish a health insurance scheme started over 50 years ago when the social security scheme for private employees was devised. The first public health financing scheme started in 1975 as a medical welfare scheme for the poor and expanded to cover other underprivileged groups. Formal sector employees both public and private have health insurance programs that provide medical care benefits. However, the expansion of health insurance coverage to informal sector had been slow and ineffective and the reliance on voluntary health insurance program to achieve universal coverage proved to be impractical.

In 2002, Thailand achieved universal coverage through the government’s strong political commitment, with support from civil society and a strong knowledge base. The new financing system relies on tax financing to cover the informal sector. The existing schemes of CSMBS and SSS still exist to cover government employees and dependents and private formal sector respectively.

The major challenge facing Thailand health financing system is how to merge the three existing schemes together into a single fund. This requires a good information system and a convergence in benefit packages and provider payment methods of three existing schemes. There is also a concern over financial sustainability of universal coverage as the population structure ages and technology changes. The system is still developing and changes are necessary to improve efficiency, equity, quality, and sustainability of the system.


The National Health Security Act, B.E. 2545. November 18, 2002


Prachachart Thurakij Newspaper, 2001. Private hospitals won't let 80 Billion Baht of the '30 Baht' go to only public hospitals. 22 March 2001; Sect. 21, 24.

Thairat Newspaper, 2001. The Director of the Bureau of the Budget pointed the 30 Baht project led to negative balance of the government budget. 1 April 2001.

Sooksanan N., 2002. “Bid to dip into fund draws fire”. The Nation Newspaper, Jan 9, 2002. Manager Newspaper. Thaksin's Polls pointed that the "30 Baht" is the most favourite. Manager.


### Appendix 1: Four main social health insurance / financing schemes in Thailand before universal coverage (1999)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>I. Medical welfare</th>
<th>II. CSMBS</th>
<th>III. SSS</th>
<th>IV. Health card</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Scheme nature</td>
<td>Social welfare</td>
<td>Fringe benefit</td>
<td>Compulsory</td>
<td>Voluntary</td>
</tr>
<tr>
<td>Model</td>
<td>Public integrated</td>
<td>Public reimbursement</td>
<td>Public contracted</td>
<td>Voluntary integrated</td>
</tr>
<tr>
<td>II. Population coverage, 1999 HWS</td>
<td>The poor, elderly and children under 12 years old, secondary school student, the disabled, veteran, monks</td>
<td>Government employee, pensioners and their dependants (parents, spouse, children)</td>
<td>Private formal sector employee, &gt; 10 worker establishment</td>
<td>Non-poor households not eligible for Medical Welfare Scheme, community leader and health volunteer family</td>
</tr>
<tr>
<td>Population 1999 HWS, mil.</td>
<td>19.8</td>
<td>5.5</td>
<td>4.36</td>
<td>11.5</td>
</tr>
<tr>
<td>% coverage</td>
<td>32.10%</td>
<td>8.90%</td>
<td>7.10%</td>
<td>18.60%</td>
</tr>
<tr>
<td>Ambulatory services</td>
<td>Only public designated</td>
<td>Public only</td>
<td>Public &amp; Private (emergency only)</td>
<td>Public &amp; Private</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>Public only</td>
<td>Public &amp; Private (emergency only)</td>
<td>Public &amp; Private</td>
<td>Public (MoPH)</td>
</tr>
<tr>
<td>Choice of provider</td>
<td>Referral line</td>
<td>Free choice</td>
<td>Contracted hospital or its network, registration required.</td>
<td>Referral line</td>
</tr>
<tr>
<td>Conditions included</td>
<td>Comprehensive package</td>
<td>Comprehensive package</td>
<td>Comprehensive package</td>
<td>Comprehensive package</td>
</tr>
<tr>
<td>Maternity benefits</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Annual physical check-up</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevention, health promotion</td>
<td>Very limited</td>
<td>No</td>
<td>Health education, immunization</td>
<td>Yes</td>
</tr>
<tr>
<td>IV. Financing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Source of funds</td>
<td>General tax</td>
<td>General tax</td>
<td>Tripartite contribution 1.5% of payroll each (reduce to 1% since 1999)</td>
<td>Household 500 Baht + government subsidy 1000 Baht</td>
</tr>
<tr>
<td>Management Authority</td>
<td>MoPH</td>
<td>Ministry of Finance</td>
<td>Ministry of Labor</td>
<td>MoPH</td>
</tr>
<tr>
<td>Payment mechanism</td>
<td>Global budget</td>
<td>Fee for service</td>
<td>Capitation</td>
<td>Proportional reimbursement</td>
</tr>
<tr>
<td>Copayments</td>
<td>No</td>
<td>No except IP at private hospitals</td>
<td>Maternity and emergency services if beyond ceiling</td>
<td>No</td>
</tr>
<tr>
<td>Expenditure per capital 1999 (Baht)</td>
<td>&gt; 363 + additional cross subsidy by public hospitals</td>
<td>2106</td>
<td>1558</td>
<td>534 + additional cross subsidy by public hospitals</td>
</tr>
<tr>
<td>Per capital tax subsidy 1999</td>
<td>363 + additional subsidy</td>
<td>2106</td>
<td>519</td>
<td>250</td>
</tr>
</tbody>
</table>
### Appendix 2: Three social health insurance / financing schemes in Thailand after universal coverage (2004)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>I. UC</th>
<th>II. CSMBS</th>
<th>III. SSS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. Scheme nature</strong></td>
<td>Compulsory</td>
<td>Fringe benefit</td>
<td>Compulsory</td>
</tr>
<tr>
<td>Model</td>
<td>Public contracted</td>
<td>Public reimbursement</td>
<td>Public contracted</td>
</tr>
<tr>
<td><strong>II. Population coverage</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population 2004 HWS, mil.</td>
<td>All non-CSMBS and non-SSS</td>
<td>Government employee, pensioners and their dependants (parents, spouse, children)</td>
<td>Private formal sector employee</td>
</tr>
<tr>
<td>% coverage</td>
<td>46.6</td>
<td>4.4</td>
<td>8.2</td>
</tr>
<tr>
<td>% coverage</td>
<td>75.24%</td>
<td>7.07%</td>
<td>13.16%</td>
</tr>
<tr>
<td><strong>III. Benefit Package</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory services</td>
<td>Public &amp; Private</td>
<td>Public only</td>
<td>Public &amp; Private</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>Public &amp; Private</td>
<td>Public &amp; Private (emergency only)</td>
<td>Public &amp; Private</td>
</tr>
<tr>
<td>Choice of provider</td>
<td>Contracted hospital or its network, registration required.</td>
<td>Free choice</td>
<td>Contracted hospital or its network, registration required.</td>
</tr>
<tr>
<td>Cash benefit</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Conditions included</td>
<td>Comprehensive package</td>
<td>Comprehensive package</td>
<td>Comprehensive package</td>
</tr>
<tr>
<td>Maternity benefits</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Annual physical check-up</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Prevention, health promotion</td>
<td>Health education, immunization</td>
<td>No</td>
<td>Health education, immunization</td>
</tr>
<tr>
<td><strong>IV. Financing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Source of funds</td>
<td>General tax</td>
<td>General tax</td>
<td>Tripartite 1.5% of payroll each (reduce to 1% since 1999)</td>
</tr>
<tr>
<td>Management Authority</td>
<td>NHSO</td>
<td>MOF</td>
<td>SSO</td>
</tr>
<tr>
<td>Payment mechanism</td>
<td>Global budget + Capitation</td>
<td>Fee for service (experimenting DRG for IP)</td>
<td>Capitation (experimenting DRG for IP)</td>
</tr>
<tr>
<td>Copayments</td>
<td>30 baht per OP visit, free for low income people</td>
<td>No except IP at private hospitals</td>
<td>Maternity and emergency services if beyond ceiling</td>
</tr>
</tbody>
</table>
Chapter 8:

Lessons Learned and Policy Implications

R. Paul Shaw

The Context Matters


A long history of SHI, beginning in Germany in the 1883 (the Bismark model), and spreading to many European countries also provides ample evidence that SHI can perform very well indeed as an alternative to general revenue tax-financed health care (the Beverage model). Thus far, twenty-seven countries have established the principle of universal coverage via this method (Carrin and James, 2005). The catch, however, is that available evidence on the aims, design and implementation of SHI derives largely from relatively rich, developed countries. Such countries can be sharply distinguished from low income, developing countries in terms of relatively high per capita expenditures on health, a large proportion of their labor force in the urban/formal sector, and relatively low dependency ratios (Table 1). They also tend to have ample administrative know-how and diversified provider markets that can serve and satisfy clients. In contrast, evidence on the design and implementation of SHI in developing countries is hard to come by (Carrin and James, 2005). This is precisely the reason for this book.

Table 1: Selected Characteristics of Countries by Different Income Level Groupings, 2000*

<table>
<thead>
<tr>
<th>Countries by Income Level</th>
<th>Per Capita GNP (US$)</th>
<th>Total Expenditure on Health (US$)</th>
<th>% Urban Population</th>
<th>% Poor Population</th>
<th>Dependency Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>390</td>
<td>29</td>
<td>10-30</td>
<td>40-60</td>
<td>.9</td>
</tr>
<tr>
<td>Upper Middle</td>
<td>3730</td>
<td>242</td>
<td>30-70</td>
<td>20-40</td>
<td>.7</td>
</tr>
<tr>
<td>High</td>
<td>26160</td>
<td>2977</td>
<td>70-100</td>
<td>&lt;15</td>
<td>.5</td>
</tr>
</tbody>
</table>

* Source: World Bank and UN statistical databases; rough averages only.

92 See the historical review by P. Musgrove, 2000.
93 A recent exception, to be discussed later, includes, Guy Carrin and Chris James, 2005.
Five case studies on Ghana, Kenya, Philippines, Columbia and Thailand shed light on the trials and tribulations of implementing SHI in contexts far less hospitable than in relatively rich countries. As conveyed in Table 2, these countries also differ among themselves on various criteria known to be important to the “enabling environment” for SHI. A low per capita income, a small formal sector, a high prevalence of poverty, and a high dependency ratio – as in Kenya and Ghana – will be particularly demanding. Accordingly, the cases presented in this volume provide a telling roadmap of the immense challenges and changes SHI can bring to a country’s health system -- in terms of financing sources and agents, remuneration of public and private providers, organization of care, regulation, behavioral change of both providers and patients, and redefined roles of government.

Table 2: Select Country Characteristics, 2000-04*

<table>
<thead>
<tr>
<th>SHI Stage</th>
<th>Pop (mils)</th>
<th>Per Capita GNP (US$)</th>
<th>Poverty Rate (%)</th>
<th>% Urban</th>
<th>% Health Expenditures 'Out-of-Pocket'</th>
<th>Dependency Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenya Design</td>
<td>31</td>
<td>360</td>
<td>50</td>
<td>41</td>
<td>56</td>
<td>.80</td>
</tr>
<tr>
<td>Ghana Initiation</td>
<td>20</td>
<td>270</td>
<td>39</td>
<td>46</td>
<td>59</td>
<td>.90</td>
</tr>
<tr>
<td>Philippines Extension</td>
<td>80</td>
<td>1020</td>
<td>37</td>
<td>62</td>
<td>61</td>
<td>.70</td>
</tr>
<tr>
<td>Colombia SHI + Managed Care</td>
<td>44</td>
<td>1830</td>
<td>50</td>
<td>77</td>
<td>17</td>
<td>.60</td>
</tr>
<tr>
<td>Thailand Universal Coverage</td>
<td>62</td>
<td>2000</td>
<td>17</td>
<td>32</td>
<td>30</td>
<td>.40</td>
</tr>
</tbody>
</table>

* Source: World Bank and UN statistical databases; rough averages only.

As explained in Chapters 1 and 2, SHI is a sharp and complex instrument of reform. Done well, it can yield positive outcomes over time. Done hastily it can be backward, disruptive, and possibly hazardous. Against this cautionary background, lessons and policy implications from this volume can be summarized in terms of four dimensions:

- SHI as a perceived instrument of reform
- positive changes that can be attributed to SHI
- major problems that challenge implementation
- implications for policy makers

**SHI as a Perceived Instrument of Reform**

Developing countries often resort to SHI in reaction to poor performance of their health systems on four dimensions: revenue mobilization for health, equity of access, efficient use of inputs, and financial risk protection.

Revenue mobilization tends to be weak and disorganized because government’s capacity to tax households and production is extremely limited. Tax revenue amounts to only 14.5% of total GDP, on average, in low-income countries and social security taxes amount to only .7% of GDP. This revenue is completely inadequate to finance public
provision of quality care for most low-income households in rural and peri-urban areas. On the other hand, out-of-pocket spending on health is typically 50-80% of total health expenditures, comes into play when people are most vulnerable to illness or injury, and is “disorganized” from the perspective of purchasing integrated, cost-effective care.

*Access is inequitable* because relatively poor households, comprising 50-60% of the population, tend to live in rural and more isolated areas where public, non-governmental (NGO), and private-for-profit health services are sparse. Inequities tend to be aggravated by the concentration of *public expenditures/subsidies* for health on urban areas and tertiary level care, where relatively rich households are better informed and have the means to access care. This is illustrated in Figure 1 for Ghana where the poorest 20% of households benefits from only 11-12% of public expenditures on health, whereas the richest 20% captures more than 50%.

*Use of inputs tends to be inefficient* because public finance and provision seldom face competitive pressures to demonstrate value for money, and private providers have little incentive to emphasize well-known, cost-effective preventive services. Inefficiencies in public provision of health services have been such that some studies have suggested they make no statistically significant impact on health outcomes in poor countries.\(^{95}\) NGO providers, such as religious missions, have a much better track record in this regard but are thinly distributed in poor areas and underfinanced.

**Figure 1: % of Total Public Expenditures on Health by Income Quintile, 1992 vs. 1998**

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*Financial risk protection is weak* because so many households are vulnerable to catastrophic financial loss at times of serious illness or injury. Without access to well-functioning public hospitals, social health insurance, private health insurance, or community health

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\(^{95}\) See, Filmer, Deon, Jeffrey Hammer, and Lant Pritchett, 1998.
funds, poor households must resort to out-of-pocket spending at times of crisis. People go bankrupt because of medical costs and reduced employment attributable to chronic disease such as diabetes, asthma and arthritis. Data from China, India and many countries in Africa suggest that 30-40% of poor households incur indebtedness and/or sell important assets, such as farm animals or land, to access health care at times of crisis. This feeds a vicious cycle where the reduction of household assets and debt servicing undercuts spending on food, housing, and other household inputs to good health.

Combined, these four performance problems shackle progress in countries where huge improvements in health system performance are required to respond to national and donor driven challenges of improving health of poorest households, attaining the Millennium Development Goals (MDGs) and other national priorities. They place a premium on finding workable alternatives to more traditional responses (see Box 1). In developing nations, this sets the stage for intense interest in “social health insurance”, not merely as a way of mobilizing earmarked funds for health, but as an instrument for reforming the financing, organization, payments, regulation and behavior of both providers and clients in national health systems.

Done properly, the dream of SHI is that it can improve a country’s health status outcomes by;

- Mobilizing more revenue for health
- Improving equity by risk pooling contributions of the relative rich and poor, relatively sick and healthy
- Reducing catastrophic financial loss at times of serious illness or injury, and thus the vicious cycle of indebtedness, debt servicing and reduced household expenditures on necessities
- Expanding access to quality services by contributing members
- Facilitating more efficient purchasing of care for SHI members in the quest to get ‘value for money’
- Facilitating the “separation” of financing and provision, whereby the SHI fund manages the financing and contracts-out to public and private providers to deliver services
- Involving more stakeholders -- industrial groups, cooperatives, religious groups -- in the determination of their own health outcomes
- Being more responsive to client preferences and complaints.
- Freeing up scarce public revenues (from general taxation) for more effective targeting to the poor
Box 1: Traditional Responses to Poor Health Sector Performance

Traditional responses to the challenges above are well known. They are guided by an epidemiological focus on reducing disease through cost-effective interventions that are largely financed and provided by government as supply-side strategies. In support of these efforts, WHO has urged governments to increase revenue mobilization to the extent that national health spending surpasses 5% of GNP. Multi-lateral and bilateral donors have also been urged to increase grants and loans for health to help scale up public efforts at reducing disease. These agencies are also fostering debt relief to enable poor country governments to allocate ‘savings’ from debt servicing payments to health and education. The good news is that large sums are involved, for example, $30 billion of debt reduction up to 2005, with $52 billion more debt reduction promised by the G-8 during a recent meeting, much of it applicable to Africa. As part of these efforts, international NGOs are making laudable efforts fill critical gaps in immunization and the fight against HIV/AIDS.

The bad news is that traditional, supply-side responses demonstrate age-old performance problems when it comes to getting the job done. One problem involves reliance on ‘top down’ government health systems where the public sector dominates provision, allocates public expenditures largely towards urban areas and tertiary care, has limited capacity to regulate quality, and lags in its ability to create an enabling environment for private providers. While new infusions of funds temporarily come to the rescue, the fact remains that government capacity to sustain higher spending through general revenue taxation will remain limited in poor countries – unable to capture the 50-70% of expenditures on health spent by individuals, out-of-pocket. Moreover, the introduction of user fees in public facilities raises little more than 10-15% of recurrent costs, while often deterring poorest households from seeking care.

A second problem involves lack of confidence in government as a provider of health services, as well as a lack of meaningful representation of stakeholders in health outcomes, including private and NGO providers, communities and households. This lack of confidence is fully justified in many poor countries where drugs in public hospitals are available for only 1-2 weeks per month and staffing is far below quantitative and qualitative norms.

A third problem involves the continued fragmentation of poor country health systems by a myriad of externally funded projects, separate project implementation units, and independent monitoring and evaluation studies. Harmonization of such efforts has always been a problem, renewing criticisms that donors and international NGOs frequently create parallel systems of delivery – to get the job done – which invariably undercuts capacities of national systems. Moreover, external aid tends to be short-term, volatile, and often dries up when donors “pull out” or fail to deliver on their commitments. IMF analysts suggest that aid is 20 times as volatile as government revenue as a percentage of GDP, and 40 times as volatile as government revenue in constant US dollars per capita. Only 60 percent of promised aid, on average, actually makes it to programs.96

Figure 2 depicts ‘pathways of influence’ by which SHI can also be expected to impact on health status outcomes that are important to achieving millennium development goals – like maternal mortality. Indeed, a simple econometric analysis of data for approximately 100 countries supports the hypothesis that the degree of risk sharing in health-financing organizations matters for health system attainment, as measured by the five health system performance indicators in the World Health Report 2000: (i) disability adjusted life expectancy (ii) index of the level of health system responsiveness to clients, (iii) index of the distribution of responsiveness, and (iv) index of equality of child survival.97

96 See Ruth Levine, 2005.
97 See Guy Carrin et al., 2003.
In addition to the above, SHI is represented as a means of shifting from supply side to demand size strategies. As conveyed by the experience of the Philippines, Columbia and Thailand, demand-side stimulus occurs because two markets are typically stimulated by SHI. On the one hand, member contributions are used to purchase services that members want, from providers they chose, in close proximity to where they live. On the other hand, the SHI Fund contracts with both public and private providers and holds them accountable for quality and client satisfaction. The Fund can also use provider payments to incentivize the market. For example, when capitation is used to remunerate providers and when clients have a choice among several providers, the provider must satisfy the client or risk losing him/her – and thus the client’s capitation payment -- to a competing provider. In other words, the system must be responsive to the client, rather than simply supply tax-financed services for free while expecting clients to come forward, happy or not. This is the essence of injecting more demand-side accountability into the finance and provision of health care through SHI.

As the case studies in this volume demonstrate, using SHI as an instrument of reform is not to exclude or deny that the public sector will continue to play essential functions. Rather, a redefinition and increased emphasis of various public roles is envisioned. Typically, this implies making better use of the public sector’s comparative advantage as (i) a steward of good health system practice, (ii) financing health goods and services that have positive externalities, and (iii) subsidizing the poor.

In short, efforts to launch SHI in developing nations are full of generic hopes and dreams – some explicit, many implicit and unstated. Reality in developing countries is a different matter, of course; it requires lessons of experience from the ground up.

**Positive Changes Attributable to SHI**

Experience of the five countries presented in this book suggests that, at various stages of implementation, SHI can be credited with at least ten positive changes:

First, in all countries, legislation was introduced to establish SHI, thus providing a legal framework to authorize mandatory, earmarked contributions for health, as well as the creation of a new, autonomous organizational entity to manage those contributions. The process of introducing and refining legislation in support of SHI facilitated national debate by parliamentarians, raising public consciousness of the problems facing the health sector -- especially sustainable financing and possible options to improve it.

Second, when implemented, SHI has enjoyed some success in raising more revenue for health – in addition to existing revenues raised by general taxation. This is no small accomplishment in countries struggling to meet the generic target set by the World Health Organization that countries spend at least 5% of GNP on health. In the Philippines, for example, SHIs share in total *public* health expenditures grew from 8.9% in 1998 to
23.4% by 2002, and from 3.8% of total health expenditures in 1998 to 9.1% by 2002 –
though this latter achievement suggests a 25% target for 2004 was too ambitious. In Co-
lumbia, health expenditures increased from 6.2% of GNP in 1993 to 8.1% by 2002, with
SHIs share rising from 1.7% of GDP in 1993 to 4% by 2002.

Third, implementation of SHI constituted a formal mechanism to pool revenues and
spread risks across population groups, from rich to poor and across the life cycle. In some
countries, such as the Philippines this was visible in a reduction in out-of-pocket (OPP)
expenditures for health from 50.4% in 1995 to 41% by 2000, though OPP climbed again
to 61% by 2002. In Columbia, it is visible in the transfer of approximately 10% of SHI
revenues to subsidize membership of informal workers and the self-employed. This re-
sulted in reduced role of unaffordability and cost as a reason not to seek care. Moreover,
only 4% of the population covered by SHI fell below the poverty line in Columbia as a
result of an ambulatory or hospital shock, versus up to 14% of non-SHI members. Ac-
knowledging that progress on improving financial fairness and risk pooling has been ex-
tremely slow in many countries – as evaluated by WHO in its World Health Report 2000
– it is clear that SHI represents a promising response to the challenge.

Fourth, implementing SHI has forced more careful and rationale planning regarding the
imperative of equating SHI revenue with SHI expenditure. Vague, overly generous, and
unaffordable ‘benefit entitlements’ are more readily viewed as a pathway to bankruptcy.
In Kenya, this is the President refused to enact the National Social Health Insurance Fund
in 2004. Moreover, unit costing is increasingly being used to determine the actual costs of
different benefit packages and to ascertain their affordability. Tough choices have been
required regarding services to be included versus those to be excluded. Co-payments and
deductibles have had to be considered as a way of shoring up lagging revenues.

Fifth, SHI contains provisions that aim to make it more ‘responsiveness to clients’ – one
of the criteria used by the World Health Report 2000 to assess performance of national
health systems. This is embodied in the ‘social contract’ between contributing members
and the SHI that requires grievance procedures to be established if benefit entitlements
have NOT been honored. In other words, SHI has given new meaning to the term “ac-
countability” in several developing countries, in ways not previously seen in publicly fi-
nanced and provided health care.

Sixth SHI has embraced the increasingly popular policy of ‘separating public finance
from public provision’ of health care. This policy stems from the impression that gov-
ernments often do a good job of raising funds for health (through taxes or SHI), but per-
form less well in directly providing health care through publicly owned and operated
hospitals and clinics. The proposed alternative is for government and other entities that
collect revenue for health to contract with different accredited providers – public, NGO,
private-for-profit. This means the SHI Fund performs more as a purchaser of quality
health care, striving to get best value-for-money from available providers. Moreover, in-
creased use of contracting with both public and private providers is viewed as a way of
stimulating the ‘market’ to be more competitive and making providers more accountable
for their performance. In Kenya, for example, it is proposed that national hospitals be-
come financially autonomous from the MOH within 2 years, provincial hospitals within 4, district hospitals gradually over 6-10 years, and health centers and dispensaries within 10 years. In Columbia, the stimulus to private versus public competition by ‘provider health plans’ resulted in growth of population coverage by private health plans from 11% to 30% between 1995-98. Nor did expansion of the ‘market’ in Columbia exclude public providers previously on government payroll because a minimum of 40% of health plan contracts go to public providers – by decree.

Seventh, the strong probability that SHI would contribute to a two-tier health system – one more prosperous for SHI members, the other less prosperous for non-members – has inspired more realistic, focused debate about expanding coverage to the poor and subsidizing the indigent. While intentions in this area tend to be excessively optimistic, at least they are being formulated and debated. Thus, SHI in Ghana aims to expand membership incrementally with a timetable and expansion path aimed at 30-40% coverage of the population in the first 5 years, and 50-60% in next 5-10 years. SHI in the Philippines recently stepped up subsidies to the poor to the extent that membership composition of indigents changed from 16% of the total in 2003 to 30% by 2005. SHI in Columbia doubled subsidies to poor households to the extent that 28% were covered in 2003 versus 14% in 1991. By 2003, 50% of the poorest income quintile were included in SHI versus less than 10% in 1991. These trends and commitments demonstrate that SHI can work for equity.

Eighth, the onus on SHI to achieve value-for-money has encouraged new thinking and experimentation with different forms of provider payments. Several countries continue to rely on retrospective fee-for-service (like Kenya and Ghana) but others are shifting to prospective capitation for primary and basic curative care (combined with fee-for-service for more expensive surgical procedures as in Columbia and Thailand). The shift away from fee-for-service has helped SHI funds to reduce administrative complexity of processing thousands of individual bills as well as the tendency for providers to ramp up the volume of patients in the quest to manipulate earnings.

Ninth, the creation of a new organization, responsible for raising earmarked revenue for health and contracting with providers, has resulted in a clarification and redefined roles of MOH. In Ghana, for example, the MOH aims to become a policymaker and regulator of health care vs. a provider of services. Accreditation of providers is an especially important role that needs to be filled through a government regulatory body. Also critical is the need to better target public funds – from general taxation – to the poor, either in the form of directly financed provision of care, or though subsidized membership in SHI. Moreover, with more earmarked SHI funds for health, government should be better equipped to channel public revenue to public health goods and services. This can be done in conjunction with SHI, as in the Philippines, where providers that offer services such as DOTS and maternity coverage are reimbursed by SHI. In Columbia, approximately 4%

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98 Membership composition of indigents actually climbed to 48% in 2004, as conveyed in the Philippines case study, but this was an election year containing promises to increase indigent enrollment. The authors understanding is that such intentions were not insulated from politics and that by 2005 indigent enrollment had slipped to 30%.
of SHI revenues are placed in a ‘promotion and prevention’ fund to finance health promotion and prevention activities by contracted health plans. Another 2% of SHI contributions is set aside for maternity leave benefits.

Finally, the commitment to SHI, over the longer haul, has demonstrated success in expanding membership, rather than simply stalling or leveling off. Thus, in the Philippines, the formalization of SHI in 1995 resulted in a steady climb of the population covered by insurance from about 50% rising to 78% by 2004. In Columbia, coverage grew from 20-70% over last 10 years. And in Thailand where 68% of the population had been covered under various risk pooling schemes, it was the expansion and consolidation of SHI itself that set the stage for universal coverage in 2004 which now covers 96% of the population.

Major problems that challenge implementation

Experience of the five countries in this book also conveys that, at various stages of development, SHI can also expect to encounter at least ten major implementation problems.

The first major challenge requires that mandatory SHI actually be enforced. It is relatively easy to pass a law and create an organization to collect premiums. Collecting those premiums is another matter. Collection will be easiest for civil servants, with regular payroll lists, and monthly deductions from employer and employee wage schedules. Collection will also relatively easy from large formal sector employers and employees, as identified by establishment surveys in urban areas, for cooperatives, etc. Collections will be much harder among smaller enterprises in the formal sector with evasion by both employers and employees a major problem. In the Philippines, for example, the office of actuary estimates that collection efficiency for those in the formal sector is as low as 30-70% of those who should be contributing. In Columbia, it is estimated that only 65% of potential contributors are actually paying with the combined effect of evasion and elusion decreasing revenues by up to 35%.

A second major challenge concerns the dependents of contributing members. The poorer the country, the higher the dependency ratio, attributable largely to high levels of fertility and family size. If dependents are excluded from SHI benefits – as was initially the case in Thailand’s and Costa Rica’s SHI – then revenue from workers contributions pays only the health care costs of workers per se. If dependents are included, such as children and spouses, then workers contributions must be increased. On the one hand, a child typically absorbs only about one-quarter the health expenditures as does an adult, and for this reason, private insurers like to insure them. For SHI, this would imply a doubling of one worker’s contribution for every four dependent children to be included in SHI coverage. Similar types of calculations are needed to adjust contribution rates if spouses and maternity benefits are to be included, and so on. In the Philippines, approximately 25% of benefit payments go to beneficiaries less than 20 years of age, 50% to those aged 20-60, and 25% to those over 60 years of age. Thailand eventually extended its coverage to dependents but only after SHI accumulated a hefty surplus.
Third, determining a financially sustainable benefit package is key to the survival of SHI. As noted in the prior section, unit costing of benefit entitlements is essential, with such techniques being increasingly applied. This is not to suggest, however, that micro-data are needed to cost every service and commodity input required of patients. Rather, more aggregated information can be used to cost (i) average consultation visits, (ii) treatments for an episode of illness, (iii) daily hospitalization rates, and (iv) rates for specialized services, such as maternity. Furthermore, it is important to appreciate differences in unit costs between public, NGO, and for-profit providers. This makes it easier for the SHI Fund to establish reimbursement rates that will simultaneously contain cost escalation without discouraging efficient producers who need to earn enough to survive. In Colombia, for example, SHI pays average costs incurred by six hospitals (based on unit cost studies) and requires more ‘expensive’ hospitals to bring their costs down.

Fourth, and related to the above, is that projected use of a realistically costed benefit package by SHI members has to be estimated to determine overall expenditure requirements. On the one hand, utilization data by households classified by age, sex, employment group and income quintile is required. On the other hand, projected utilization will need to be adjusted to accommodate realities of moral hazard associated with introduction of SHI. That is, health services of higher quality than in the past, without financial barriers to use them, are likely to lead to a big increase in utilization -- in primary care consultations for example. This may require quick and negatively perceived adjustments in the form of co-payments and deductibles to curtail the moral hazard.

Fifth, only when the cost and utilization of SHI entitlements allow full estimates of SHI expenditures, can revenue requirements be determined in terms of employer and employee contribution rates. Is a 6% contribution rate enough, split evenly between employer and employee; is 9% enough, 12%? What level is politically acceptable and collectible. If revenue coming in is less than required, as usually happens, what is to be cut back on the entitlements side. And what happens when the economy takes a downturn and unemployment rises substantially. All this means that continual adjustment will be required and that the technical skills and required data will have to be in place to do so effectively. In a country with a per capita income of $2,000 or more, these problems will be a big challenge; in a country with a per capita income of $500 or less, they will be monumental. In all countries, sound actuarial analysis will be essential.

Sixth, enrolling those in the informal or self-employment sector will always be a major challenge because mandatory enrollment is not an option (or at least not enforceable). And even for those who do join voluntarily, adverse selection – meaning the poor and sick with highest medical bills will be most likely to join -- will be a major threat to sustaining expenditures. This says nothing of the administrative costs to enroll, monitor and collect contributions from this population which can also be very high. In the Philippines, two-thirds of voluntary enrollees did not pay on a regular basis, motivating the SHI fund to give religious and cooperative organizations ‘group discounts’ as a way of enrolling their entire membership. Still, this was only a partial strategy, reaching a small share of the population. In Thailand, coverage and collection problems were such that government
decided to use general revenues to pay for self-employed workers. Finally, the more confidence workers have in government and SHI, and the more recourse government/SHI has to effectively punish those who evade, the less enforcement problems will prevail.

Seventh, defining, measuring, and subsidizing the poor and indigent is a major nemesis and will continue to be during all stages of SHI. As implied by Kenya and Ghana, the poorer the country, the worse the problem because their numbers will be voluminous and the capacity to monitor and evaluate them will be limited. Moreover, actually getting public subsidies to the poor and indigent will be a major hurdle, requiring proper cross-subsidization and pooling of risks between rich and poor regions if SHI contributions are held at district level or in different funds. Relying on SHI revenues to subsidize the poor presumes that a surplus will accrue from a paying membership, or that benefits will be cut back to accommodate wider access.

Eighth, infrastructure will have to be progressively built up if clients in peri-urban and rural areas are to have access and if portability of benefits is to be achieved. Moreover, improving performance through contracting (on the supply side) and through choice of providers (on the demand side) will be hugely compromised without sufficient providers to allow some form of competition.

Ninth, experiments with provider payment mechanisms that aim to shift the ‘financial risk’ for provision to the provider – such as capitation – will have to be continuously monitored and evaluated. As Thailand’s experience shows, capitation without special provisions for the indigent or expensive cases can lead to crème-skimming and risk selection, because the provider has a big incentive to keep services at a minimum.

Tenth, improving the administrative efficiency and effectiveness of SHI requires battles on several fronts. In some countries, such as Ghana and Columbia, several different types of insurance schemes existed prior to or concurrent with the expansion of SHI, resulting in fragmented risk pools and inefficiencies linked to large transaction costs. In Ghana, SHI faces the challenge of integrating various schemes that have varied terms of membership, benefits, premiums and types of providers. In Columbia, the administrative costs of health plans was so variable, ranging from 4-60% of the value of the premium, that a Decree was issued to require plans to have a minimum of 200,000 enrollees. This led to a wave of mergers that reduced the total number of plans to 43 – with 45% being private, 42% community based, 6% public, and the remainder being health plans for indigenous people. Moreover, administrative budgets have to be realistically determined and adhered to, set at 5% of SHI revenues in Kenya to as high as 12% for Philippines. And within those budgets, SHI administrations have to be more effective in discharging their responsibilities, thus placing a premium on recruiting good managers.

Eleventh, leakage of SHI funds through potential corruption will be a perpetual threat. In Kenya, compulsory social health insurance for hospital services suffered greatly from poor management and corruption – with only 22% of the fund actually used to pay for benefits, with 25% going to administrative costs, 53% for investment projects, such as lavish new headquarters, and a large portion of the accumulated reserve lost due to cor-
ruption. In Kenya’s plans to launch a new national SHI, rules have been formalized to constrain the board’s behavior including (i) a proposed 5% limit on administrative costs, (ii) a 3% limit on reserves, and (iii) abstention from voting on investments or contracts if board members have any prior financial links to them. Finally, fraudulent claims will hound SHI, as in the Philippines where the Office of Chief Actuary estimates that somewhere between 10-20% of the claims are fraudulent.

Policy Implications

In dozens of countries, special technical groups are advising Ministers of Health and Ministers of Finance on better policy making and capacity building for SHI. Many of these technical groups have participated in brainstorming meetings or dedicated learning events on SHI sponsored by the World Bank Institute. More informed assessment of the pre-conditions for SHI, as discussed in Chapter 1, has motivated some groups to put their plans to implement SHI ‘on hold’. Others have decided to forge ahead, aware that huge challenges await. The policy implications summarized here are cautionary statements, intended to minimize misconceptions and mistakes before they happen.

1. SHI is complicated, taking many years to implement effectively and efficiently.

SHI is a sophisticated financing method and its effective implementation requires a reorganization of the MOH and the establishment of a new agency. The MOH has to be transformed from being a funder, manager and operator of public health services to be a policymaker, a regulator and an overseer. The new SHI agency has to have a sound organizational structure, effective leadership and management, capable and dedicated professional staff, sophisticated management information and IT systems. For example, for human resources, the SHI agency has to recruit capable medical doctors, actuaries, accountants, financial managers, IT specialists, policy analysts and planners. The executives and managers have to be educated in the nature and functions of SHI. In managing health services, the SHI agency needs to select and contract health care providers and monitor their services, which would require hospitals to develop modern accounting, financial and medical record systems. Most low-income countries simply do not have the required human resources and knowledge now. They will have to be developed over time.

2. It takes decades to achieve universality

Passing a law to introduce the principle of universal coverage through SHI is only the first step. In relatively rich countries, the number of years between the first law related to health insurance and the final law to effectively implement universal coverage through SHI was 127 years in Germany, 118 in Belgium, 79 in Austria, 72 in Luxembourg, 36 in Japan, and 27 in the Republic of Korea. These estimates, provided by Carrin and James (2005), go on to show it took 40 years in Austria (from 1890 to 1930) for population coverage to grow from 7-60 percent, and then another 35 years (from 1930-1965) to reach 96 percent. More relevant to the countries discussed in this volume, it took 20 years for SHI to reach a population coverage of 17 percent in Costa Rica (1961), another 5 years to
double coverage to 34 percent (1966), another 10 years to again double coverage to 74 percent by 1978, and then another 13 years to attain 83 percent coverage by 1991.99

The most severe constraint in achieving universality in low and middle income countries is a country’s tax revenues and portion of workers employed in the formal sector, which depends on that country’s stage of economic development. Poor countries not only have small tax bases, but they are also narrow because of large informal sectors. It is easy to enroll civil servants and employees of large firms, but much more difficult to enroll the self-employed and informal sector workers. The challenge for enrolling the poor is funding them.

Economic growth can have four positive effects on SHI enrollment: (a) it lifts people out of poverty, meaning more people can afford to pay, (b) it brings more workers into the formal sector, which increases the number of people in the contributory regime, (c) it raises general revenue for the government, meaning more poor can be subsidized, (d) growth tends to increase the administrative capacity of the government to collect taxes and insurance premiums. It took Thailand more than 25 years to reach universality, at which point income per capita had reached $2,400 level. In sum, the expansion of SHI coverage and attaining universality depend on a nation’s rate of economic development.

3. In the early stages, it maybe unrealistic to have the same benefit package for all groups

All countries would like to offer a comprehensive benefit package to all citizens. Unfortunately low- and middle-income countries may not be able to afford such a package. Formal sector employees demand comprehensive benefits and might be able to pay for it. However, a difficult trade-off has to be made for the poor and near poor. The choice involves covering fewer poor and near poor with a comprehensive package or covering more of them with a less comprehensive package. For example, Colombia had to limit the benefit package of the poor to make it only half as expensive as that of formal sector employees so it can be affordable. Now Colombia is expanding its coverage to the near poor with a benefit package less comprehensive than that of the poor.

4. Designing and costing the benefit package(s) is difficult but essential

Costing out the benefit package is a major technical and political hurdle in implementing SHI. Usually, politicians like to promise the most and pay the least. A sound SHI program requires adequate and sustainable financing. The initial “wishful” benefit package has to be costed to ascertain its affordability and acceptability by the funders. In practice, it requires several rounds of “designing a benefit package—estimating its actuarial cost—modifying benefit package—estimating its actuarial cost” to reach a balance between “wishes” and economic reality. Kenya did not conduct such a process which resulted in the President’s refusal to sign the bill into law. Ghana has yet to cost its benefit package. Philippines has undertaken no actuarial studies of the real cost of providing benefits.

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99 This information borrows from an excellent historical analysis by Guy Carrin and Chris James (2005).
packages, even after 10 years of SHI. Absence of this kind of information is simply dis-empowering to managers.

5. **User fees have to be in place to motivate people to join**

People have to have incentives to pay SHI premiums, especially if their wages cannot be garnished by employers. This applies especially to self-employed workers who would not be motivated to join SHI if government services are provided “free” or nearly free. This is not an insignificant issue in countries with high levels of poverty and strong political pressures for elimination of user chargers at public facilities. And, people will not want to pay for SHI unless user fees are relatively high, if patients have to purchase drugs and suppliers, or if public services are so poor that many patients pay out-of-pocket for private providers and are susceptible to catastrophic financial loss at times of serious illness or injury.

6. **SHI has to create adequate incentives for workers to enroll**

The mainstay of SHI membership will be workers in the formal sector – where they can be identified as employees of organizations and mandated to pay monthly premiums. However, even when contributions are mandatory, adverse selection can remain a critical problem, with evasion most likely among smaller employer groups. To overcome this, SHI has to create incentives for workers to enroll by requiring employers to pay a share of the SHI premium. (Private group insurance also does the same to reduce adverse selection.) Thus, Kenya, Ghana, Colombia, Philippines and Thailand all designed their SHI so employers pay one-half or more of the premium. This parallels the experience of SHI in many developed countries where the contribution rate is split approximately between employers and employees in countries like Bulgaria (4.5% each), in Bulgaria (4.3% each), and in Romania (6.1% each).

7. **Large general revenues are needed to cover the poor**

All low and middle income countries have large poor populations who are unable to pay the premium. Nations use different criteria to establish the poverty level. The indigent population usually makes-up 40%-50% of the low income nations. Even the United States has 12% of its population living below its poverty line. The government has to have the budget to subsidize the poor. It could reallocate its budget from other programs to health and/or raise new tax revenues. For example, Ghana imposed a new 2.5% value-added-tax to help finance the subsidized regime, but it’s not clear the new sources of revenues will be sufficient to fund all the poor as Ghana’s SHI coverage expands. Philippines used revenue from a national sweepstakes lottery to help finance premiums of the poor.

8. **SHI has to convince stakeholders of actuarial soundness**

Social insurance is required to maintain its own solvency, and thus have greater transparency and accountability to the people. Solvency cannot be adequately assessed without
actuarial calculations that consider near and longer-term characteristics of the work force and the level of workers’ earnings. These, in turn, will depend upon many economic and demographic factors, including future birth rates, death rates, labor force participation rates, and rates of economic development and wage increase. In the United States, for example, actuarial calculations must show predicted revenues and expenditures for 25 years into the future for US Medicare – a program financed primarily by a payroll tax that covers 38 million elderly and disable Americans. Absence of actuarial studies will leave SHI policies and implementation plans vulnerable to intense public scrutiny and criticism regarding solvency.

9. It is necessary to reduce the supply-side subsidy

In most low income countries, the governments subsidize the public health facilities with an annual budget. Under SHI public health facilities will receive their revenue from SHI payments. The supply side subsidy should be reduced in synchronization with the implementation of SHI. The savings could be used to expand the subsidy for the poor. Otherwise the public health facilities will be overpaid, a poor use of scarce resources. Colombia had planned to reduce this supply-side subsidy while SHI expanded, but it has not been able to do so because of the political power of public health workers’ unions. As a result, the planned expansion of SHI to cover the near poor has been retarded. Instead, the additional revenue from SHI payments were used by public health facilities to increase the compensation of their staff and for new capital projects.

10. The SHI agency should be insulated from politics and political interference

The SHI needs to be independent from the government to represent the interests of the insured and prevent corruption. The new independent agency must be transparent in their finances, which requires independent audits. Many countries establish the SHI agency under the Ministry of Health without adequate representation from the insured and premium payers. Typically, MOH is dominated by medical professionals who tend to protect the supply-side interests. This was the case in Colombia and the Philippines. Under such governance, much of the new revenue went to increasing the salaries and profits of providers.

11. The SHI agency should be a prudent purchaser of medical services and goods

It is hard for the Ministry of Health to manage the SHI, because doing so requires a transformation of their corporate culture from that of a funder and operator of public services to becoming an active prudent purchaser for the insured. The contrasting experiences of the Philippines and Thailand provides a good example. The SHI agency in the Philippines has acted like a traditional passive private insurance company – just a financial intermediary. They enroll, collect premiums, and pay the claims. The National Health Security Office in Thailand selectively contracts with provider networks and pays them a capita-
tion rate – a payment system designed to discourage overuse. As a result, Thailand has not had the same problems the Philippines has of new funds being used to benefit the suppliers instead of the insured.

12. Certification of qualified providers before or concurrently with SHI is a must

As a purchaser of services, SHI will need to contract with public, NGO and private-for-profit providers. SHI members will expect these providers to provide more or less uniform quality of services and have more or less uniform capacity to deliver them. To a large degree, public providers will be trying to conform to established, and published, provider guidelines – with the onus on public providers to live up to those guidelines if contracted by SHI. On the other hand, quality of private sector health services is highly variable, and it is difficult to detect fraud and price “gouging” when SHI pays claims. These kinds of deficiencies have to be remedied before or concurrently for SHI to gain sustained public support, perform its role to assure reasonable quality and sustain its operations financially.

13. A single fund is preferable to many funds.

There are three main arguments for establishing a single insurance fund instead of many. First, low-income countries lack the human resources, experience, and IT systems to start even one fund properly, so having multiple funds would further dilute the human resource pool. Secondly, it would increase administrative costs at both the insurer and provider levels, meaning less of the scare resources would be spent for health services. Lastly, a system with multiple funds develops political and bureaucratic barriers to universal SHI with equal access. Thailand’s major hurdle to equalize access is to merge its various funds. Kenya, Ghana, Colombia, and the Philippines learned from the struggles of more advanced economies like Germany, South Korea and Taiwan that had multiple SHI funds and each established a single SHI fund. Nonetheless, several economists argue from the theory that many funds would give people choice and competition among funds would promote greater efficiency. However, there is no credible evidence to support the theory.

14. Donors could play a valuable role in supporting implementation of SHI

Donors are especially keen on targeting international or national public subsidies to improve health of the poor. Their traditional approach has been to channel donor assistance to publically financed and provided health goods and services – under the presumption these funds actually benefit the poor. However, as benefit-incidence studies of public funding typically show, it is the households in the richest quintiles that typically benefit most, that ‘capture’ the public subsidy that tends to go to hospital services in urban areas within in easy reach of the rich. In addition to multi- and bi-lateral donors, international NGOs channel large infusions of funds to supply-side provision of public health goods and services – such as much needed vaccinations supported by GAVI – which impact directly on health status outputs and outcomes. Donor support of SHI is a much needed complement to traditional development assistance because it shifts emphasis from im-
proving health status alone to improving BOTH health status and financial risk protection. Avenues of support include the following:

- Use of funds from ‘debt forgiveness’ in developing countries that are undertaking SHI as a way of subsidizing membership of the poor and indigent. This is what Ghana is planning to do.

- Provide direct grants to SHI that are ‘earmarked’ to enroll the poor and indigent, and/or expanded benefit entitlements to special interest groups – such as DOTS or maternity benefits in the Philippines.

- Increase technical assistance to manage and operate SHI, in the form of resident, seconded staff who have experience with unit costing, budgeting, actuarial analysis, contracting, and performance monitoring.

Conclusion

Theory on SHI is at its best when it speculates on ‘what-to-do’ when designing SHI. Theory is at its worst when it advises on ‘how-to-do-it’. The reason is simply that implementation of SHI in economically, socially and culturally diverse environments produces unexpected challenges, thus opening the door to whole new kinds of learning.

The five case studies presented here are all about the trials and tribulations of implementation – the ‘how-to-do-it’. They provide a rich roadmap of the design options, aims and intentions, mid-course revisions, successes and pitfalls involved in SHI.

Perhaps the most important message of this volume is that social health insurance should not be seen as a ‘magic bullet’ that will solve the woes of health care financing and provision in developing countries. It clearly holds potential to make a positive contribution, but success comes slowly because many potential drawbacks and risks lie ahead. It is hoped that by contributing to awareness of these issues that this volume will assist policy makers in developing nations to chose the right things, and then, once chosen, to do them right.


Figure 2: Links between Financial Risk Protection + Health Status Outcomes

Pathways of Influence
- Access
- Equity
- Efficient Purchasing
- Risk Protection
- Community + Stakeholder Involvement
- Responsive to Clients

Indicators
- Utilization
- Continuity of care
- Gender equity
- Indigent peoples
- Cost-effective interventions
- Quality enhancement
- Engage private providers
- Reduced debt maintains
- Health spending maintained
- Nutrition maintained
- Increased awareness
- Entitlements clearer
- Healthy practices at home
- Client satisfaction measures

Health Status Outcomes
- Lower Average IMR + MMR
- Lower IMR + MMR among poorest quintiles