Report of the technical support mission for the

Feasibility assessment and financial projection results for a Social Health Insurance Scheme in Lesotho

Exploring Possible Options

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Acronyms

ADB  African Development Bank
AFRO  WHO African Regional Office
ART  Anti-retroviral therapy
CHAL  Christian Health Association Lesotho
CHW  Community health worker
CWIQ  Core Welfare Indicators Questionnaire
DHMT  District Health Management Team
GDP  Gross domestic product
GOL  Government of Lesotho
HPSD  Health Planning and Statistics Department
HSA  Health Service Area
Ibid.  same place
IDA  International Development Agency
IP  Inpatient
KOL  Kingdom of Lesotho
M  Maloti
MCC  Maseru City Council
MoF  Ministry of Finance
MOHSW  Ministry of Health and Social Welfare
MoL  Ministry of Labour
MoPS  Ministry of Public Service
MoU  Memorandum of Understanding
NGO  Non-governmental organization
NRPL  National Reference Price List
OOPs  Out-of-pocket spending
OP  Outpatient
p.  page
p.c.  per capita
PHI  Private health insurance
PPP  Public-private partnership
PRS  Poverty reduction strategy
QEII  Queen Elizabeth II National Referral Hospital
RSA  (Republic of) South Africa
SEFF  Supplementary Emergency Funding Facility
SHI  Social health insurance
SimIns  WHO-GTZ Health Insurance Simulation Model
TB  Tuberculosis
TWG  Technical working group
UN  United Nations
USD  US Dollars
WB  World Bank
WHO  World Health Organization
Executive Summary

The Ministry of Health and Social Welfare (MOHSW) of Lesotho requested the World Health Organization (WHO) to undertake a financial feasibility study of social health insurance (SHI) as an option of financing health care in Lesotho. This technical support was undertaken from June to November 2007. It comprised two missions to Lesotho and desk work, including stakeholder consultations and information/feedback workshops, data collection and preparing of financial projections. There is not one optimal way to social protection for health and therefore WHO aims to assist in narrowing down the possible options that are adequate and technically feasible in order to facilitate policy decision making by the Lesotho government.

The outcome from the discussions with stakeholders is a vision of social health insurance for all Basotho, introduced in a phased manner. Financial projections were made using the SimIns tool from WHO and GTZ. These give policy-makers an indication of the financial implications of a policy under consideration. They do not constitute a complete and detailed actuarial analysis, which needs to be completed after the policy decision has been made.

Based on the stakeholder consultations, the financial scenario whose results are projected here is one of a social health insurance with the following key characteristics and assumptions:

- The formal sector population (public service officers and pensioners) including their families join the scheme as quickly as possible, while the informal sector workers and their family are included gradually. Universal coverage is reached after 10 years.
- The MOHSW budget for curative care is maintained and SHI complements rather than replaces it.
- Formal sector employees make monthly contribution payments (payroll deductions) of 5% that are shared between employees and employers. Pensioners only pay the ‘employee’ half, i.e. 2.5%.
- Informal sector workers pay a flat contribution amount of M450 per year for themselves and their family.
- The poor, about three fourths of the informal sector population, are exempted from paying contributions.
- The benefit package comprises of all essential outpatient and inpatient care at GOL and CHAL health facilities, as well as some outpatient care at private providers and authorized referrals to RSA.
- A substantial quality increase (50% in monetary terms) is assumed to be implemented with the help of SHI financing.

The projected revenue and expenditure of such a SHI with the above input variables and assumptions shows that it would produce a yearly surplus in the initial years but a deficit after some 7 years. This is a result of a phased introduction that covers the formal sector population first, who contribute more. As the projection progresses, an increasing number of poorer people are included who add more to the SHI expenditure than to its revenue.
This is the financial manifestation of an equity effect inherent in social health insurance, whereby the better-off subsidize the poor, and the healthy subsidize the sick.

Under universal coverage in such a national SHI system, a yearly deficit of around M70 million (constant prices), or about 25% of SHI revenue, would be accrued. There are various options that can be combined to address this situation. The onset of this deficit could be delayed by 5 to 10 years by balancing it with the accumulation of the initial years’ surpluses, assuming good financial management and a willingness by the population to contribute now for health benefits in the future. Another option is to revise contributions rates for formal sector workers, which could start at 2% in the initial years and increase to 7% (shared between employer and employee); this may be sufficient to balance SHI revenues and expenditure. Furthermore, the government could provide a subsidy for some or all the shortfall, which may be financed from general tax revenues or by soliciting donor monies for this purpose.

To conclude, universal coverage for all Basotho through SHI appears feasible and financially sustainable in principle, however universal coverage requires more funding in the long term, through contribution rates beyond 5% and/or through other subsidies. Also, the current funding levels provided by the MOHSW budget to GOL and CHAL health facilities for curative care need to be maintained (in constant prices), and increased in line with population growth and inflation. It is important to be aware of these and other challenges as well as success requirements with respect to realizing a SHI scheme. To address these requires careful reflections and planning on the design and implementation of SHI.

The government is advised to take key decisions in the following areas:

- The type of health financing, i.e. the decision to favour social health protection via a tax-funded system with supplemental social health insurance or rather increases (or stagnant) tax-financing only;
- The type of SHI, whether one of the type "Phased SHI for all Basotho", or "SHI only for the formal sector";
- The way health services are to be improved to better serve the population using SHI funding;
- The type of governance and management structure of the SHI

Once these key decisions are made and if the government opts for a SHI, it will have to decide on critical key design issues and to negotiate with the respective stakeholders, foremost the contribution rates and provider remuneration rates. Also, it will have to develop and agree upon an implementation schedule to establish step by step the SHI scheme and the agency with personnel. This could be realized in the form of an "Implementation Project", which financial support for investments in infrastructure and administration and training of staff in the various management and administration skills.

Such a SHI scheme is much more comprehensive than earlier concepts of a medical aid scheme for civil servants only. In fact, the proposed SHI scheme is able to offer better
services to all Basotho, while increasing equity in access and equity in financing. When successfully implemented, it will hopefully lead to better health for all Basotho.

The main recommendations on key issues for a SHI scheme are summarized below. These are based on the stakeholder consultations views as well as the financial feasibility assessment.

Recommendations for establishing a "Phased SHI for all Basotho" scheme:

**Resource collection:**
- The MOHSW budget for curative care is maintained (in constant prices).
- Resources mobilized through SHI do not replace but complement existing government funding.

**Extension of coverage:**
- Formal sector coverage is extended rapidly, whereas informal sector coverage increases in phases. The latter as quickly as is technically feasible.

**Contribution rates:**
- The formal sector pays a uniform contribution rate based on their salary, which is linked to SHI expenditure.
- The poor are exempted from contributions.

**Membership:**
- Membership is mandatory, i.e. all population groups will join the SHI scheme.

**Benefit package:**
- The benefit package comprises of all essential outpatient care at GOL and CHAL health centres, GOL and CHAL hospitals and private providers, as well as inpatient care at GOL and CHAL facilities including the QEII tertiary hospital.
- Specialized care for specific cases could be obtained in RSA on the basis of referral through QEII.

**Provider payment mechanism:**
- The payment mechanism is an important factor that should be linked with quality improvements. Providers can be remunerated on the basis of a combination of capitation and flat case payments, the latter serving for high cost services. There may be an element of better payments for increased performance.

**Accreditation and quality management**
- The existing accreditation scheme should be extended to all health care providers.

**Governance and management of the SHI agency:**
- Governance and ownership of the SHI fund can be semi-public (parastatals) or autonomous. The supervisory board should encompass a wide range of different stakeholders representing different social groups.
The management of the SHI agency could be undertaken by a parastatal or contracted out to a private company.

**Legislation:**

- It is recommended to develop a freestanding SHI Law, jointly with MoL and MoPS as well as MoF.

**Specific recommendations for the SHI TWG:**

- The further progress of developing and implementing a better health financing system is currently in the hands of the MOHSW and the SHI TWG. To make use of this opportunity, the SHI TGW should be extended:
- Development partners could be involved in future consultations and discussions on SHI to get their support.
- An awareness raising campaign needs to be developed, which is tailored to the specific information needs and group interests of the various target groups.
1. Introduction

1.1. Overview and purpose of the report

The Ministry of Health and Social Welfare (MOHSW) of Lesotho requested the World Health Organization (WHO) to undertake a financial feasibility study of social health insurance (SHI) as an option of financing health care in Lesotho.

This technical support was undertaken in three steps:
1. A first mission in Lesotho for stakeholder consultations and data collection (June 28 - July 11, 2007);
2. desk work to analyse the collected data and to analyse basic financial projection scenarios;
3. a second mission (17-26 September, 2007) to present and discuss the findings and subsequently finalize the report.

This report presents the financial feasibility assessment for a Social Health Insurance in Lesotho. The financial projection scenarios illustrate the expected financial consequences of the policy directions that they represent. They serve to inform policy makers, and as such are one tool among others that the SHI Technical Working Group may use to help plan possible future financing options.

The outcome of the first mission were two financial projection scenarios representing alternative policy directions with varying implications for the design of the health financing system. These were:
Scenario A: "SHI for all Basotho"
Scenario B: "SHI for the formal sector only"

Both scenarios were presented and discussed with the various stakeholders. Scenario A resonated more among the stakeholders and was therefore further revised and refined by including the comments and feedback gained during the second mission. This is Scenario A+ "Phased SHI for all Basotho" option that covers initially all civil servants, formal sector employees and pensioners and then gradually extends coverage to the informal sector over several years.

As such, this scheme is more comprehensive and achieves wider objectives of health financing than earlier concepts of a medical aid scheme for civil servants, while at the same time achieving the earlier objectives as well.

As there is not one optimal way to social protection for health, WHO aims to assist in narrowing down the possible options that are adequate and technically feasible to facilitate policy decision making by the Lesotho government. This report explores and analyses the feasibility of social health insurance as per the Terms of Reference, yet this does not automatically constitute a recommendation for SHI against other financing mechanisms.
The report is structured as follows: After this introduction, Chapter 2 outlines the study objectives and methodology. The Basotho health care system and health financing system are portrayed in Chapter 3, including the private health insurance sector. Considering this context is important to understand the implications and challenges of a SHI scheme. Chapter 4 presents the findings from the stakeholder consultations from the first and second missions. Both Chapter 3 and 4 serve as the basis for Chapter 5, which discusses key design issues for a potential SHI scheme. Chapter 6 explains and analyses the SHI financial projection scenarios made as part of this study and discusses their implications for the health financing system. It focuses on a revised scenario, Scenario A+, whereas the initial scenarios made after the first mission (called A and B) are presented in Annex 3. Chapter 7 provides conclusions and a way forward.

The present report goes beyond the Terms of Reference (TORs). It not only discusses feasibility in financial terms, but also preliminarily in technical terms. Furthermore, it touches upon some of the political feasibility aspects.

### 1.2. Health financing mechanisms

Social health insurance is one of several options of health financing. A health financing system seeks to organize the way that payment is made for health systems in an efficient and equitable way. The most common ways of financing health care are tax-funding, social health insurance, private health insurance, community-based health insurance and out-of-pocket spending (OOPS). The following list provides a very brief overview:

- **Tax-based financing:** the money to pay for health services comes from general government revenue (sales taxes, income taxes, import/export taxes, etc.) and is usually spent by government on public health facilities, but also increasingly on private provision. Everyone is automatically included and has access to these facilities. Taxes may be progressive (the better off pay more than the poor) or regressive (favouring the better-off).
- **Social health insurance:** members pay a contribution based on their income to a health insurance agency, which purchases health services from either public or private facilities. The payment is proportional to income, so that within the pool of SHI members, the better-off subsidize lower income groups. Also, the healthy and young subsidize the sick and elderly. To avoid a high-risk pool, SHI is usually compulsory.
- **Private health insurance:** People buy health insurance for themselves from private, for-profit insurance companies. These companies pay providers for health services for their members and charge premiums from their members according to their health risk status. As a consequence, the poor can usually not afford private health insurance.
- **Community-based health insurance (CBHI):** Local insurance schemes raise money from their members to pay for their health services. CBHIs show both characteristics of private health insurance and social health insurance, as they are usually voluntary, premiums are not risk-rated and schemes are often self-
managed. However, in poor communities CBHIs rarely raise enough funds to provide adequately for health services.

- Out-of-pocket spending: OOPS is not a health financing scheme in itself but rather the way money is spent on health in the absence of a system. Here, people buy health services straight from health providers and pay the full price for the services. OOPS is very problematic as it causes people to fall into poverty because of medical expenses. This is called catastrophic expenditure. Because health services can be extremely expensive and because illnesses are unplanned, people cannot save (enough) money individually for health services.

Wherever OOPS occurs, it should be replaced by a prepayment mechanism, such as the other ones outlined above. Each has benefits and disadvantages, none is perfect, and most countries choose a mix of them as their health financing system. The systems that provide the most protection against catastrophic payments to the highest number of people are usually tax-based financing and social health insurance systems. What is most appropriate depends on the country context.

1.3. The rationale for social health insurance in Lesotho

SHI could be an alternative means to increase resource mobilization. In general, the reasons why a low-income country may want to introduce a SHI include:

A. Increasing spending on health care through prepayments rather than through increasing user charges (out-of-pocket expenditure)

B. Mobilizing resources from the incomes of the working population to raise revenue for health care either (i) in addition to tax-funding or (ii) to replace tax funding.

C. Providing better or more services to the insured population, typically the formal sector first.

D. Improving financial risk protection by reducing out-of-pocket spending and replacing that with prepayment into a SHI, or by abandoning private insurance for SHI.

E. Introducing organizational change to improve the efficiency of the health system, e.g. purchaser provider split, new provider payment mechanisms, etc.

The government of Lesotho appears to be seeking points A, B(i), C, D and possibly E, an in-depth analysis of the latter being beyond the scope of this report. Raising revenue for health services is seen as a necessity to be able to solve the problems in quality of care and human resources in particular, which should then lead to improved health status and satisfaction with the health care system among the population. Other possible sources of financing include tax revenues and donor funding. While the latter is being sought, it is not seen as a sustainable and systemic solution to the problem. Furthermore, increasing the budget to the health sector from government revenue, either at the expense of other government sectors or through increased taxes, is seen as unattainable by MOHSW officials.
It should be noted however, that from the point of view of the individual members of a potential SHI, the contribution is a payroll tax.

By instituting a system into which members pay proportionate to their income, the GOL hopes to improve equity in financing of the health system. The extent of this improvement ultimately depends on the coverage of such a system, which is why the GOL seeks to ultimately extend it to the entire population (see Chapter 6.1.2. for further elaboration on the equity implications).

In previous years, a medical aid scheme for civil servants has been reflected on, and various analyses and commenting were made. This report does not provide an analysis of this previous proposals, since according to the MOHSW, the medical aid scheme plans are no longer pursued. However, various respondents and informants do keep referring and mentioning this medical aid scheme, and it is hence unclear whether there is full consensus on not proceeding with the medical aid scheme.
2. Study objectives and study methods

2.1. Terms of Reference

Lesotho is a small country in Southern Africa. It consists of 10 districts, with a population of about 2 million people. Its territory is completely enclosed by the Republic of South Africa (RSA). Indeed, some of the health care needs of its population are met through medical referrals to RSA, a problem that has motivated government decisions in the following area:
The formulation of a social health insurance (SHI) program initially to cover public servants.

The objective of the mission is to provide technical support to the SHI Technical Working Group (TWG) revolving around the area of actuarial analysis of the planned SHI. The technical support consists of three parts:

a) Stakeholder consultations and feasibility assessment to generate additional information to formulate appropriate assumptions for applying a financial projection tool. The stakeholder consultations are also meant as an opportunity to educate would-be members, providers, and supporters of the SHI.

b) Financial analysis of the proposed SHI scheme.

c) Local staff training in the financial projection and simulation software SimIns and institutionalization plan

For the full Terms of Reference (TOR), please refer to Annex 1.

Upon arrival of the first mission, the mission team met with the SHI Technical Working Group to gain further background information and to discuss the TORs. Likewise, discussions took place with the General Director of Services and the Director of the Planning Unit of the Ministry of Health and Social Welfare (MOHSW) in order to clarify the objective and rationale of the planned SHI. Hence, in addition to looking at civil servants, it was agreed to consider the entire population in the SHI feasibility assessment, foremost the formal sector employees, to achieve equity goals (cf. Chapter 3.6., Health Policy Objectives).

The WHO mission team comprised of:
- Ole Doetinchem
- Dr Joses Kirigia
- Dr Inke Mathauer
- Charles Waza (for the 2nd mission)

2.2. Methodology

Data collection during the first mission:
Based on the TOR discussion, a wide range of different actors and interest groups were consulted. All key government ministries were met, as well as nine professional
associations and trade unions representing different professional group. Health facilities of GOL, CHAL and the private for-profit sector were selected on purposive sampling. Also, non-state actors were met to gather additional or contextual information (see 2.3 for a list of stakeholders met). In most cases, two persons were met during each of these meetings.

Data was collected through interviews as well as focus group discussions based on guiding questions. The questions covered the range of issues as outlined in the terms of reference. Usually, open questions were asked, and only if respondents felt unable to answer, were questions changed into closed ones or respondents were prompted. In addition to the stakeholder consultations, secondary data was collected from the MOHSW and MOL as well as from UN sources (see list of references).

**Stakeholder feedback and refinement during the second mission:**
The second technical support mission in mid-September 2007 served to present and discuss the financial feasibility study with the Government of Lesotho, the MOHSW and the SHI TWG. Also, additional interviews and discussions for data and information collection were carried out. This feedback and the comments from the discussions have now been included in this present final report of the financial feasibility assessment.

Three feedback workshops were organized during the second mission for the following stakeholder groups:
1. Providers from the public, private for-profit and NGO sector, including CHAL
2. Beneficiaries (professional associations, trade unions)
3. Governmental stakeholders.

These workshops had the following objectives:
- Explain the concept of Social Health Insurance and its importance
- Inform about the findings from the 1st mission
- Inform about the SHI plans and how people can benefit from it
- Get feedback and views from workshop participants
- Point to the further implications regarding the key institutional design issues on which the Government of Lesotho needs to decide upon.

In addition, several meetings were held with the MOHSW Planning Unit and the TWG SHI to discuss the findings and issues brought up during the stakeholder workshops in more detail. In particular, the next steps to be undertaken at technical as well as political level were deliberated. Most importantly, the discussion with the Minister of Health herself showed that there is strong concern and commitment for the SHI plan.

The mission team was greatly assisted by the team of the MOHSW and the WHO country office in getting contacts, arranging appointments and meeting discussion partners. However, getting contact points for some of the stakeholders was difficult, and hence arranging meetings took more time than planned. It would have been desirable to have met more representatives of informal sector groups.\(^3\)

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3 In this report, as a working definition, the informal sector is understood as follows: All those persons not working in the public service, in parastatals or in the formal sector (the latter comprising all those
2.3. Stakeholders and respondents consulted

Government stakeholders
- MOHSW
- Ministry of Public Service (MoPS)
- Ministry of Finance (MoF), Pensions and Macroeconomics Division
- Ministry of Labour (MoL)
- SHI TWG
- Central Bank, Head of Research

Potential beneficiaries
Representatives from the following professional associations and trade unions were met:
- Lesotho Public Servants Association
- Lesotho Association of Teachers
- Lesotho Bus and Minibus Operators Association
- Lentsoe Sechaba Workers Union
- Drivers, Earth Moving Operators & Allied Workers Union
- Factory workers association
- Lesotho clothing and allied workers union
- Transport, Security an Allied Workers Union
- Group of informal sector workers at a Maseru City Council (MCC) market
- Nursing Council
- Council of non-governmental organizations (NGOs)
- Farmers NGO
- Lesotho Association of Employers

Providers
- 1 government hospital
- 1 CHAL hospital
- QEII Hospital
- 1 District Health Management Team
- A group of 10 CHAL superintendents,
- 1 CHAL health centre
- 2 private clinics (in Maseru and in a District town)
- Maseru Private Hospital
- CHAL secretariat
- Lesotho Medical Association
- Executive Committee of the Traditional Health Practitioners Council

Other groups and individuals
- Administrator of a private health insurance
- 1 village health worker
- Irish Development Aid, Health Sector Coordinator

registered companies that pay corporate tax) form part of the informal sector. The latter also includes subsistence farmers.
2.4 SimIns projections

The financial projections produced as part of this work and described in Chapter 6 were calculated using the "SimIns" tool (version 2). SimIns is a health insurance simulation tool in a software package that analyses the basic mechanisms of health insurance.\(^4\) SimIns projects the development of incomes and expenditures under certain assumptions over a 10 year period. Its principal purpose is to produce financial projections of SHI schemes.

SimIns has three principal uses:
1. To illustrate the implications of initial policies with respect to key health insurance variables, thus reflecting (as opposed to setting) different policy options.
2. To determine what sets of contributions and/or utilization patterns and/or health care costs can ensure financial equilibrium in a dynamic, changing environment.
3. To illustrate the impact of health insurance on the overall structure of health financing.

The key focus is on the revenue-expenditure account of social health insurance, the surpluses or deficits, and ways to address deficits. The basic output also includes estimates of health care expenditures for the non-insured and insured. These are based on cost estimates (for different health service categories) multiplied by associated utilization rates (for different population groups, further separated into non-insured and insured). Financing of these health expenditures comes from the government health budget, health insurance contributions, user fees or co-payments and government subsidies.

Assumptions for key input variables of the models were developed from secondary data as well as from the different stakeholder discussions. As the "Omnibus" study had not yet been undertaken, important information for the SimIns projection had to be estimated on the basis of other available data.

Chapter 6 and Annex 3 present the detailed scenarios produced with SimIns. Annex 4 explains for each input variable how it was calculated, what the source of the data is and what assumptions were made.

2.5. SimIns Training

During the second mission six local staff were trained in the usage of SimIns. The objective was to ensure that the TWG has the capacity to produce financial projections in a continued basis to facilitate their work on designing a sustainable financing mechanism. The projections show the financial consequences of policy proposals, so that these

proposals’ financial feasibility can be verified and adjusted if necessary. As the proposal for SHI in Lesotho matures, the financial implications should be tracked using such tools as SimIns.

The training consisted of 5 half day sessions and covered the following syllabus:

- The SimIns interface
- Data input
- Output, calculations and graphs
- Projection cycles
- Data housekeeping

The focus was on hands-on usage of SimIns, and the participants worked on several exercises and contributed to the development of the projections described in Chapter 6 of this report.

The local staff trained are: Matumaole Seboka, Masebota Khuele, Mamolitsane Thoothe, M. Mohapi, M. Maapesa (all from MOHSW), Machachamise (MoPS).
3. The Lesotho health care system and health financing system

3.1. Health policy objectives and health sector reform objectives with respect to health financing

There are some key sections of the Lesotho health policy, strategy and health sector reform program that provide the basis for deriving a SHI strategy and should be highlighted:

Mission of the Lesotho Health Policy:
- "… a system that will deliver quality health care efficiently and equitably …" (MOHSW 2004a, p. 9)

Objectives of the Lesotho Health Policy
- "To reduce inequalities in health and social welfare, and in access to health and social welfare services" (ibid, p. 10)

Guiding principles of the Lesotho Health Policy
- "… all Basotho shall have equal access to basic health care and social services" (ibid., p. 10)
- "Efforts will be made to ensure that all Basotho receive quality health and social care… " (ibid., p. 13)

Institutional arrangements for implementation of the MOHSW Strategic Plan 2004/5-2010/11 with respect to establishing a sustainable health care financing system:
- "The health financing system adopted by MOHSW should protect the poor and vulnerable population and allow access in these sub-populations" (MOHSW 2004b, p.77).

Health sector reform program objectives
"The objective of the Government of Lesotho’s health sector reform program, which is led by the Ministry of Health and Social Welfare (MOHSW) and financed by IDA and other partners (e.g. Irish Development Aid, ADB and UN Agencies), is to achieve a sustainable increase in access to quality preventive, curative and rehabilitative health care services in Lesotho.

This program’s purpose serves the overall sectoral goals, as outlined at the inception of the reform program: “(i) universal coverage, so that every citizen will have access to essential health care and social welfare services; (ii) social justice, so that those in greatest need will receive particular attention; and (iii) equity, so that every person no matter what their social standing in society, will receive the same treatment, the only determining factor being their need for health and social welfare services.” (GOL,
Overall, there is a large degree of coherence between the guiding principles of the Lesotho Health Policy and the World Health Assembly Resolution 58.33 on sustainable health financing, universal coverage and social health insurance. Any health financing system, or reform thereof, should thus be expected to adhere to the mission, objectives and guiding principles highlighted above.

### 3.2. Health expenditure

Lesotho's population amounts to about 2 million people, growing at a rate of about 0.6% per annum. 99% of the population are Basotho. The following table provides key indicators relating to health care expenditure (Table 1).

**Table 1: Health expenditure data**

<table>
<thead>
<tr>
<th>Indicator for 2005 (unless indicated)</th>
<th>Source and year</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP growth</td>
<td>2.9 %</td>
</tr>
<tr>
<td>Total Health Expenditure (THE)</td>
<td>M 614,000,000</td>
</tr>
<tr>
<td>THE p.c.</td>
<td>USD 54 (= M 343)</td>
</tr>
<tr>
<td>Government health expenditure p.c.</td>
<td>USD 45 (= M 286)</td>
</tr>
<tr>
<td>Private health care expenditure p.c.</td>
<td>USD 9 (= M 57)</td>
</tr>
<tr>
<td>OOP p.c.</td>
<td>USD 1.67 (= M 11)</td>
</tr>
<tr>
<td>External resources on health as % of THE</td>
<td>11.8%</td>
</tr>
<tr>
<td>% of health expenditure in total household expenditure (2003)</td>
<td>2%</td>
</tr>
</tbody>
</table>

Exchange rate 2005: M 6.36 per US$  

The table reveals that health care financing is primarily tax-based and that out-of-pocket spending is low in comparison to other African countries.

---

3.3. Access to health care

Related to geographical access, 75% of the urban population can reach health care facilities in less than 45 minutes (walking distance), whereas more than 75% of the rural population take 45 minutes or more to reach a health facility (walking distance) (KoL 2002). The need for medical services is estimated at 22.1%, but care is not sought at that level, and is lower among the rural population than the urban one (15.1% versus 19.6%) (KoL 2002).

13.2% of rural people in need of health services cited cost to be the reason for not seeking care, while among the urban it was only 7.9%. In particular, 17.8 percent of the informal sector mentioned cost as the main reason for not seeking care (ibid.).

In 2002/03, 56.6%, or over 1 million people, were classified as poor. It is also noteworthy, that income is distributed rather unequally, with a Gini-coefficient of 0.66 (MOHSW 2004a).6

3.4. Health care provision

3.4.1. Decentralization and the role of the DHMTs

The formation of District Health Management Teams (DHMT) is part of the ongoing MOHSW health sector reforms and decentralization process. It was necessary to de-link the provision of preventive and curative services to avoid carrying forward the past bias towards curative care, as reflected in the allocation of various resources. In this context, the MOHSW decided to pilot-test DHMTs initially in three districts and subsequently set-up 10 Health Service Areas (HSA) managed by DHMTs.

The DHMT is responsible for planning, estimation of budgetary needs for primary health care in the district, and supervision of health centres, whereas hospitals are supposed to be managed separately. The budget for DHMTs is allocated from the central level by the MoF. The DHMTs use this budget to purchase medical supplies for GOL health centres. Furthermore, the responsibilities of DHMTs include the provision of immunization, maternal and child health services, social services and other primary health care services; supervision of both government and CHAL health centres in the district; and health reporting for the entire district.

In practice, the relationships between the hospitals and DHMTs are not yet fully clarified, partly due to the fact that the DHMTs are just being established and have just moved to their new locations (outside the hospital compound).

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6 The Gini-coefficient is an indicator of the degree of income equality varying between 0 and 1. The closer the coefficient is to 0, the higher the degree of income equality, or expressed otherwise, the lower the degree of income inequality.
3.4.2. GOL providers

There are 79 government health centres (out of a total of 195), in addition to 10 district hospitals (out of 19) and one public referral (tertiary) hospital at the national level in Maseru, called "Queen Elizabeth II" (QE II). The hospitals at district level have about 130-160 beds, whereas QE II contains 410 beds (Bicknell et al. 2002). Table 2 indicates the current user fee structure at GOL facilities. The GOL hospital visited engages debt collectors, in case the patient has not settled the bill after several weeks.

Table 2: User fee structure at GOL facilities for adults (in Maloti)

<table>
<thead>
<tr>
<th>Facility level</th>
<th>Costs per service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health centre OP</td>
<td>5</td>
</tr>
<tr>
<td>Hospital OP</td>
<td>10</td>
</tr>
<tr>
<td>Hospital IP</td>
<td>10 per day *</td>
</tr>
<tr>
<td>QE II OP</td>
<td>10</td>
</tr>
<tr>
<td>QE II IP</td>
<td>10 per day **</td>
</tr>
</tbody>
</table>

* including drugs and other diagnostic services
** excluding drugs and other diagnostic services

Patients of the TB and mental departments are exempted from consultation fees, as are community health workers, because they work as volunteers and are not salaried. It was reported and observed that a number of patients are unable to pay their bill. Government collects about 6% of the MOHSW budget through user fees (WB 2001). It is planned to abolish user fees at the health centre level and to reduce user fees at the other levels of care over the next months, but no final decision has been taken by the Joint Commission of Cooperation.

There are about 5,000 Basotho (i.e. 0.27% of the population) who receive "public assistance" of a monthly cash payment of M 100. They are exempted from user fees at GOL and CHAL health facilities.

3.4.3. Faith-based providers

The majority of faith-based health care providers are united under the Christian Health Association of Lesotho (CHAL), which is an umbrella organization for 6 Christian churches and which was established in 1974. CHAL manages 79 health centres and 9 hospitals, particularly in hard to reach places around the country, serving about 40% of the population (MOHSW 2005). In addition, there are a few non-CHAL faith-based primary health care providers and NGO-based providers. For example the Red Cross Lesotho manages 4 health centres in rural areas.

There is no uniform user fee structure at CHAL facilities, and user fees currently vary across hospitals and health centres. Table 3 below provides an idea of the range of user fees charged for various services. In previous years, CHAL facilities collected about 35-40% of their total budget from out-of-pocket payments (WB 2001). CHAL hospital
managers reported that about half of their patients have difficulties to pay the user charges, and hence some of the hospitals accumulate large debts.

Table 3: Approximate user fee structure at CHAL facilities (in Maloti)

<table>
<thead>
<tr>
<th>Health centre OP</th>
<th>Adult</th>
<th>Child</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20-45 *</td>
<td>15</td>
</tr>
<tr>
<td>Hospital OP</td>
<td>10 **</td>
<td>5?</td>
</tr>
<tr>
<td>Hospital IP</td>
<td>20 per day **</td>
<td>10?</td>
</tr>
</tbody>
</table>

* including drugs
** excluding drugs and other diagnostic services

CHAL facilities are co-funded by government resources for staff salaries and parts of operational costs. Under the earlier Supplementary Emergency Funding Facility (SEFF), running from 2003-2006, M37.5 million were provided for the year of 2004/2005, which is approximately 14% of the total recurrent budget of the Ministry (MOHSW 2005).

A Memorandum of Understanding was agreed between MOH and CHAL and signed in February 2007. Its purpose is to harmonize service provision and user charges between GOL and CHAL facilities. Once all CHAL health centres are officially registered with the Office of Law and once specific letters of intent are signed by each CHAL hospital as well as the CHAL secretariat and the MOHSW, user fees in CHAL facilities will be reduced to the level of government user fees according to this MoU. This is expected to happen by early 2008. The CHAL facilities will be compensated for the decrease in user fee revenue through increased budget funding from government. Under the new scheme, CHAL is expected to mobilize about 20% of its total budget from other sources (church, donors), whereas 8% are supposed to come from user fees.

Under the MOU, CHAL will receive three types of grants from the GOL: (i) a grant for providing services to indigent/destitute people, tuberculosis patients and the malnourished; (ii) a grant for addressing HIV/AIDS; and (iii) a grant to cover the revenue lost by CHAL health facilities as a result of user fee harmonization. In addition, there is an agreement that CHAL would be free to levy different user fees for any services provided over and above those contained in the Lesotho Essential Health Services Package; although these would also be regulated.

3.4.4. The private sector

Much less information is available about the private for-profit health sector, as there are no official statistics available on the number of providers and utilization rates. Yet, the private sector is developing and growing, particularly in Maseru. The interviews and estimations from respondents reveal that there are 64 private providers (general practitioners and specialists) in Lesotho, 24 of which are in Maseru, some of them working part-time in GOL facilities. In addition, there is one private hospital, called Maseru Private Hospital with 28 beds, 3 resident doctors and two operating theatres.

7 In this report, we distinguish service providers as public, faith-based (mainly CHAL) and private for-profit.
One of the private health insurances visited has contracted 36 private providers (GPs, specialists) (24 in Maseru, 12 outside), 5 (foreign) dentists and 7 other professionals (mental health, optometrist, ophthalmologist, radiologist, laboratory).

One of the challenges is weak regulation of the private sector, which is also due to the institutional weakness of the Medical, Dental and Pharmacist Council. But respondents also acknowledge that its capacity is increasing. It was also reported that South African private practitioners living near the border come to Lesotho to provide services for 2-3 days a week, mostly in Maseru, given its market potential. Yet these practitioners are not always registered in Lesotho.

Table 4 presents monthly utilization rates of selected private sector facilities. Together with total number of private providers, an overall utilization rate for the private sector could be estimated.

<table>
<thead>
<tr>
<th>Private provider</th>
<th>Patients per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maseru private clinic OP *</td>
<td>320</td>
</tr>
<tr>
<td>Private clinic in a district town **</td>
<td>200</td>
</tr>
<tr>
<td>Maseru Private Hospital OP **</td>
<td>700-800</td>
</tr>
<tr>
<td>- OP</td>
<td></td>
</tr>
<tr>
<td>- Under 5</td>
<td>200</td>
</tr>
<tr>
<td>Maseru Private Hospital IP **</td>
<td>15-20</td>
</tr>
<tr>
<td>- Operations (minor and major)</td>
<td>5-10</td>
</tr>
<tr>
<td>- Deliveries</td>
<td>50-60</td>
</tr>
<tr>
<td>- IP (medical, surgical, children)</td>
<td></td>
</tr>
</tbody>
</table>

* Facility's record
** Estimation by management staff

User charges at private facilities differ substantially and available information is scarce. Table 5 provides some idea on user charges at private facilities on the basis of information collected during the interviews. Respondents from GOL hospitals pointed to the fact that private providers often refer their more costly patients to the GOL hospitals, particularly if treatment involves more expensive drugs.

Private providers also have a strong interest in health insurance as they anticipate an increased income and profit by serving the insured. The patients covered by a private health insurance are very attractive for private providers, as the latter are reimbursed on a fee-for-service schedule based on the 2006 South African National Reference Price List (NRPL), which are partly more than twice as high as user charges for cash patients in Lesotho. Some private providers directly engage and negotiate with employers to offer health services to their employees. One private practitioner reported that he provides services to employees of 18 private companies and 12 parastatals. Out of the approximately 320 patients per month, two thirds are paid for by their employer, whereas 30% are "cash-patients". Only 4% of patients were covered by a private health insurance, which indicates that after all, this is a minority.
At Maseru Private Hospital, it was reported that approximately 30% of the clients have private health insurance cover. The hospital usually provides the services and claims reimbursement from the insurance companies for the patients with health insurance cover. The hospital has contracts with the main private health insurance companies in the country (e.g. Mammoth, Oxygen, Prosperity). The patients who do not have health insurance cover are required to make a deposit before admission.

Table 5: User charges in selected private facilities (for adults), in Maloti

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Cash patients</th>
<th>NRPL 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maseru Private clinic OP - consultation, excluding drugs</td>
<td></td>
<td>120</td>
</tr>
<tr>
<td>Private clinic in a district town - consultation including drugs</td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>Maseru Private Hospital OP - consultation, excluding drugs</td>
<td></td>
<td>80</td>
</tr>
<tr>
<td>Maseru Private Hospital IP - medical or surgical case per bed day</td>
<td>350</td>
<td>908</td>
</tr>
<tr>
<td>- excluding all other costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Caesarean</td>
<td>5500</td>
<td>7280</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+ 1680 for subsequent days</td>
</tr>
</tbody>
</table>

Source: Interviews with providers

Several respondents emphasized that many people consider the higher price tag at private facilities as an indicator for better quality and therefore prefer these providers. Other factors cited in favour of private providers include shorter waiting queues, friendlier staff behaviour and more time granted by the doctor. Little information is available about the profile of patients that can afford to pay user charges at private facilities. The patient records made available at one private provider reveal that these are not only from Maseru and not only formal sector employees (see Table 6 on patient profiles).

Table 6: Patient profile at a private provider (N=317)

<table>
<thead>
<tr>
<th>Profession</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionals</td>
<td>58%</td>
<td></td>
</tr>
<tr>
<td>Pensioners</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>38%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Residence</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maseru</td>
<td>65%</td>
<td></td>
</tr>
<tr>
<td>Outside Maseru</td>
<td>35%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Patient records of one selected private provider

3.5. Key challenges in the health sector

3.5.1. Quality of care and quality improvement

The CWIQ 2002 reveals that of all the sampled persons who consulted health providers, 86.8% reported dissatisfaction with the services provided while only 13.2% were
satisfied, with differing degrees across districts. The main reasons reported for dissatisfaction include:

- long waiting time (52.1% of urban respondents, 32.2% of rural respondents);\(^8\)
- cost (39% of respondents)
- non-availability of drugs in pharmacies (33% of respondents)
- unsuccessful treatment (14% of respondents)
- inadequate staff attitude (8.6% of respondents)

The CWIQ survey results also revealed that about 22.7% of respondents in the sample who sought care were highly dissatisfied with the private doctor or dentist (KOL 2002).

Most Basotho in rural areas have limited access to a doctor, and it is likely that the doctor they see is an expatriate. People complain that many expatriate doctors do not speak Sesotho, creating communication barriers. However, it is reported that the nurses that help translating are not perceived as patient or friendly. This is in line with the findings of the Annual Joint Review from Leribe District, where patients complain that there is "no communication with doctors", since "most did not speak either English or Sesotho language, such that "patients were not examined at all before being prescribed drugs" (MOHSW 2007a, p.48).

Another quality concern consists in drug non-availability and stock outs, which is due to problems within the drug supply system and non-rational use of drugs (MOHSW 2004a). During the accreditation review, only 6% of the hospitals had all 20 of randomly selected medicines in stock, whereas 63% had a number of drugs expiring on the shelves (MOHSW 2007a). Complaints about quality of care were mainly reported about GOL facilities. There is agreement among key stakeholders and donors that quality of care needs to be improved in the health care sector.

An accreditation scheme has been developed by the MOHSW and all hospitals and health centres from CHAL and government underwent an accreditation audit. Those CHAL facilities not meeting the standards are given two years to meet the required standards or risk the financial support from the government being suspended. While it was felt at provider level that the set of accreditation indicators and standards are very high and thus often not achievable within the given financial constraints, the exercise was perceived as a good and cooperative learning process that revealed the gaps and that provided a way forward to quality improvements. As a result, many facilities have set up quality committees.

### 3.5.2. Human resources for health

The Lesotho Health and Social Welfare Policy states that "the entire public sector is faced with inadequate personnel, and many are not appropriately trained, motivated, rewarded, deployed or supervised" (MOHSW 2004a). Table 7 lists the numbers of staff

\(^8\) E.g., waiting time is 6.5 hours in the OPD of Mafeteng Hospital for 2006 (having been 10 hours the year before) (MOHSW 2007a).
in each staff category, and reveals the much lower staff densities than the average in the AFRO region.

The staff shortage is not due to lack of qualified staff, but mainly due to attrition. Health workers leave the MOHSW, as salaries are low, working conditions are poor and the reward system is not rational. Furthermore, at GOL hospitals, 29% of doctor/consultant posts and 75% of pharmacist posts are not filled (MOHSW 2007a, p. 62). In general the vacancy rate among health workers is very high.

Table 7: Overview of health professionals in Lesotho in total numbers and density

<table>
<thead>
<tr>
<th>Category</th>
<th>Total number</th>
<th>Density per 1000 (Lesotho)</th>
<th>Density per 1000 (AFRO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>89</td>
<td>0.049</td>
<td>0.217</td>
</tr>
<tr>
<td>Nurses and midwives</td>
<td>1123</td>
<td>0.623</td>
<td>1.172</td>
</tr>
<tr>
<td>Dentists and technicians</td>
<td>16</td>
<td>0.009</td>
<td>0.035</td>
</tr>
<tr>
<td>Pharmacists and technicians</td>
<td>62</td>
<td>0.034</td>
<td>0.063</td>
</tr>
<tr>
<td>Environmental and public health workers</td>
<td>55</td>
<td>0.013</td>
<td>0.049</td>
</tr>
<tr>
<td>Laboratory technicians</td>
<td>146</td>
<td>0.081</td>
<td>0.057</td>
</tr>
<tr>
<td>Other health workers</td>
<td>23</td>
<td>0.013</td>
<td>0.173</td>
</tr>
<tr>
<td>Community health workers</td>
<td>n.a.</td>
<td>n.a.</td>
<td>0.449</td>
</tr>
<tr>
<td>Health management and support</td>
<td>18</td>
<td>0.010</td>
<td>0.411</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1562</strong></td>
<td><strong>0.850</strong></td>
<td><strong>2.626</strong></td>
</tr>
</tbody>
</table>

Source: WHO 2006

Procedures for personnel selection and recruitment, and procedures for staff induction and performance assessment are not routinely used. Also, human resource management decisions are highly centralized and bureaucratic.

### 3.6. Private health insurance

Private health insurance (PHI) companies are keen to stimulate demand for health insurance and enter the Lesotho market. There are about 8 South African private health insurance companies trying to increase their market share in Lesotho. Their marketing strategy appears to focus on approaching companies as well as the government as the largest employer.

The company Oxygen has undertaken a market study, but the report was not available. Table 8, which provides a rough idea of the PHI market in Lesotho, is based on the estimations of one PHI administrator. Under the current system, the same PHI administrator estimated the potential total market for private health insurance at 8,000 people.
Health insurance benefits offered by formal sector employers vary. Some of them pay a fixed amount, others pay 50%, whereas a few pay 100% of premiums. PHI plans offer group-based memberships, i.e. for an employer's group of employees, which is the more frequent type of membership, but people can also join individually. General waiting time is three months before being eligible for benefits, but this is waived for group members who signed up for example through their employing company.

The assessment of the structure of premiums suggests that the PHIs undertake a community rating (rather than a risk-adjusted premium setting). People applying for PHI membership have to fill in a questionnaire, which determines waiting times for certain diseases, e.g. for hypertension, it was said to be 24 months. No information was obtained to what extent applicants are rejected if they are considered as high risk groups (cream-skimming), but given that PHIs intend to increase their market share and reputation, it may be the case that they opt for longer waiting periods until members can accrue benefits rather than rejecting new, applying members. Applicants and members can also register for specific disease management programs, including ART.

Most PHIs offer various packages, from "basic" coverage to more comprehensive plans. Some companies also offer medical savings accounts for outpatient care and combine this with a premium for inpatient care. Table 9 below indicates monthly premiums for a principal member, his/her spouse and two children and sets this in relation to a monthly salary of 6,000 M, which corresponds to Grade F (higher scale) of civil servants.

<table>
<thead>
<tr>
<th>Name</th>
<th>Number of principal members</th>
<th>Companies/groups covered for example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosperity</td>
<td>3000</td>
<td>Students</td>
</tr>
<tr>
<td>Momentum</td>
<td>500</td>
<td>Lesotho Revenue Authority; Standard Bank; Beylar College of Medicine; SA High Commission</td>
</tr>
<tr>
<td>Mamoth</td>
<td>400</td>
<td>Lesotho Company; Lesotho Sun/Maseru Sun</td>
</tr>
<tr>
<td>Oxygen</td>
<td>800</td>
<td>National university of Lesotho</td>
</tr>
<tr>
<td>Discovery</td>
<td>NA</td>
<td>Vodacom resigned from Discovery and moved to another company.</td>
</tr>
<tr>
<td>Bankmed</td>
<td>200</td>
<td>Netbank, First National Bank, Postbank</td>
</tr>
</tbody>
</table>

Most PHIs offer various packages, from "basic" coverage to more comprehensive plans. Some companies also offer medical savings accounts for outpatient care and combine this with a premium for inpatient care. Table 9 below indicates monthly premiums for a principal member, his/her spouse and two children and sets this in relation to a monthly salary of 6,000 M, which corresponds to Grade F (higher scale) of civil servants.
Table 9: Monthly premiums for selected PHI plans

<table>
<thead>
<tr>
<th></th>
<th>Individual membership</th>
<th>Group membership</th>
<th>% of salary of 6,000 M</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Momentum</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Option A</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(&quot;Basic or Core&quot;):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- unlimited OP in Lesotho</td>
<td>M1263</td>
<td>21%</td>
<td>M1053</td>
</tr>
<tr>
<td>- limited OP in SA (pre-authorization)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- IP up to 500,000 per family/yr:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- in Lesotho government or Mediheal Hospital in RSA (pre-authorization)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Option B</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(&quot;Comprehensive&quot;):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- unlimited OP</td>
<td>M2508</td>
<td>41.8%</td>
<td>M2090</td>
</tr>
<tr>
<td>- unlimited IP in Lesotho</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- unlimited IP (government) or Mediheal Hospital in RSA (pre-authorization)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prosperity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Option &quot;Econ&quot;</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hospital Only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- only IP up to 500,000/year per beneficiary</td>
<td>M996</td>
<td>16.6%</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Option &quot;Econ&quot;</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Standard</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- OP up to 5,000 per beneficiary/year</td>
<td>M1352</td>
<td>22.5%</td>
<td>NA</td>
</tr>
<tr>
<td>- IP up to 500,000/year per beneficiary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Option &quot;Econ&quot;</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Comprehensive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- OP unlimited</td>
<td>M1948</td>
<td>32.5%</td>
<td>NA</td>
</tr>
<tr>
<td>- IP up to 500,000/year per beneficiary</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Company brochures and internet

The Insurance Law of Lesotho dates back from 1976 and is outdated from the point of view of private providers and private health insurance companies. This is why, according to them, the SA NRPL has to be applied.

3.7. Key differences between Private Health Insurance and Social Health Insurance

Table 10 below provides a comparison between private health insurance and social health insurance along critical key dimensions.

Table 10: Key differences between PHI and SHI

<table>
<thead>
<tr>
<th>Benefit package</th>
<th>PHI (based on offers available in Lesotho)</th>
<th>SHI (as suggested for Lesotho)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Depends on the package and premiums: E.g.</td>
<td>Unlimited OP at all provider types</td>
</tr>
<tr>
<td></td>
<td>More basic options (lower premiums):</td>
<td>Unlimited IP at CHAL and GOL</td>
</tr>
<tr>
<td></td>
<td>- Unlimited OP in Lesotho or OP up to M 5,000 per year per beneficiary</td>
<td>Unlimited IP at private providers, if included in the benefit package (increases overall expenditure and hence deficit in the later years)</td>
</tr>
<tr>
<td></td>
<td>- IP in GOL Lesotho or pre-authorization for one hospital in RSA (Mediheal)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>More comprehensive options (higher premiums):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Unlimited OP in Lesotho</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Pre-authorization for OP in RSA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- IP up to 500,000 per year per beneficiary</td>
<td></td>
</tr>
</tbody>
</table>

9 A check of the webpage on September 30 reveals that OP care is limited to R 5,000 per beneficiary.
Monthly contributions for a monthly salary of M 6000* Depend on a person's health risk and how much they can afford and are willing to pay. e.g., M 996 ("Hospital-only") Up to M2508 for more comprehensive option Based on ability to pay, i.e. every employee pays the same percentage of his/her salary M 300

Solidarity No solidarity: Everybody is in charge of his/her own fate regarding health. Solidarity across the population

Waiting time Normal waiting time for individual members: 3 months For group members (those joining as a group of company employees): no waiting time For chronic sick: Depends, can be 24 months None

Co-payments Depends on each plan: Co-payments for specific procedures and diagnostic facilities No co-payments at health centre level M 5 for OP at GOL and CHAL hospitals M 30 for OP at private providers M 10 per IP day at GOL and CHAL hospitals

* for a family of four person

### 3.8. Key features of Lesotho's health financing system

This section highlights some additional key features of the health financing system.

**Health care expenditure and catastrophic illness costs**

The Household Budget Survey does not differentiate health care expenditure by quintile, yet the CWIQ 2002 states that 19.1% of a sample of respondents among the general population are dissatisfied with costs, and among the rural poor, these are 38.8% (KOL 2002).

No information is available on which proportion of households experience catastrophic expenditure, i.e. households that spend more than 40% of their available non-subsistence household consumption expenditure. Given the comparatively low user fees and OOPs in Lesotho, it may be that this percentage is lower than in other countries with higher OOPs.

As fees are the same for all population groups, higher income groups spend proportionally less on health care. Yet, some of the better-off resort to the private sector with a much higher quality of health services when it includes referral to RSA.

**Current purchasing and provider payment arrangements:**

*Resource allocation for GOL services*

GOL services in the health service areas are financed through budget allocation based on historic budgeting. A consultancy has been undertaken for the MOHSW - financed by the Lesotho Health Sector Reform Program - to revise the existing and to recommend new district budget allocation criteria (MOHSW 2007c). Moving away from historical budgeting to a rational resource allocation based on explicit and agreed upon criteria is an

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important step towards introducing an element of strategic purchasing, as resource allocation will be better aligned to needs, thus increasing efficiency and effectiveness.

**Resource allocation for CHAL services**
The new MoU between the MOHSW and CHAL introduced some initial form of strategic purchasing. The budget for each of the 10 CHAL hospital is calculated based on the following criteria:

- Previous budget level (salary costs, some operational costs)
- Estimated utilization with reduced user charges
- Budget support is linked to achieving quality standards. If these are not met after 3 years of the initial accreditation, funds will be withdrawn (as outlined in the new 2006 Certification and Accreditation Procedures).

Developing and signing the MoU has taken considerable time, which was necessary for building trust, mutual understanding and consensus building. Once the so-called Letters of Intent are signed by each CHAL facility, this new form of financing can begin. It remains to be seen how the CHAL Secretariat manages this process internally.

Administrative capacities need to be built up both at the level of the CHAL Secretariat, the CHAL facilities as well as with the MOHSW unit in charge of this.

Some scepticism from staff at CHAL hospitals remains. It is not clear to all them how the budgets are calculated, as the formula process is rather complicated. Past experience with the quarterly transfer of budget tranches from the GOL are that they often arrive late and thus make smooth hospital operations very difficult for the intervening weeks.

**Private providers**
Private providers operate on a fee for service scheme, so there is no strategic purchasing either. Once a provider is contracted by a private health insurance, the latter has little control of what services are provided and hence of the overall health care expenses.

**Financial management capacity**
According to the MOHSW's assessment, "thus far the Ministry has succeeded in improving the structure of cost centres and developing a budgeting system which attempts to link programme objectives to the budget. A costed three year programme based on the strategic plan has been developed to guide realization of the sector priorities in the long run. [...] The practice of generating monthly expenditure reports has been improved." (MOHSW 2005)

The accreditation review of all hospitals also provides insights into the administrative and financial management of hospitals. The following indicators are used for:

**Administrative management:**
- A senior management is in post
- A senior management team is operating appropriately
- A clinical leadership structure and process is in place
Financial management:
- Appropriate accounting methods are in place and adhered to
- Qualified accounting staff are available as required
- A budget process is in place
- A standardized financial reporting system is in place

The average score across all GOL and CHAL facilities of meeting the standards in administrative management is 50%, whereas it is 47% for financial management,\textsuperscript{11} i.e. only about half of the targets were achieved.

\textsuperscript{11} Own calculations, based on MOHSW (2007b): Hospitals Certification/ Accreditation Results 2006-07.
4. Findings from stakeholder consultations

4.1. Rationale for SHI

The Senior MOHSW policy-makers interviewed explained that the rationale for wanting to implement SHI were:

- to generate extra revenue for the health system;
- to provide extra motivation for providers to improve quality of health services;
- to enhance equity in health care;
- to facilitate access to quality health services for the population;
- to provide financial risk protection to workers who were succumbing to illnesses leading to absenteeism from work and loss in productivity; and
- to meet the demand for a medical aid scheme for civil servants (as part of government employees entitlement).

It was pointed out that the demand for SHI among the general public will depend on knowledge of health insurance and affordability of the contributions. It was further explained that even though the culture is that the better-off support the poor, there would be need to explain properly (at every opportunity) and emphasize the spirit of solidarity through cross-subsidization within SHI. Finally, the policy-makers further expounded that the introduction of SHI should not increase the gap between the better-off and the poor; and thus, there would be need to explore the feasibility of covering the entire population within a realistic time span.

4.2. Views from potential beneficiaries

As mentioned in the preceding chapter, stakeholder consultations were conducted with the leadership of 9 professional associations and trade unions.

The trade union sector of Lesotho is highly fragmented. There are 3 umbrella trade union confederations, each assembling 5-6 trade unions, with a total of 16 trade unions, as revealed by the MoL Survey in 2003. For textile workers, there are four major trade unions, the two biggest one counting 8897 and 4342 workers respectively. Smaller ones only assemble 70. The teachers are organized in 2 unions, just like the transport workers. Taxi and minibus drivers have their associations, which are organized around 50 transport routes.

Table 11 summarizes the responses from the professional associations and trade union representatives. Given the limited time available for consultation, it was not possible to interview individual members. However, since the primary motive of professional associations and trade unions is to maximize the welfare (however defined) of the members, the views of the leaderships are assumed to closely mimic and approximate the preferences and concerns of their members.
As a general remark, it is noted that various stakeholders, including civil servants, were rather concerned with their own group interests. The eventual objective of universal coverage and wider risk sharing appeared to be less immediate to them.

**Membership fee for professional associations and trade unions:** The average membership fee is M32 per month (STDEV=63) and the median membership fee was M10. The membership fee varies from M3 at the Informal Sector Association at the Mbabane City Council Market to M200 at the Lesotho Bus & Minibus Operators Association. The information about trade union membership fees is important for three reasons: (i) it shows willingness to pay to improve workers welfare (including protection from unfair dismissal); (ii) it is a manifestation of solidarity; and (iii) it is a financial commitment that potential SHI members already have.

**Average salary (in Maloti):** The salaries earned by the employees are an indicator of their potential ability-to-pay for SHI. At the bottom line, monthly earnings amount to M500 among informal sector workers (at MCC). Grade H civil servants, for example, earn around M8,797.

**Current source of care:** Trade unions members largely seek health care at the Government of Lesotho health infrastructure. LAT and LEPSA leadership indicated that a small proportion of their members also seek medical care at CHAL and private providers. All those interviewed among the trade unions lamented the low quality of health services provided at the GOL health facilities. They indicated that GOL health facilities are characterized by dearth of nurses, paramedics and doctors.

**Subscription to private health insurance:** Subscription to private health insurance could arguably be used as an indicator of (i) degree of aversion to the risk of catastrophic health care costs; (ii) knowledge of usefulness of health insurance; and (iii) ability-to-pay health insurance premiums. Out of the nine trade unions interviewed, only the Factory Workers Association and the Lesotho Public Service Staff Association indicated that some of their members assumingly have private health insurance policies. According to the district respondents, a small percentage of workers in the district have private health insurance policies.

**Willingness to enrol in SHI:** All the representatives consulted interviewed unequivocally indicated that their members would be willing to enrol in SHI. They also expressed willingness to participate in educating their members about SHI once they themselves have been sensitized adequately.

**Willingness to pay for SHI:** The representatives of the professional associations and trade unions estimated that their members would be willing to contribute between 2% and 5% of their monthly salaries to the SHI fund. As expected the expressed willingness to pay is directly proportional to earnings or income. They also indicated that they would expect employers to make a matching contribution towards their employees' SHI cover.

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12 They referred to the employee's share of contribution.
While most respondents and representatives of professional associations saw a need for health insurance and hence expressed willingness to make contributions, it is important to contextualise their responses. Most of the representatives are rather familiar or have heard of private health insurance. Their level of education is often on average higher than those of the members they represent. Yet, their expectations regarding the benefit package may be higher as well.

Representatives from trade unions as well as other professional associations all emphasized that the introduction of a SHI scheme would require a lot of explanation, awareness raising and convincing.

**Possible resource collection channels for civil servants and formal sector employees:**
The formal sector employees thought that their contributions to the SHI could be collected using the existing Ministry of Finance tax mechanisms. In other words, the contributions could be deducted from the payroll in the same manner as income tax. The collection of premiums from the informal sector may also need to use the existing mechanisms within communities, e.g. cooperatives, burial associations. Market stand workers suggested the Maseru City Council. Transport workers proposed the transport and road associations. The NGO Council considered the community councils an appropriate institution to collect contributions.

**Preferred benefit package:** All the respondents indicated that the benefit package should include outpatient and inpatient health services (including dental and eye services). They indicated that the SHI should also cover chronic diseases and injuries sustained during road accidents.

**Preferred service providers:** Nearly all respondents said that their members would prefer the private and CHAL providers. Three of the groups interviewed said that the GOL could also be subcontracted to serve the SHI members but on condition that the quality of services is significantly improved. Most of the respondents realized that in most of the rural areas the only service provider may be the GOL health facilities.

Civil servants and CHAL Secretariat employees expressed wish to have option of referrals to South Africa included. Health workers said that they prefer GOL (hospital) services. They also experience that so many people who first went to the private health sector, are later referred back to hospital, so that it appears best to go to hospital right away.

According to the District respondents, the majority of civil servants at the district level (but not those working in the health sector) seek care among private doctors (for those who can afford) and government hospitals.

**Preferred governance and fund management structure:** Six of the nine beneficiary stakeholder representatives indicated that the fund should be managed by a private company or a special agency and overseen by board of directors consisting of representatives of all the stakeholders. They saw the role of the GOL as legislating, regulating and monitoring the adherence to the SHI.
The main reasons for preferring private sector management of the SHI were pertinent experience, human and institutional capacity, and perceived relative efficiency. However, some stakeholders thought that given the fact that the private sector is profit motivated, there would be need for the GOL to closely monitor and regulate their actions to obviate exploitation of the SHI. It was also felt that if the SHI fund is managed by a private company, it should be a Lesotho based company, as capacities should be developed for Lesotho.

**Challenges to the start-up and running of the SHI**

The respondents thought that the start-up and running of the SHI would confront a number of challenges:

- Limited awareness and knowledge of SHI among some of the workers.
- Low incomes.
- High level of unemployment limiting the ability of the unemployed to pay SHI contributions.
- Instability of jobs for those working in the private sector (e.g. manufacturing and textiles, transport), and hence the inability to sustain the contributions to SHI. It was felt that this may limit the scope of the benefit package.
- Large extended families.
- Poor health care infrastructure, especially in the rural areas, limiting inaccessibility of health services (SHI benefit package). The health system is confronted by a dearth of human resources for health (e.g. doctors, nurses, technicians), which in turn limits the capacity to provide satisfactorily the SHI benefit package.
- Limited administrative capacity to start-up and efficiently operate the SHI.

**Other concerns:** Another concern was whether pensioners would also be covered, given that elderly people would be in greater need of health care.
Table 11: Summary of responses from discussions with representatives of professional associations and trade unions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Lesotho Public Servants Association</th>
<th>Lentsoe Sechaba Workers Union</th>
<th>DEMOWU**</th>
<th>Lesotho Association of Teachers</th>
<th>Lesotho Clothing &amp; Allied Workers Union</th>
<th>Transport, Security &amp; Allied Workers Union</th>
<th>Informal sector workers (MCC Market)</th>
<th>Factory workers association</th>
<th>Lesotho Bus and Minibus Operators Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of members</td>
<td>About 5000</td>
<td>739</td>
<td>1200 (about)</td>
<td>6606</td>
<td>8000</td>
<td>850</td>
<td>230</td>
<td>8897 (out of 50,000 factory workers)</td>
<td>20-40 paid up members</td>
</tr>
<tr>
<td>Membership fee per month (Maloti)</td>
<td>10</td>
<td>10</td>
<td>15</td>
<td>10</td>
<td>10</td>
<td>20</td>
<td>3 (MCC)</td>
<td>10</td>
<td>16.67</td>
</tr>
<tr>
<td>Average salary (in Maloti)</td>
<td>See Table 12</td>
<td>610-710 (660)</td>
<td>Probation: M999.90-1400 Completed: 1,035-1500 Auto electrician+mechanics+ Panel beaters: M1586 Filling station: M910</td>
<td>Referred to Teachers Services Department</td>
<td>710-880</td>
<td>800-982</td>
<td>500</td>
<td>780</td>
<td>800 plus lunch (20 M per day)</td>
</tr>
<tr>
<td>Current source of care</td>
<td>Depends on grade: GOL+CHAL; higher grades: private sector</td>
<td>GOL - QEII</td>
<td>GOL</td>
<td>CHAL, Private, GOL</td>
<td>Company clinic + GOL</td>
<td>GOL</td>
<td>GOL</td>
<td>-</td>
<td>GOL, QEII</td>
</tr>
<tr>
<td>PHI policies</td>
<td>Better-off</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No?</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Willingness to enrol in SHI</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Willingness to pay to SHI (% of salary)/month</td>
<td>20-30</td>
<td>2% (M13.2)</td>
<td>M10</td>
<td>3 to 5%</td>
<td>3 to 4%</td>
<td>M27 (3%)</td>
<td>M10 (2%)</td>
<td>M20 (2.6%)</td>
<td>M 30-50</td>
</tr>
<tr>
<td>Expected</td>
<td>50% share</td>
<td>2</td>
<td>M10</td>
<td>5%</td>
<td>-</td>
<td>M27</td>
<td>-</td>
<td>-</td>
<td>NA</td>
</tr>
<tr>
<td>employer contribution (%)/ month</td>
<td>Services to be covered under SHI</td>
<td>Preferred service providers</td>
<td>Preferred governance of SHI Fund</td>
<td>Challenges</td>
<td></td>
<td></td>
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<td>----------------------------------</td>
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</tr>
<tr>
<td>Outpatient and inpatient; Choice between several plans</td>
<td>Outpatient and inpatient</td>
<td>CHAL &amp; private</td>
<td>Private</td>
<td>Employment instability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient and inpatient</td>
<td>All outpatient and inpatient</td>
<td>GOL, CHAL &amp; Private</td>
<td>Private &amp; CHAL</td>
<td>(a). Instability of jobs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>Private &amp; CHAL</td>
<td>CHAL &amp; private</td>
<td>(b). Scope of benefit package</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>Private insurance company</td>
<td>Private insurance company (efficiency &amp; capacity)</td>
<td>(a). Administrative capacity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>Private insurance company + GOL</td>
<td>Government or private company (TU on the board)</td>
<td>(b). Large extended facilities (polygamy)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>Government or private company</td>
<td>Private company</td>
<td>(a). Scope of the package</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Board of Directors with representation of TUs &amp; GOL</td>
<td>(b). Infrastructure – inaccessibility of health facilities in rural areas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Not by government, but gvt should regulate</td>
<td>(c). Brain drain of HRH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>-</td>
<td>NA</td>
<td>(d). Dearth of HRH (nurses, technicians, doctors)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>-</td>
<td>NA</td>
<td>Poverty limiting ability to pay</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>-</td>
<td>NA</td>
<td>(a). Adequate campaigns to make workers accept it.</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

** DEMOWU: Drivers, Earth Moving Operators & Allied Workers Union (+ auto electricians, motor mechanics, panel beaters, petrol/filling station attendants)**

Empty cells (- ) mean that the information was not obtained.
4.3. Views of health service providers

Perceived risks and benefits of participating in SHI as a provider
The interviews with various providers revealed following perceived risks:
(i) People's lack of confidence in the quality of services provided mainly due to poor infrastructure and shortages in human resources for health;
(ii) little knowledge of SHI by the population;
(iii) limited administrative capacity to manage SHI; and
(iv) bureaucratic, cumbersome and frustrating reimbursement mechanisms that hinder timely acquisition of health service inputs.

Perceived benefits of participating in SHI as provider:
(i) external motivation/incentive for improving the quality of services;
(ii) reduced cost of recovering bad debts, if the GOL would be paying premiums on behalf of the poor under a SHI scheme;
(iii) assured revenues for providers, which can be used to enhance quality of services.

Desire to be accredited as provider of services and to receive payments from SHI for services provided
The GOL, CHAL and private providers expressed interest in becoming accredited service providers within the SHI scheme. The close partnership already existing between GOL and CHAL (see Chapter 3.3.3.) may provide a good basis for a similar contract that could be entered once SHI started.

Licensing and accreditation standards and phasing in of those standards
The GOL has already instituted a system for licensing and accrediting CHAL hospitals and health centres as a prerequisite for continued government funding. Respondents from providers felt that the system could be adapted for SHI purposes and also be extended to private health service providers.

Preferred provider payment system and remuneration rates

While CHAL is in principle interested and willing to be contracted as a service provider to deliver health care to SHI members, there remains some scepticism and caution. This is because past experience taught them that agreed upon funds have not come on time, which thus created substantial difficulties at the level of CHAL hospitals. Hence, they would expect payments to be timely and reliable. At the same time, their concern is that funds are sufficient in order to avoid making a loss out of the SHI scheme.

One of the CHAL providers indicated that their reimbursement mechanism of preference would be fee-for-service. While capitation was in principle accepted as an appropriate remuneration scheme, challenges were seen in its actual implementation, as it was feared not to cater for disease epidemics or other unforeseen costs, and hence the provider would have to bear all the risks.
However, in general, among all providers, there was clear recognition that any provider remuneration scheme must be simple to administer to take account of the existing administrative capacities and to avoid fraud.

Most of the provider respondents did not know of their unit costs per service. Given the limited experience with different provider payment mechanisms at GOL and CHAL facilities, who operate on a budget basis, it proved difficult to further discuss remuneration rates.

The private providers that are contracted by a private health insurance have some experience with the fee-for-service reimbursement scheme and obviously would prefer that this system with the NRPL of South Africa continues. On the other hand, there was recognition that these fees may not be affordable for a SHI scheme in Lesotho.

Quality assurance and utilization review
Currently, there is no quality assurance and utilization review mechanisms in place, and hence providers have little experience on the basis of which to reflect about these issues. In principle, however, managers of health care providers agree that there is need to improve the quality of services. There was likewise recognition that surveillance is an important activity in strengthening purchasing. Surveillance and monitoring serves to ensure that health providers meet certain quality standards, refrain from over- or under provision and follow the claims management procedures. As such, surveillance is also a means to control fraud and corruption.

Administrative issues including medical records and claims payment
Some providers felt that the administrative capacities for registering SHI members, keeping their medical records and processing of claims may not be adequate. It was further said that there would be need to build computerized system for keeping medical records and managing claims for payment.

Preferred governance structure of the SHI fund
The service providers felt that the day-to-day management of the SHI fund should be contracted to an experienced insurance company or agency. The SHI fund should then be under stewardship or oversight of a representative and competent board of directors with public and private sector management expertise and experience. The public accountability mechanism could be a committee consisting of Ministries of Finance, Health, Labour and Public Service.

Regulatory issues
The need for building-in cost-containment measures was highlighted to curb both client and provider moral hazard.

Other programmatic issues from providers’ perspective that impinges on the design of the SHI
The health services providers mentioned that the SHI was likely to encounter the following challenges:
High unemployment rate
Most of the people are peasant farmers, whose incomes are very low
Most of the people in formal employment are factory workers and government employees, whose earnings are fairly low.
Limited culture of solidarity across groups
Unstable health service provision situation, with contracts of foreign health workers coming to an end.
Unregulated private medical practise
Dearth of human resources for health (exacerbated by brain drain) to provide the benefit package.
Lack of health infrastructure especially in rural areas to assure access to the benefit package.
High prevalence of HIV/AIDS as well as chronic noncommunicable diseases.
Family social structure characterized by large extended families.
High cost of sending a large number of patients to South Africa for specialized treatment.

4.4. Consultations among key ministries and other stakeholder groups

4.4.1. Inter-Ministerial SHI Technical Working Group (TWG)

When asked whether there existed a reasonable number of administrators who could be trained to administer the SHI, TWG informed the mission team that the national University of Lesotho offered a degree specialization in public administration. Thus, it was felt that there existed some administrators who could be trained to administer the SHI.

Concerning the legal framework, the mission team was informed that even the pensions and regulation bill was still in draft form. It was recognized that there would be need for developing legislation on SHI by the Attorney General’s Office, with external technical legal support due to its specialized nature. The TWG felt that the debate and ratification of legislation by the parliament could take several months.

There was also the view that the management a new Lesotho SHI should be Musotho in the long-term, rather than coming from abroad. This may entail building up capacity within the country, probably in collaboration with the National University.

Regarding mechanisms for regulating providers, TWG indicated that usually the doctors register with the Medical Council, and the nurses with the Nursing Council. However, there is no follow-up after registration to ensure adherence with the international medical ethics standards and guidelines. It was felt that the same licensing and accreditation system could be adopted and applied for SHI purposes.
The TWG indicated that the major challenge for SHI would be the high levels of unemployment (and hence the inability to pay premiums among those concerned) and the meagre salaries among the factory workers (who earn 600 to 700 Maloti per month) and other workers who earn less. Not to mention those in the informal sector.

4.4.2. Ministry of Health and Social Welfare (MOHSW)

The MOHSW thought that the health system had the capacity to deliver the SHI benefit package but certain aspects of the health system would require strengthening. The aspects that need improvement include: social aspects of medical practice, especially responsiveness to non-medical expectations of clients (including improvement in staff attitude); upgrading of physical health infrastructure; and increase in production and retention of human resources for health.

Respondents from the MOHSW felt that the roles of the MOSHW should be: (i) provision of health services through the GOL health facilities; (iii) standard setting; (iii) quality assurance through continuation and extension of the current certification and accreditation system; (iv) monitoring and evaluation; (v) drafting of the SHI policy.

With regard to governance of SHI, it was felt that it should be run by an autonomous or semi-autonomous company operated in a professional manner. It was felt that the private sector would be more efficient in managing the SHI, under GOL regulation.

Efforts to introduce SHI may encounter the following challenges according to MOHSW respondents:
- limited solidarity;
- resistance to SHI since it is an unknown concept among majority of the people;
- wide-spread poverty;
- scepticism attributed to life insurance; and
- shortages of human resources for health which undermines to ability of the health system to guarantee provision of the benefit package.

4.4.3 Ministry of Public Service (MPS)

The MPS has a particular interest in a SHI to assure access of civil servants to health services and to shield them from catastrophic health costs. The urgency for such a scheme was underscored for the majority of public service workers who are in salary grades A, B and C.

The MPS respondents indicated that employees' willingness to enrol in SHI scheme will depend on:
- their disposable income after contributing to the various planned schemes and paying taxes;
• access to health care abroad (mainly in South Africa) for conditions that cannot be managed locally; and
• the range (scope) of health services covered.

The respondents were of the view that the public service workers would be willing to pay between two to three percent of their salaries into the SHI scheme. It was also felt that this could be matched by the employer, i.e. in this case the government.

The respondents were of the opinion that the SHI scheme should not be run by the government. This is because the government machinery is perceived as inefficient and not trustworthy. In addition, doubts were expressed regarding availability of pertinent skills within the government to start and operate a SHI. And even if the necessary skills existed, respondents expressed concern that there would be the risk of managers of the SHI fund being employed on the basis of some other criteria rather than their relevant competencies and functional skills. They indicated that their preferred governance framework would be an autonomous or semi-public SHI agency managed by a private management company (it was reported that the Ministry of Agriculture engaged a private company through a management contract to run the Lesotho Flour Mills). The interviewees underscored that the role of the Government should be among others quality control (through licensing and accreditation of health service providers), regulation (legislation and enforcement), monitoring and evaluation.

The potential challenges to launch a SHI insurance scheme would be: low salaries among those in formal employment; dearth of ability to pay among farmers and informal sector workers; weak health systems, and hence, dearth in capacity to assure provision of the benefit package; scope of the benefit package; cultural reliance on traditional healers, and hence, the challenge of how to deal with them within SHI; and SHI sustainability issues.

4.4.4. Ministry of Labour

In the context of Decent Work program ideas, the Ministry of Labour is currently reflecting on extending its social security system by 2012. The (Draft) Consolidated National Social Security Act from 2000 is being reviewed. This Draft Act had foreseen the establishment of a General Organization for Social Security, as a body corporate, under which individual Insurance Funds are established for old-age pension, for employment injuries compensation, and maternity.

In addition to the above, the Draft Policy document of 2003, which is equally being revised, also includes a "Medishield" program to cover medical care in case of sickness for employees. No further information on what benefits this would entail could be obtained. Table 12 below outlines the envisaged employee/employer contribution rates. In the case of health insurance, the envisaged employee/employer share of contribution is 50/50.

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13 They referred to the employee's share.
Table 12: Possible insurance schemes under reflection

<table>
<thead>
<tr>
<th>Insurance</th>
<th>Contribution rates (in %)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>By the employee</td>
</tr>
<tr>
<td>Old age</td>
<td>5</td>
</tr>
<tr>
<td>Industrial injuries and occupational diseases</td>
<td>-</td>
</tr>
<tr>
<td>Maternity</td>
<td></td>
</tr>
<tr>
<td>Medishield</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>8</strong></td>
</tr>
</tbody>
</table>

4.4.5. Ministry of Finance (MoF)

It appeared that the technical levels of the MoF had so far not been so actively involved in the discussions on SHI and hence were less familiar with the reasons why the MOHSW assesses a SHI scheme. Its major concerns were obviously not so much health policy based, but mainly related to macroeconomic, labour market fiscal and financial aspects. There was also the view that the MOHSW budget could be reduced, once resources are collected through the SHI scheme.

It is unclear to what extent the MOF technical have been involved in the previous discussions on the medical aid scheme, however, based on the MOF informants, internal discussions regarding the Medical Aid Scheme appear to be ongoing. A questionnaire, developed with the support of one of the private health insurance companies would soon be sent out to all civil servants to get information on their preferences regarding the benefit package, premiums and other aspects.

4.4.6 Medical Association

A representative of the Medical Association of Lesotho (MAL) indicated that the Association had approximately 25 active members. Most of the members usually obtain health care from their places of work. Some of the members have private health insurance policies. The respondent indicated that MAL members would prefer the SHI fund to be managed by private sector and overseen by a board of directors consisting of representatives from all the stakeholder groups. It was also noted that foreign doctors should be covered. It was emphasized that there is interest in SHI, but providers would wish to operate under a clear contract.

4.4.7. Nursing Council

There are approximately 2000 nurses registered with the Nursing Council of Lesotho. Each member pays an annual fee of M100 per year. The average salary for nurses is about M3000 per month. The respondent indicated that the nurses currently obtain health care from GOL, CHAL and private practitioners, largely depending on where they work.
The mission team was informed that some of the nurses have personal savings accounts for covering catastrophic medical expenditures.

The management of the Nursing Council thought that the nurses would be willing to enrol in SHI and each would be able to contribute about M30 (1%) per month into the SHI fund. This lower willingness to pay contributions is related to the fact that most nurses receive free or subsidized care at their place of work. Thus, nurses obviously see less need in being insured, since they usually do not encounter catastrophic costs when ill.

The respondent indicated that nurses would expect the SHI to cover both outpatient and inpatient services (including cardiology, oncology, leukaemia, severe accidents). It was indicated that the nurses would like to be given choice of seeking care from private health service providers. The respondent indicated that they would not mind GOL and CHAL health facilities being accredited service providers for SHI on condition that the quality of services is significantly improved.

Concerning the preferred governance of SHI fund, the respondent indicated that the nurses preference would be a non-governmental organization (NGO). This is because of NGOs were thought to be transparent and efficient.

The respondent thought that the implementation of SHI may be confronted with the challenges of effectively administering the scheme and demonstrating transparency in its management.

**4.5. Stakeholder feedback during the second mission**

Various meetings with key stakeholders were held: The Minister of Health, a group of Principal Secretaries (MOHSW, MoPS, Ministry of Labour), and the SHI TGW. Also, two workshops were held with representatives from potential beneficiaries and from health care providers. Annex 2 outlines in detail the proceedings, the discussions and the questions and comments raised during these meetings and workshops. All of these issues and questions have been taken up in this report in Chapters 5 and 6.
5. Key design issues of Social Health Insurance

This chapter discusses key design issues of a SHI scheme using the three health financing functions of resource collection, pooling and purchasing. In relation to these key design issues, the chapter also explains the assumptions and their rationale that have been made for the financial projections (presented in Chapter 6).

5.1. Resource collection

5.1.1. Additional resource mobilization

The institutional design of health financing mechanisms primarily determines how the funds for providing health services flow. Who pays at what time and how much, i.e. revenue collection, is one important function within the system. When health spending in a country is too low overall to ensure the populations' good health, then the resource mobilization function is also concerned with increasing the funds available to be spent on health. Raising additional funds relative to the status quo requires there to be enough “fiscal space”, however. Having fiscal space means that the additional resources must be raised in a sustainable manner and must not jeopardize economic stability. Thus, economic stability must be considered when introducing payroll deductions as health insurance contributions or when raising taxes to fund health care. Receiving increased donor funds for health spending should be planned well, ensuring that they will be available for at least the medium term.

SHI can be a mechanism that generates additional funds. It is essentially a prepayment mechanism as people are asked to make regular contributions, e.g. on a monthly basis. In order to increase available resources for health care, i.e. to be able to offer more and better services, resources mobilized through SHI should supplement the existing tax-based financing of health care through the MOHSW budget, rather than replace them.

That is to say, government spending on health, notably MOHSW budgetary spending, should continue as before. Consequently, for the financial projections, it as assumed that the Government of Lesotho will maintain its current level of health care funding through the MOHSW (in constant prices), yet adjusting it according to population growth and inflation. In this context, when referring to maintaining MOHSW funding for health care, we specifically mean the MOHSW budget for personal curative care. As Lesotho receives no budget support and as donor funding is mostly going into the development budget, the issue of sustainable donor funding is of less concern at this point.

Obviously, policy-makers need to discuss this assumption, as there may be different views regarding the MOHSW budget under a SHI scheme.

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15 The MOHSW budget for preventive and promotive health should be equally maintained.
Assumption of financial projections:
**Government of Lesotho maintains its current level of funding for the health sector.**
**Additional resources are mobilized through SHI.**

5.1.2. Contribution rates

Equal access to health care is one of the major guiding principles of the Lesotho Health Policy. Another major objective is the reduction of inequalities in health and social welfare (see Chapter 3.1). Therefore, equity in contributions would be fully coherent with these objectives, which reflects a desire for equal access to healthcare. For that matter, rather than flat rate premiums, SHI payments are income-related (and not related to individual health risks), which translates into a uniform contribution rate as a percentage of gross salaries.

Stakeholder consultations revealed that employees' contribution rates ranging from 2-5% of their salary would be acceptable. A 3/4/5% contribution rate as a payroll deduction would imply the following payroll deductions (Table 13), if we assume a 50% share by the employer (and in the case of civil servants by government). These contribution shares are compared with PHI premiums that a family of four (two adults, two children) would have to pay, assuming that 50% of their premiums would be covered by the employer (far right column).

Table 13: SHI contributions by employees for different contribution rates (assuming a 50/50 split of contribution payment between employer and employee)

<table>
<thead>
<tr>
<th>Contribution rate:</th>
<th>Professional group:</th>
<th>Average monthly salary</th>
<th>Employees’ share of contribution rate of 1,5%*</th>
<th>Employees’ share of contribution rate of 2%*</th>
<th>Employees’ share of contribution rate of 2.5%*</th>
<th>Comparison with 50% of PHI premium**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Civil servants</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>903</td>
<td>13.55</td>
<td>18.06</td>
<td>22.58</td>
<td>631</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>1,192</td>
<td>17.88</td>
<td>23.85</td>
<td>29.81</td>
<td>631</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>1,756</td>
<td>26.34</td>
<td>35.12</td>
<td>43.90</td>
<td>631</td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>2,642</td>
<td>39.62</td>
<td>52.83</td>
<td>66.04</td>
<td>631</td>
</tr>
<tr>
<td></td>
<td>E</td>
<td>3,883</td>
<td>58.25</td>
<td>77.66</td>
<td>97.08</td>
<td>631</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>5,502</td>
<td>82.53</td>
<td>110.03</td>
<td>137.54</td>
<td>631</td>
</tr>
<tr>
<td></td>
<td>G</td>
<td>7,216</td>
<td>108.24</td>
<td>144.32</td>
<td>180.40</td>
<td>631</td>
</tr>
<tr>
<td></td>
<td>H</td>
<td>8,797</td>
<td>131.96</td>
<td>175.95</td>
<td>219.93</td>
<td>631</td>
</tr>
<tr>
<td></td>
<td>I</td>
<td>11,439</td>
<td>171.59</td>
<td>228.79</td>
<td>285.98</td>
<td>631</td>
</tr>
<tr>
<td></td>
<td>J</td>
<td>13,270</td>
<td>199.05</td>
<td>265.40</td>
<td>331.75</td>
<td>631</td>
</tr>
<tr>
<td></td>
<td>K</td>
<td>15,392</td>
<td>230.89</td>
<td>307.85</td>
<td>384.81</td>
<td>631</td>
</tr>
<tr>
<td></td>
<td>L</td>
<td>18,301</td>
<td>274.52</td>
<td>366.03</td>
<td>457.53</td>
<td>631</td>
</tr>
<tr>
<td></td>
<td>Formal sector:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Example 1</td>
<td>6,500</td>
<td>97.50</td>
<td>130</td>
<td>162.50</td>
<td>631</td>
</tr>
<tr>
<td></td>
<td>Example 2</td>
<td>3,000</td>
<td>45</td>
<td>60</td>
<td>75</td>
<td>631</td>
</tr>
<tr>
<td></td>
<td>Example 3</td>
<td>1,500</td>
<td>22.50</td>
<td>30</td>
<td>37.50</td>
<td>631</td>
</tr>
<tr>
<td></td>
<td>Example 4</td>
<td>800</td>
<td>12</td>
<td>16</td>
<td>20</td>
<td>631</td>
</tr>
</tbody>
</table>

* The number of children does not affect the contribution payment.
** Premium as a group member for a family with two parents and two children (compare Table 6).
The table reveals that SHI contributions are significantly below the employee's share of a PHI premium for a basic package (cf. Chapter 3.5).

When considering a payroll deduction from gross salaries/wages for health insurance contributions, it is important to bear in mind that total payroll deductions would go beyond health insurance and include income tax and other contributions:

- Parastatal employees are currently the only ones benefiting from a contributory pension based on the Corporate Body Pension Scheme, being a capital based scheme. Both the employer and employee contribute each 5%.

- Currently, civil servants make no contributions for their pension scheme, but the mission team was informed that it is planned to introduce a contributory pension scheme for civil servants rather soon (by early/mid 2008), with a contribution rate of 5% by the civil servant and 10.1% by the government, based on a 2003 Draft Act. It is planned to set up a parastatal organization that manages the funds, but so far no further concrete steps have been undertaken.

- Similar plans for formal sector workers are under way in the Ministry of Labour, though plans are less concrete so far. The concept foresees a contribution rate of 5% for the employee and 8% for the employer.

- The income tax rates are progressive, ranging from 0% to 35%. For an annual income of M 60,000, the tax rate is about 25%.

In light of the existing payroll deductions and based on the stakeholder discussions, the financial projection have started with a total SHI contribution rate 5%. If one assumes that this contribution rate of 5% is shared by 50% by the employer, the payroll deduction for employees amounts to 2.5%. As potential beneficiaries stated to be willing to pay 2-5% from their salaries, the above contribution rate that is used for the financial projection is at the lower end of people's stated willingness to pay. If both spouses are working, both will have to pay SHI contributions.

The contributions of formal sector employees and civil servants could be paid on a 50/50 basis by employees and the employer. As there is no employer for pensioners, and hence no employer's share, the contribution rate would be only 2.5%. The 50/50 share would constitute equal and balanced sharing of the SHI financing by both the employer and the employee. However, another balance may be chosen based on a different rationale.

The financial projections assumed payroll deductions to be made before income taxation, i.e. contributions are calculated on the basis of gross salaries. Were contributions deducted on salaries net of income tax, overall financial feasibility of the SHI scheme would look

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16 “The pension is calculated on the basis of 2% of pensionable emoluments for every pensionable year of service during which the employee has contributed to the scheme”, Labour Code.

17 Teachers do not fall under the Ministry of Public Service, as they are employed by the Teachers' Service Commission. Under specific conditions, teachers receive a pension.

18 Up to a yearly income of M 33,075 (for the year 2007), income is taxed at a flat rate of 25%, however there is a tax credit of M2911 (for 2007), hence any monthly income of M970 or below is not taxed. Any income beyond M 33,075 is taxed at a flat rate of 35% (information obtained from key respondent of Lesotho Revenue Authority).
different. Likewise, there would be tremendous reductions in income tax revenues, if income tax is deducted of salaries net of SHI contributions, as one discussant suggested.

For the informal sector, a flat contribution amount is usually applied, since it is difficult to assess the income of the active population outside the formal sector, on the basis of which to deduct a specific percentage. Further information and analysis is required to see whether contributions can be differentiated according to informal sector workers’ ability to pay, but this would increases administration tasks of a SHI fund.

The poor are exempted from paying contributions and co-payments. Half of the population are poor (KOL 2006a). Hence, about 75% of the informal sector would be exempted.\textsuperscript{19}

\begin{table}[h]
\centering
\begin{tabular}{|l|}
\hline
\textbf{Assumption for the financial projections:}  \\
\textit{Gross salary-based contribution rates are at 5\% for public service officers and formal sector employees.}  \\
\textit{Half of the contribution is paid by the employer.}  \\
\textit{Pensioners pay the ‘employee’ half of the same rate, i.e. 2.5\%.}  \\
\textit{The informal sector workers contribute a flat amount.}  \\
\textit{The poor are exempted from paying contributions and co-payments.}  \\
\hline
\end{tabular}
\end{table}

Those unable to pay SHI contributions due to their poverty status are protected via risk-sharing through the SHI system, including cross-subsidization between higher income and lower income groups, as well as through government funding. There is a strong rationale for a SHI for all Basotho, even though a large part of the informal sector does not pay contributions: There is one fund where all risk pooling takes place, and hence everybody can access the same benefit package and overall improvement in health care services can be organized within one system rather than several ones, hence the risk of having two separate service delivery systems at different degrees of quality is counteracted. These equity issues are also further elaborated in Chapter 6.2.

During the second mission’s stakeholder workshops, the question was raised why pensioners should pay SHI contributions. Given that pensioners belong to the better-off population group and since their pension constitutes an income, it is argued that they are equally able to make contributions. However, given the small numbers of pensioners, exempting them from contributions would not change significantly the overall financial feasibility of the SHI fund.

Another critical point for discussion is how to go about the temporarily employed and unemployed. The issue at stake is whether this group would still be covered during the initial few months of unemployment. Coverage could be guaranteed during this initial period, with government making the necessary financial transfers to the SHI system.

\textsuperscript{19}The financial projections assume that the exempted members are all part of the informal sector, i.e. nobody in the formal sector is exempted. However, the SHI design may equally take into account that a share of formal sector employees and their family may also fall below the poverty line.
Alternatively, such workers could fall into the category of the informal sector, hence asked to pay the flat contribution amount of informal sector workers.

Finally, it is important to note that the contribution rate of 5% as initially set for these financial projections is not carved in stone. The rates may have to change according to the size of the benefit package and other considerations. Chapter 6.2. presents a variant of the main financial projection scenario with different contribution rates.

5.1.3. Collection methods

For civil servants and formal sector employees who pay income tax, contributions could be collected by the Revenue Authority of Lesotho. Yet, most of the formal sector employees in the textile sector do not pay income tax and are hence not registered with the Revenue Authority, as their monthly wage falls below the taxable income threshold (of M 970). Collection through the Revenue Authority would require to register all the employees with the Revenue Authority.

Another option is to apply the same principles of existing payment procedures used for the parastatal employees’ pension contributions. These procedures should be further assessed to learn from existing practice. For the parastatals employees, the employer deducts the employee's share from the salary and transfers this - together with the employer's share - to the National Lesotho Insurance Group, which administers the funds. In other words, employers could transfer contributions to the pooling agency / SHI agency. In this case, employers would bear some of the collection costs, as some additional staff time may be required to make these payments.

Other options should also be considered, e.g. contributions could be collected through the banks that pay out wages, similar to the way funeral insurance premiums are deducted by banks at the end of the month during salary cash payouts. Factors to take into account are the costs of setting up this payroll deduction channel, especially for some 60,000 textile workers, as well as immunity against corruption or other ways of non-compliance with the contribution payment rules.

More information on the informal sector and further analysis and reflection is required to propose an appropriate collection channel for contributions from informal sector workers. Market stand workers suggested the Maseru City Council. Transport workers proposed the transport and road associations. The NGO Council considered the community councillors an appropriate institution to collect contributions. Compliance with collection rules may improve via a preferred agent, however the downside is that collection costs may increase if the collection arrangement does not use economies of scale. A related question is what an adequate remuneration for this administrative task of collection would be. When determining the level and structure of contributions, this needs to be taken into account.

\[\text{Community councilors are not salaried, but receive an allowance from the Ministry of Local Government.}\]
Another difficult question is to determine who within the informal sector will be exempted and who will not be exempted. Related to this, the question is how to ensure that the non-exempted do pay contributions.

It is also worth considering the funeral associations, which are a widespread and accepted institution of collection funeral insurance premiums. The widespread acceptance of funeral schemes could provide a basis to increase understanding and demand for a health insurance scheme. People are used to making monthly contributions, and for many schemes, they queue patiently at the payment points.

A very high proportion of employees, self-employed and informal sector workers subscribe to funeral schemes and make regular, monthly contributions. The purpose of funeral schemes is to ensure that the members and/or their family members are given a decent burial when they die. Membership to funeral schemes ensures that the bereaved family members do not bear the full impact of the potentially catastrophic funeral-related costs.

Respondents also referred to the existing "community funds" at the local level: People make regular contributions to collect funds which are then distributed - based on a specific formula - to the contributors, e.g. before Christmas, in order to be able to buy food.

5.1.4. Willingness to pay SHI contributions in the current context of low user fees

In light of the fact that out-of-pocket expenditure is relatively low in Lesotho and will decrease even more, once user fees will be lowered at CHAL hospitals and abolished at all GOL and CHAL health centres, the question is how to convince people to make mandatory contributions.\(^{21}\) Of course, reducing OOPs spending is an important reform step. Yet, the population would need to be made aware that low user fees imply high government subsidies. SHI contributions - as a prepayment method rather than OOPs - would be required to raise additional resources and to pay for an adequate level of health care with improved quality.

For health workers, the situation is again different: Even though there is no explicit policy, most health workers would receive free health care, usually from the facility they are working at, and also often for their family. MOHSW staff would also frequently be exempted from user fees at government facilities. In general, this situation is not necessarily ideal, as free use of care may induce moral hazard or excess demand. Health workers from the district level consider their government health care services acceptable. Therefore, this group may be less willing to make contributions to a SHI scheme, since they have already access to health care free at the point of use. Depending on how widely this practice of free care for health workers (and their families) exists, the government may wish to clarify the MOHSW position and policy on this. One option is

\(^{21}\) One of the CHAL hospitals had attempted to set up a provider based health insurance scheme for the surrounding community, but the scheme failed; one of the reasons, as it was reckoned, was that people felt unfamiliar with the health insurance concept.
to adapt income for health workers through salary increases, performance-based payments as part of the new SHI provider payment scheme, or other financial incentives. This could be financed through the increased funds collected through SHI (cf. Chapter 5.3.2.).

In conclusion, a major challenging task ahead is to negotiate with the various groups and stakeholders, to deal with their group interests around a social health insurance scheme and to find agreements between the various actors. The changes in user fees charged and the possible introduction of SHI should be seen as two steps of the one and the same reform, which moves health payments from indiscriminate direct payments to prepayment SHI contributions based on ability to pay.

5.1.5. Willingness to pay SHI contributions among the very high-income earners

A specific population group that may be reluctant to join a SHI scheme are those who currently have a private health insurance. It is important to note, however, that private health insurance is only affordable to the very well-off (top 5000-8000 Basotho). Particularly in those cases, where the employer pays part or all of the premium, private health insurees may be interested to maintain their current benefit package. But a large part of the 5000 PHI principal members may actually also prefer lower SHI contribution rates, which would still grant them access to outpatient care at private providers. Access to inpatient care at private providers in Lesotho or inpatient care in RSA is another issue. Here, the question of whether and if so what role the PHI sector should be attributed becomes relevant.

A good communication strategy, information provision and awareness raising around advantages of SHI for both individuals as well as society will be important to get them on board. Employers, on the other hand, may welcome the SHI scheme, as its contribution rates are lower than those of PHI, while it still offers a core package of health care services (compare Table 13).

The very high income earners may be particularly reluctant to pay contributions to the SHI, since the 5% contribution rate will amount to a large sum of money. Yet those who have taken out PHI for several family members (let's say for a family with two adults and two children) will find that their PHI premium is still higher than the SHI contribution. As the SHI contribution would cater for a basic package, including outpatient care at private providers in Maseru, the difference between their previous PHI premium and new SHI contribution could be used for a specific topping up package by a private health insurance, catering particularly for inpatient care at private providers in Maseru or for inpatient care in RSA. The calculation examples below, which are based on the premiums of Prosperity PHI for different package options, illustrate this in further detail (see Box 1).

If a SHI Law comes into place, PHI companies operating in Lesotho will as a consequence have to adjust their packages on offer. Insurance theory predicts that such
topping up plans can be offered at much lower costs than a full PHI plan. In fact, some PHIs already offer such "hospitalization-only" packages at lower rates, as predicted.

Box 1: Examples of health insurance costs for high income earners

**Example 1: Public service officer at Grade K**
- For a family of four (2 adults, 2 children)
- Monthly salary at Grade K: M 15,392

<table>
<thead>
<tr>
<th>PHI premium (at Prosperity):</th>
<th>Malotí</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option &quot;Econ&quot; - Comprehensive</td>
<td>1948</td>
</tr>
<tr>
<td>SHI Contribution</td>
<td>385</td>
</tr>
<tr>
<td>2.5% of M 15,382</td>
<td></td>
</tr>
<tr>
<td>Difference between PHI and SHI</td>
<td>1563</td>
</tr>
<tr>
<td>(1948 - 385)</td>
<td></td>
</tr>
<tr>
<td>PHI premium (at Prosperity):</td>
<td></td>
</tr>
<tr>
<td>Option &quot;Econ&quot; - Hospital Only</td>
<td>996</td>
</tr>
<tr>
<td>Savings through joining the SHI scheme</td>
<td>567</td>
</tr>
<tr>
<td>(1563 - 996)</td>
<td></td>
</tr>
</tbody>
</table>

**Example 2: Private sector employee at top management level**
- For a family of four (2 adults, 2 children)
- Assuming a monthly salary of an employee: M 25,000

<table>
<thead>
<tr>
<th>PHI premium (at Momentum):</th>
<th>Malotí</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option B &quot;Comprehensive&quot;</td>
<td>2508</td>
</tr>
<tr>
<td>SHI Contribution</td>
<td>625</td>
</tr>
<tr>
<td>2.5% of M 25,000</td>
<td></td>
</tr>
<tr>
<td>Difference between PHI and SHI</td>
<td>1883</td>
</tr>
<tr>
<td>(2508 - 625)</td>
<td></td>
</tr>
<tr>
<td>PHI premium (at Prosperity):</td>
<td></td>
</tr>
<tr>
<td>Option &quot;Econ&quot; - Hospital Only</td>
<td>996</td>
</tr>
<tr>
<td>Savings through joining the SHI scheme</td>
<td>887</td>
</tr>
<tr>
<td>(1883 - 996)</td>
<td></td>
</tr>
</tbody>
</table>

**Example 3: Self-employed person (business owner)**
- For a family of four (2 adults, 2 children)
- Assuming a monthly salary of a self-employed: M 25,000

<table>
<thead>
<tr>
<th>PHI premium (at Momentum):</th>
<th>Malotí</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option B &quot;Comprehensive&quot;</td>
<td>2508</td>
</tr>
<tr>
<td>SHI Contribution</td>
<td>1250</td>
</tr>
<tr>
<td>5% of M 25,000</td>
<td></td>
</tr>
<tr>
<td>Difference between PHI and SHI</td>
<td>1258</td>
</tr>
<tr>
<td>(2508 - 1250)</td>
<td></td>
</tr>
<tr>
<td>PHI premium (at Prosperity):</td>
<td></td>
</tr>
<tr>
<td>Option &quot;Econ&quot; - Hospital Only</td>
<td>996</td>
</tr>
<tr>
<td>Savings through joining the SHI scheme</td>
<td>262</td>
</tr>
<tr>
<td>(1258 - 996)</td>
<td></td>
</tr>
</tbody>
</table>
Another option is to consider a cap on the contribution rates, i.e. contribution payments would not go beyond a certain amount and hence not reach 5%. Setting a cap results in an even larger difference between what high-income person would pay for SHI in contrast to PHI premiums (see the calculation example in Box 2). However, finding the right level of cap is difficult, because from an equity and solidarity perspective, the contribution rate of those individuals benefiting from a cap should not deviate too much from the 5% contribution rate that applies to the rest of the (less affluent) population. In order to define and set a cap, it is necessary to look at the salary incomes of the top 2% of Basotho. For example, if one sets the contribution cap at M 800 for the employee's contribution, this means that anybody above a monthly salary of M 32,000 would pay a contribution rate less than 5%.

Box 2:
Examples of health insurance costs for high income earners with a SHI contribution cap

<table>
<thead>
<tr>
<th>Example: Employee</th>
<th>a) Without a cap</th>
<th>b) with a cap of M 800</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For a family of four (2 adults, 2 children)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assumed monthly salary of an employee: M 50,000</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHI premium (at Momentum):</td>
<td>2508</td>
<td>2508</td>
</tr>
<tr>
<td>Option B &quot;Comprehensive&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHI Contribution</td>
<td>1250</td>
<td>800</td>
</tr>
<tr>
<td>2.5% of M 50,000 = M 1250, but cap of M 800</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difference between PHI and SHI</td>
<td>1258</td>
<td>1708</td>
</tr>
<tr>
<td>a) 2508 - 1250</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) 2508 - 800</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHI premium (at Prosperity):</td>
<td>996</td>
<td>996</td>
</tr>
<tr>
<td>Option &quot;Econ&quot; - Hospital Only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Savings through joining the SHI scheme</td>
<td>262</td>
<td>712</td>
</tr>
<tr>
<td>a) 1258 - 996</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) 1708 - 996</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.2. Pooling

5.2.1. Type of membership

In universal coverage schemes such as SHI schemes, prepayment is combined with spreading risk among members of a pool. This offers greater protection against high-cost expenditures and thus improves financial accessibility. For that matter, it is important that no population group is excluded and that the risk pool(s) are sustainable.

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22 Chapter 5.2. is fully is based on and cited from Carrin/James 2005.
However, if membership is voluntary, a serious implication is adverse selection, where high risks chase low risks out of the insurance market. This is because the same benefit package is offered to everyone in the pool, implying subsidization from low-risk to high-risk individuals, and from those contributing more to those contributing less - with richer individuals contributing more in absolute terms if contributions are based on an equal share of one's income. With voluntary membership, low-risk individuals may not decide to join the scheme.

Voluntary membership thus leaves a risk pool composed of mainly the higher risks. Further, new members might only enrol when they fall ill. The likely outcome is financial strain on the SHI fund: high-risk individuals are more likely to make demands from the benefit package, but contributions are insufficiently adjusted to this high-risk profile. Thus voluntary membership with risk pooling based on SHI principles may not be sustainable.

In countries with a large informal sector and a high poverty rate, gradual introduction of mandatory membership needs to be carefully planned. A decision needs to be taken how fast the informal sector could be included in the social health insurance scheme. The financial projections assume that coverage of the self-employed is extended across the country at a much slower pace, since more administrative and logistic hurdles have to be overcome.

**Assumption of the financial projections:**

*Membership is mandatory for civil servants and formal sector employees as well as pensioners.*

*Mandatory membership is gradually extended to the informal sector from Year 3, such that all Basotho are SHI members within 10 years.*

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Based on the discussions with the group of ministry officials that underwent training in SimIns, the financial projections assume that extension of coverage to informal sector workers is piloted in Year 3, with initially 10% of the informal sector joining the insurance scheme. In Year 5, a second pilot with another 10% could be added. Starting in Year 7, the simulation assumes that coverage is then extended to include everyone else within 5 years at the end of the financial projection period. The extension schedule as assumed for the financial projections is as follows:

- Year 3: first 10% (pilot)
- Year 5: next 10% (pilot)
- Year 7: next 15%
- Year 8: next 15%
- Year 9: next 15%
- Year 10: next 15%
- Year 11: final 20%

The detailed extension schedule and modalities as well as criteria on which informal sector population groups start joining need to be further developed, based on further stakeholder negotiations between the respective groups and civil society actors.
5.2.2. Membership basis

By including all dependants of civil servants, employees of private and public enterprises and other contributing groups, adverse selection is further reduced, whereas financial risk protection and coverage is increased. The membership basis is usually the family, i.e. parents and their dependants.

Assumption of the financial projections:
Membership is family-based and dependants are equally covered.

Further discussions are necessary to assess how orphans can be covered. Likewise, income earners who take care of their parents may wish to provide health insurance coverage to them, in case these do not receive a pension through which they would be a mandatory SHI member. How to determine whether grandparents live with their children to be treated as dependants and to be covered by the family insurance is a technical question that requires further analysis.

An important concern, though, is potential fraud in the form of individuals claiming to be dependants of a contributor when they are not. This can be resolved by clearly defining all of a contributor's dependants, for instance via individual health insurance cards for all beneficiaries and with photo identification.

5.2.3. Number of pools

Although a SHI scheme by definition pools risks, risk pooling is not complete, when there is fragmentation in risk pooling, i.e. when there are too many small risk pools. In this case, certain segments of the population, especially the low-income groups, may have less financial protection against health expenditures than others, as certain risk pools will receive a lower average contribution, leading to a more limited benefit package and restrictions on access. Thus minimizing the level of fragmentation enables a greater financial accessibility of health services for all.

SHI schemes can either be made up of multiple risk pools / multiple funds, or a single risk pool / single fund (the terms "risk pools" and "funds" are used interchangeably). In a single risk pool, all financial operations flow through it, even if there are branch offices, whereas in a multiple pool system each risk pool has its own financial fund. Single fund systems are attractive, because pooling is maximized, with all members' risks combined into one pool and with the right to the same benefit package. However, in a multiple pool system, the level of fragmentation can be reduced by risk equalization mechanisms, i.e. by shifting funds from low-risk pools to high-risk pools.

For the reasons explained above, and also given the size of the Lesotho population, it is suggested to consider one SHI pool only, rather than establishing a fragmented system with one fund for civil servants, another one for formal sector employees, and further fragmentation through small private health insurance schemes. Since there are also ideas
being developed around a Medishield scheme for formal sector employees, it is suggested to consider how these different plans could be merged, rather than ending up having several funds.

**Assumption of the financial projections:**

*There will be one single social health insurance fund, rather than multiple funds that would cover different member categories.*

There is also the risk for multiple funds to imply higher overall administrative costs, as each fund would have to establish its own core management functions, as such resulting in duplication. A single fund can be normally managed in a simpler and effective way. Administrative costs would thus be minimized, tantamount to achieving economies of scale in administration, so that a larger share of contributions will be spent on actual benefits. There is no danger of monopoly in a SHI scheme with one single fund, if well regulated and well overseen by a supervisory board (see Section 5.4.).

### 5.3. Purchasing

#### 5.3.1. Benefit package

As patients must receive the necessary health interventions, careful considerations are necessary what to include in the SHI benefit package. Subject to the financial feasibility constraints, the benefit package should be as comprehensive as possible, while at the same time be based as much as possible on explicit efficiency and equity criteria. Efficiency relates to cost-effective services included in the benefit package; equity refers to what and whose disease burden is primarily addressed, and whether the health interventions included in the package address the most severe health conditions. Efficiency and equity criteria and the way they are balanced against each other should also account for societal preferences and expectations. As such, it is important that there is an explicit and transparent process through which the benefit package is defined and through which it is clearly specified which services are excluded (cf. Carrin/James 2005).

In principle existing local infrastructure should be utilized wherever possible and care should be delivered close to where people stay and work. Therefore, it is assumed that outside Maseru, the majority of health care needs will be met through GOL and CHAL facilities. Yet, widespread acceptance of the SHI scheme and of paying contributions will be contingent upon substantial service and quality improvements within government and CHAL facilities. Less is known about the (technical) quality of private providers, but patient surveys also revealed dissatisfaction with private providers (KOL 2002), hence quality assurance, quality improvement as well as close regulation and monitoring would be required for all providers.

If needed services in Lesotho are not available or perceived unsatisfactory, particularly the civil servants will consider their contribution rate as a payment with very limited benefit in return, contrary to their expectations of deserving an extra benefit in their remuneration package. On the other hand, if open access to South African health care
services are included in the benefit package before the new PPP QEII is functional, it will be very hard to break the institutionalised pattern of utilization and expenditure for health care in South Africa. Yet, it is also clear that health care in South Africa cannot be financed by the scheme except for specific IP referrals that are issued and monitored by QE II. The rationale for including rationalized referral for inpatient care in RSA into the benefit package is also based on the considerations of the QEII PPP feasibility study report. It states that the new QEII PPP may not be able to offer all specialized tertiary care services, and hence there may be a continuous need for referrals to RSA.

Given the expectations of salaried employees regarding the benefit package, ways must be found of integrating the private sector providers' services into the benefit package.

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**Assumptions of the financial projections:**

The benefit package contains the following services:

- **Outpatient care at GOL, CHAL and private providers**
- **Inpatient care at GOL and CHAL hospitals**
- **Tertiary care at QEII**
- **Authorized referrals for inpatient care in RSA**

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Lesotho has defined an Essential Service Package, which covers essential public health interventions, communicable disease control, sexual and reproductive health and essential clinical services (MOHSW 2003). The SHI benefit package could be based on this Essential Service Package, but it is advisable that the MOHSW and SHI TWG discuss and spell out the key priorities, preferences and criteria on the basis of which the final benefit package is developed. In the financial projections, the services covered in the benefit package are all those being currently provided at the health facilities through MOHSW and CHAL funds.

Access to tertiary care should be limited and only possible through referral from lower levels. There is need to closely regulate and monitor referral to RSA only for services that are not available in Lesotho and that are part of the benefit package.

During the feedback workshops with stakeholders, the question was raised whether ART and care for the chronic sick would be included. To answer this question, two critical steps are necessary:

1. Unit costs and utilization rates need to be known for pre-ART and ART services as well as for chronic disease care.
2. Once known, these figures should be included in the SimIns financial projections to see whether covering these services is affordable at the current levels of contribution rates (or whether it would require higher contribution rates, or other extra income for the SHI fund in order to break even).

Some costing studies for ART services have been undertaken (MOHSW 2007d, Cleary 2007). Based on this data, Chapter 6.1.4. provides a financial projection including ART services.
Given that various donor organizations are currently supporting the GOL in scaling up ART services by setting up the management and financial structures, it is recommended to continue this way, at least over the medium run, and provide ART outside the SHI scheme, rather than interrupting these current efforts. Furthermore, since the informal sector (about two thirds of the population) would only be covered by the SHI scheme gradually over the years, the majority of those in need of ART would not even be able to benefit from ART if it were integrated into the benefit package.

Similar calculation proceedings are suggested for any other specific health care intervention that is considered for integration in the benefit package. More detailed financial costing and actuarial analysis may be necessary to assess the implications of including additional and more specific services that are currently not included in the Essential Service Package, such as lenses or prostheses. Based on such analyses, a decision can be taken on whether and when to include these in the benefit package.

Respondents also mentioned that many people use traditional healers when seeking care. There is little official data on them regarding the types of services offered, their total number, their cost structure, their treatment success rates and quality of care etc. During the meeting with the members of the Executive Committee of the Traditional Health Practitioners' Council, the number of traditional healers was estimated at 10,000-15,000, which would imply that there is 1 healer per 120-150 Basotho, a rather high figure. Further, it remains unclear whether these are all registered with the Council. So far, there are no District Councils in place, hence no organizational structures beyond the national Committee. The Council has got an office within the MOHSW, and institutional relations have increased over the past years. The MOHSW has provided training on HIV/AIDS (symptom identification, referral) to some 300 traditional healers.

According to the Executive Committee, there is no clear differentiation among traditional healers: They all engage to varying extent in herbal medicine, bone setting, evil spirits/spiritual healing and other methods to treat physical or psychological suffering and social relations. Some of the traditional practitioners, however, are specialized.

The following factors make it particularly difficult to further consider integrating traditional healers' services into the SHI benefit package:

- Traditional healers’ services are not only health-related, but cross into other fields of rectifying social relations and evil spirits.
- As long as there is an absence of data on cost-effectiveness of traditional healers’ medical services, it would be incoherent to include such services, or a subset of them, in an Essential Service Package established on the basis of important criteria such as cost-effectiveness.
- It remains unclear how they can be contacted in a systematic way. As they work as individuals (without a bank account), it is difficult to integrate them in a modern streamlined provider remuneration payment system.
- Even though their training follows certain rules within the Council, it would be very tedious to accredit their services for quality assurance purposes.
If the MOHSW wishes to undertake further efforts and reflections with respect to integrating traditional healers' services in the SHI benefit package, it may be useful to analyse the experience of other countries. For example in Ghana, selected traditional healers' services have been included in the benefit package, if they meet certain standards.

5.3.2. Strategic purchasing and provider payment mechanisms

The introduction of a social health insurance scheme provides the opportunity of strengthening strategic purchasing, i.e. the systematic and continuous search for the best ways to maximize health system performance by deciding what should be purchased, how and from whom. This entails finding the best and most context-appropriate provider payment mechanisms. Each purchasing approach and payment mechanism has advantages and disadvantages. Adding or combining elements of different provider payment mechanisms can help strengthen incentives to achieve efficiency, equity and quality in health care (cf. Park et al. 2007). Strategic purchasing also often involves a purchaser-provider split.

As outlined in Chapter 3.8., some initial steps were undertaken in the direction of strategic purchasing within the current health care provider remuneration system. Administrative and financial management capacities need to be further built up both at GOL hospitals, the DHMTs, the CHAL hospitals, as well as the CHAL Secretariat and the relevant MOHSW divisions in charge of financial management.

Among all providers, there is clear recognition that any provider remuneration scheme must be simple to administer to take into account the existing administrative capacities and to avoid fraud. Hence, given the currently available administrative skills (small financial management/accounting teams in each hospital and DHMTs) and in the absence of a computerized and network system, it appears best to build upon the current practice of provider payment within the existing payment transfer/banking infrastructure, at least for the initial years.

The current practice of quarterly budget transfers to DHMTs and government and CHAL hospitals could be developed and translated into a capitation system, which could also be combined with a flat case payment for specific, relatively costly health services and emergency services. In other words, the amount and allocation of funds from the MOHSW to GOL and CHAL hospitals and DHMTs (for health centres) would continue; both GOL and CHAL facilities would receive additional resources through the SHI scheme. Related to private health care providers, a similar payment mechanism system could be designed.

The detailed payment structure and managerial proceedings need to be elaborated to ensure that GOL and CHAL health facilities receive their facility income through both the existing channel of MOSHW budget transfers and the new capitation/flat payment system in parallel. This includes establishing or strengthening clear accountability channels for heads/managers of health facilities.
It is important to note the disadvantages of a fee-for-service remuneration scheme, especially related to curative health services. The incentive of a fee-for-service scheme is for health care providers to deliver as many services as possible, resulting in over-provision that is unnecessary and often clinically detrimental. Apart from the administratively burdensome claims handling and management as well as the lack of a cost-containment incentive, the fee-for-service scheme places the uncertainty of expenditure levels solely on the insurance scheme, i.e. the beneficiaries. The latter would have to cope with increased expenditure through increased contribution rates and/or increased co-payment rates, ultimately making health care unaffordable.

In an alternative institutional setting, the MOHSW financial resources could also be channelled to the SHI agency directly that then assumes the role of a sole purchaser of health services. For hospitals and health centres to make efficient use of the additional resources gained from SHI, i.e. for quality increases, they require a certain degree of autonomy to decide how they best spend their funds. As such, it may also be necessary to think about the (new and modified) roles of the DHMTs within a SHI scheme.

It is also important to keep in mind that the financial projections are based on the assumptions that resources from co-payments go to the health providers and hence are not remitted to the Treasury.

As emigration of health workers is a huge problem in Lesotho - due to reasons of relatively lower salaries than in surrounding South Africa as well as poor working environments among other factors - it is advisable that a share of the additional provider remuneration funds coming from SHI is used for staff motivation purposes and performance related bonuses to staff.

5.3.3. Setting provider remuneration rates

Setting provider remuneration rates is a complex task. Depending on the differences of rates for different services, providers may be inclined to change their provider behaviour towards those services with higher remuneration rates. Provider remuneration rates must take into account unit costs. Often, these are not known. The Omnibus study currently under way is therefore very important to get precise data on unit costs of different services at different levels as well as utilization rates, particularly of private sector providers. But a one-off costing exercise is not enough. Ideally, unit costs are assessed and re-examined on a regular basis in order to review provider remuneration rates accordingly.

For the financial projection scenarios, the mission team relied upon the results of the costing study for CHAL and government services, which was undertaken by the Boston Health Alliance for Lesotho (Boston Medical Centre 2006). No cost figures were available for the private sector. Unit costs for outpatient care at private providers therefore had to be estimated on the basis of current user charges. With shorter waiting times and more time spent on each patient - quality aspects highly appreciated by
respondents, the unit costs (and thus payment rate) for private providers are set at a higher rate than the unit costs for government and CHAL providers in these financial projections.

**Assumption of financial projections:**

*Unit costs express full costs for outpatient and inpatient services.*

*The necessary increase in quality at GOL and CHAL providers is built into the financial projections by augmenting the provider remuneration via increased unit costs by 50% over 5 years. For private providers, this increase amounts to 20%.*

This increase in funding health care services allows for the necessary inputs for quality improvements (e.g. improved drug availability, more staff, motivated staff, etc.). It is an ambitious challenge to ensure that the resource increase will actually translate into substantial quality improvements. More detailed analysis is necessary to be able to setup an implementation plan for the required quality increases. If the MOHSW considers such quick and substantial quality improvements not feasible, adjustments to the financial projections need to be made.

5.3.4. Contracting

In principle, all providers could be eligible for being contracted and accredited as a service provider for SHI members, for a specific range of services subject to their qualification and available equipment and under the condition that they meet certain quality standards.

Purchasing could hence be based on well developed contracts that spell out the obligations and rights of both providers and the main purchaser, i.e. the SHI agency. Contracts should be clear on the following aspects:

- Provider remuneration mechanism
- Provider remuneration rates
- Claims management and payment transfer process
- Payment schedule
- Accreditation and quality management measures
- Surveillance, utilization reviews and claims control
- Monitoring and enforcement processes

Likewise, such a contract needs to specify the co-payment schedule. Providers should then not be allowed to charge patients beyond the agreed co-payment schedule.

5.3.5. Accreditation and quality management

The existing accreditation scheme is a strong asset in the endeavour to introduce strategic purchasing and appropriate provider payment mechanisms that set the right incentives to providers. Increasing the quality of care at the various provider types is of great
importance to make the new SHI scheme acceptable and attractive and thus sustainable. The accreditation scheme therefore plays a crucial role in the efforts of improving quality. Accreditation and attainment of defined accreditation and/or quality management standards could be a contractual obligation for all providers types and could also serve as one determining factor to set the final remuneration rate. When private health care provision is part of the benefit package, private providers should equally be accredited.

5.3.6. Co-payments

There is a certain tendency for insured individuals to use more services than needed or than if they were not insured, especially if services are easily accessible geographically or in the event of low risk illnesses. This tendency, called moral hazard, raises the costs of coverage. Co-payments are one form to counteract this problem, but careful consideration is necessary to determine their levels in order to avoid introducing again financial barriers to necessary health care.

**Assumptions of financial projections:**

*In line with the government plans, there are no co-payments charged to access outpatient care at government and CHAL health centres.*

*Co-payments are levied at the outpatient department of GOL and CHAL hospitals, as people should ideally first use health centres.*

*Even though moral hazard may be rather weak, co-payments are levied for inpatient care at GOL and CHAL hospitals and at tertiary care level; this is for financing reasons.*

*Co-payments for outpatient care at private providers will be levied, which are higher than those at outpatient departments of GOL and CHAL hospitals. The co-payments at private providers reflect the approximate difference in unit costs.*

When self-referring to tertiary care, additional co-payments could be levied. It could be considered whether there is a maximum total annual amount of co-payments to be made by members. Particularly the chronic sick may require and benefit from such a rule.

Government stakeholders were concerned about civil servants in Grade A and B, who encounter barriers to accessing health care as they are unable to pay the current co-payment rates. The new co-payment rates are lower, but also net income of these civil servants is slightly lower given that they would pay SHI contributions. The same may be true for other low-income earners or informal sector workers.

5.4. Governance and management of the SHI fund

The governance and management of any new SHI requires careful design to make it both acceptable to the population, the various stakeholders and interest groups, as well as to ensure effective and efficient functioning. A central question here is the degree to which
the SHI operates within or outside government institutions. This question should be looked at firstly in terms of governance and secondly in terms of management.

5.4.1. Governance structure

As any SHI agency, whether run by a private or parastatal company, would be mandated by the government and would be given the task to work for the benefit of the country of Lesotho, final oversight and stewardship over SHI would be expected to be provided by government. However, based on the stakeholder consultations, it appears important to give other stakeholders their fair share of influence over the functioning of SHI. These stakeholders would include representatives from health care providers, associations of health professionals, the employees (e.g. professional associations for civil servants, formal sector employees, unions) and the employers, as well as the self-employed and the rural population. These, plus government representation (from MOHSW, the Ministry of Finance, the Ministry of Public Service, Ministry of Labour, and others) could be grouped together in a Board that would have certain powers pertaining to appointment of key positions at the SHI, determination of the benefit package, the provider remuneration system, contribution levels, and exemptions, among others.

Given the above, the ownership and governance of such a SHI agency would be of parastatal nature. A clear framework regarding decision-making power and regulation setting needs to be established to clarify the division of labour between the Government and such a board. This would also require legislation.

5.4.2. Management structure and administration

As to the management, the options of integration into or independence from government are much more diverse, from operating as an organizational unit of the MOHSW to being outsourced to a fully private, and profit-making, firm. The consultations undertaken during the first mission indicated a strong preference for a SHI management that is largely independent from government and rather privately run. The reasons cited where the hope for a more efficient management and a lower risk of corruption. Going down this path would, however, also necessitate building in a strong incentive for a private firm to take on this management function in an efficient way. Obviously, the private management agency would need to keep a share of the SHI income as a remuneration for its management activities.

Another option, often used in mature SHI systems, may be to designate the SHI to be of parastatal status. While individual subdivisions could have financial incentives for effective purchasing and good financial management of the fund, the overall organization would have a non-profit status, its stated mission and objective being the eventual attainment of universal coverage.

In light of the size of the SHI fund (as to the overall number of members), it appears advisable that - instead of outsourcing specific sub-functions - all management tasks be
kept under one roof, i.e. the administrator and insurance functions would not be separated. This is because management and administrative tasks relating to resource mobilization, pooling and purchasing are strongly interlinked. Hence, outsourcing some of them increases transaction costs, which have to be assessed against the potential efficiency gains of outsourcing them. There would be one exception to this, namely the collection of contributions (compare Chapter 5.1.3).

Operating a social health insurance scheme entails a huge number of different managerial and administrative tasks, such as:

- Information provision to new members and consumer education
- Member identification in the formal sector
- Registration and enrolment of formal sector employees
- Collection of contributions from formal sector employees
- Monitoring that employers register employees as members and deduct contributions
- Member identification in the informal sector
- Registration and enrolment of informal sector workers
- Collection of contributions from informal sector workers
- Determining which informal sector workers are exempted from contributions
- Pooling of resources
- Negotiation with health providers
- Purchasing and contracting
- Provider payment and claims management
- Claims review and surveillance
- Accreditation and quality management

Other general tasks include:

- Planning
- Budgeting
- Actuarial analysis
- Financial management and monitoring, accounting and auditing
- Information and data management
- Monitoring and enforcement

Staff with adequate skills in these areas need to be available. Fund managers should have incentives for effective purchasing and good financial management of the fund.

5.5. Administration costs and reserves

Administration costs of a SHI scheme are in general difficult to estimate, more so during the initial years, as each country setup is unique, thus implying different cost factors. However, administrative expenditure from other countries can provide some indication and guidance. Whereas in developed countries, average administrative costs amount to a maximum of 6-7% of expenditure, costs are higher for developing countries, particularly in the first 10 years, for a number of reasons, including a less developed IT infrastructure.
For developing countries, administrative costs are estimated to range from about 10-15%. These would exclude setting up the infrastructure in the initial introductory phase, such as building, computers, communication systems and other fixed costs. In line with the recommendation to keep the provider payment mechanism and payment system administratively simple, at least initially, and given that during the first few years, only the formal sector employees, including civil servants as well as pensioners, will be registered, it is suggested to set administration costs at a maximum of 12.5% of total SHI expenditure.

Health insurance schemes are faced with an inherent uncertainty regarding their expenditure and incomes. For example, epidemics may temporarily increase utilization rates and hence expenditures, or downturns in the economy may temporarily reduce the contributions collected. Setting aside reserves to protect against this inherent uncertainty is an important measure for a health insurance to remain financially solid. It is suggested to set reserves at 4% of total health insurance expenditure.

**Assumption of financial projections:**
Administration costs amount to 12.5% of total health insurance expenditure. Reserves are set at 4% of total health insurance expenditure.

### 5.6. Regulatory framework and a SHI Law

The current Insurance Law dates from 1976 (with amendments in 1981), and various respondents referred to it as being inappropriate and out of date given the challenges faced in 2007. A new Insurance Law is currently being developed. This process is driven by the Central Bank, which has a strong interest in this order to be more in line with and prepared for the SADC protocols and the liberalization process. At the same time, the new Law is also intended to give more regulatory power to the Central Bank. The new law will have a stronger focus on consumer protection. It is also said to have a section on health insurance (this needs to be checked).

A Social Health Insurance will not fall under this Law. Yet, the establishment of a SHI fund for whatever population groups requires regulatory action in the following areas:
- Ownership, governance and management of the SHI fund
- Membership basis (SHI for all Basotho or for specific groups only)
- Mandatory membership
- Extension of coverage
- Setting of contribution rates
- Collection of contributions
- Decision on whether income tax is deducted before or after deduction of SHI contribution
- Benefit package definition
- Contracting of providers
- Setting the provider remuneration scheme
- Setting provider remuneration rates
- Claims management procedures
- Specific complaints mechanisms procedures
- Accreditation of health care providers
- Quality management requirements within the contract
- Surveillance and claims review (including peer review)
- Benefit package consumption (complaints mechanism, patient appeals mechanisms)
- Investment of SHI funds

Passing several separate regulations and administrative orders in these areas leads to a fragmented regulatory framework with high transaction costs and is threatening to be incoherent and providing regulatory loopholes. To overcome this risk, developing a new, comprehensive SHI Law is necessary.

As outlined in Chapter 4.4.4., legal provisions for a SHI scheme could be part of a wider Social Security Act. But given that SHI is not only for the workforce, but for all Basotho, it is recommended to develop a freestanding SHI Law, jointly with MoL and MoPS as well as MoF. Such a specific SHI law would still allow to link and integrate SHI into a wider Social Security concept.

Furthermore, the government needs to specify the role of private health insurance companies. It needs to decide whether and if so to what extent it will recognize and integrate PHIs into its health system. As the calculation examples of Chapter 5.1.5. showed, the very high-income earners could keep up their level of insurance coverage under a SHI scheme. Their basic package would be covered by the SHI, whereas the top-up package could be offered by PHIs.

If PHIs are allowed to provide a full package (including the basic package), i.e. if the PHI role is defined not merely as supplementary health insurance, the issue of risk equalization mechanisms between the PHI and the SHI scheme becomes relevant. In particular, one would need to clarify how to deal with those employers, employees and civil servants that have taken out a private health insurance.
6. Financial Projections

A number of financial projections were made using the WHO-GTZ health insurance simulation model SimIns (version 2) to assist the TWG in designing a SHI policy that is financially feasible. Based on the stakeholder consultations during the first mission, two strategic directions were explored initially. These were presented and discussed with the MOHSW and other stakeholders during the second mission to then prepare a third scenario presented in this report. The two initial scenarios are referred to as:

- Scenario A “SHI for all” and
- Scenario B “SHI for the formal sector only”.

Scenario A focuses on a health insurance that covers the entire population (with gradual extension to universal coverage), whereas Scenario B analyses a social health insurance for the formal sector only. These two scenarios are presented in Annex 3.

From the stakeholder feedback during the second mission, it became clear that Scenario A resonated more among them, however there were some concerns, especially with respect to the speed of coverage extension to the informal sector. Therefore, the third scenario takes this and other issues into account. We refer to it as Scenario A+ “Phased SHI for all Basotho”. As its name suggests it is based on the preliminary Scenario A and also projects the results of eventually achieving full coverage of the population with SHI. In doing so, it applies some adjustments from the original Scenario A, such as a slower expansion of coverage of the informal sector and provisions for improved quality of health services within a shorter time. Table 19 at the end of this chapter provides a summary overview of Scenario A+, A and B.

The projection presented here provides a first approximation of the directions that policy-makers are considering. It is important to note that as policy formulation progresses and new ideas are being developed, these scenarios need updating to reflect such changes and continue to inform policy makers about the financial side of their plans. It will be a continuous task for the SHI TWG to fine-tune data inputs and to use the results of such projections for dialogues with partners and policy makers. We consider simulation projections as valuable inputs for ongoing policy discussion processes and not just one-off exercises.

**Scenario A+: "Phased SHI for all Basotho"**

6.1. Description of Scenario A+

This simulation projects the financial results for a potential social health insurance system for Lesotho that eventually covers the entire population (after an initial period of increasing coverage). It has the following key characteristics, the rationales of which have been outlined in Chapter 5. All assumptions and input figures used for the financial projections are further outlined and explained in Annex 4.1.
Financial projections are made from Year 1 to Year 11. The base year is 2008 (= Year 1) for which wages, prices, population figures etc. of earlier years have been projected. If the scheme will be initiated later, baseline figures have to be adjusted accordingly.

Coverage and contributions
• In Scenario A+, everyone in Lesotho is eventually covered by the same social health insurance system, and universal coverage (i.e. 100% population coverage) by this scheme is achieved within 10 years (see Figure 1 and Table 14 for SHI coverage).
• Coverage is for the whole family
  Formal sector:
  • Coverage for the formal sector increases rapidly in this scenario: the entire government sector is covered immediately. Half of the employees of the formal sector (e.g. the garment industry) are covered in the first year of the projection period, and after two more years every formal sector employee is covered (i.e. 100% of the formal sector workforce).
  • (Formal sector) pensioners are covered at the same rate as government employees, i.e. all within the first year of the projection period.
  • Government and formal sector employees as well as pensioners pay a contribution rate of 2.5% of their salary (or pension). This is matched by their employers, except for pensioners, as there is no employer for them.
  • For this financial projection, it was assumed that contributions are calculated from gross salaries.
  Informal sector:
  • Coverage of the informal sector (which includes the rest of the population) is extended across the country at a much slower pace, assuming that more administrative and logistic hurdles have to be overcome. It is assumed that it will take at least 7 years to reach any significant coverage levels of this part of the population.
  • Based on the discussions with the group of ministry officials that underwent training in SimIns, the financial projections assume that extension of coverage to informal sector workers is piloted in Year 3. The following extension schedule was assumed for the financial projections:
    Year 3: first 10% (pilot)
    Year 5: next 10% (pilot)
    Year 7: next 15%
    Year 8: next 15%
    Year 9: next 15%
    Year 10: next 15%
    Year 11: final 20%
  • For the informal sector, a flat amount is set as contribution for the whole family. It was assumed that about half of current average out-of-pocket expenditure for health services of Basotho households can be considered to be within their ability to pay. This flat payment starts at M 450 per year and is adjusted regularly for inflation over the 10 year projection period.

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23 To avoid confusion, note that SimIns calls this population group the “self-employed”.

60
The SHI members from the informal sector who are poor are exempted from paying contributions and co-payments. Assuming that the poor are based within the informal sector, this translates into an exemption rate of informal sector workers of 75% (compare Chapter 5.1.2, Footnote 19).

Given the above extension schedule, about half of the total population would be exempted by the end of the projection period, as Table 14 shows, which corresponds to the proportion of the population classified as poor in Lesotho (KOL 2006a).

### Table 14: Population coverage

<table>
<thead>
<tr>
<th>Year</th>
<th>Population covered</th>
<th>Population exempted</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>454,488</td>
<td>0</td>
</tr>
<tr>
<td>2009</td>
<td>578,553</td>
<td>0</td>
</tr>
<tr>
<td>2010</td>
<td>844,315</td>
<td>99,990</td>
</tr>
<tr>
<td>2011</td>
<td>1,002,312</td>
<td>100,902</td>
</tr>
<tr>
<td>2012</td>
<td>1,197,528</td>
<td>362,250</td>
</tr>
<tr>
<td>2013</td>
<td>1,411,785</td>
<td>521,645</td>
</tr>
<tr>
<td>2014</td>
<td>1,628,558</td>
<td>682,099</td>
</tr>
<tr>
<td>2015</td>
<td>1,847,977</td>
<td>843,923</td>
</tr>
<tr>
<td>2016</td>
<td>2,140,357</td>
<td>1,061,785</td>
</tr>
</tbody>
</table>

### Benefits and co-payments

- The same benefit package is made available to all members, as outlined in Chapter 5.3.1.
- The co-payments as assumed in the simulation are in line with the planned co-payment policy by the MOHSW, which envisages that co-payments at GOL and CHAL facilities are the same and roughly half of the current GOL levels, ranging from 2.5% to 23.5% (Table 15).
- With the start of SHI, utilization rates are assumed to increase in Year 1 relative to current levels due to lower co-payments.
Use of outpatient care at private providers comes with a higher co-payment rate of M30 per visit, given higher unit costs and higher remuneration rates at private health care providers (see Table 15).

Costs

- Unit costs for the different service categories used for the financial projections are listed in Table 15.
- Outpatient care at private providers is remunerated at a higher rate than outpatient care at GOL or CHAL providers given assumed higher unit costs due to higher quality. (compare Chapter 5.3.3.).
- Scenario A+ assumes that costs (and hence payments) for GOL and CHAL health services will increase by 50% over the first 5 years of SHI implementation (in constant prices, i.e. on top of inflation). This represents the increased funding of the health system through SHI introduction in Year 2, the primary purpose of which is to improve quality of care and ultimately health outcomes.
- Payments for private sector facilities will also increase, but only by 20%, since their remuneration started already at a higher rate and since the need for quality improvements is not that large.
- After 5 years, the remuneration rates for outpatient care will be the same at GOL and CHAL outpatient departments of hospitals and private providers, as it is assumed that the level of quality will then be the same. Importantly, this scenario assumes that the budgets paid to GOL and CHAL facilities for curative care from the MOHSW remain in place (in constant prices). That is to say, MOHSW maintains its funding of a large share of the provision of health care services through the current financing system – and this level of funding stays constant.

The SHI is then expected to finance the additional health care expenditure resulting from the substantial quality increases, which are required to make services more acceptable and to bring them to more appropriate standards, as outlined in Chapter Chapter 5.3.3. Hence, the expenditure for providing health services is initially funded entirely by the MOHSW budget and direct payments by households (co-payments), whereas by the end of the simulation period, health costs are funded by the MOHSW budget, co-payments and the SHI. Figure 2 illustrates this point, showing that the MOHSW budget (in green) is maintained at the same level over the projection period, while the SHI brings in additional funding (in red).
Figure 2: Funding shares from constant MOHSW budget, SHI and co-payments for curative health care

Table 15: Unit costs for health services and co-payments

<table>
<thead>
<tr>
<th>Health service</th>
<th>Unit costs in Year 1 (in 2008 Maloti)</th>
<th>Unit costs in Year 11 (in 2008 Maloti) increases for quality improvements</th>
<th>Co-payments in Year 1 (in 2008 Maloti)</th>
<th>Co-payments (as % of unit costs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health centre outpatient</td>
<td>64</td>
<td>96</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Hospital outpatient</td>
<td>104</td>
<td>156</td>
<td>5</td>
<td>4.81%</td>
</tr>
<tr>
<td>Hospital inpatient (per day)</td>
<td>424</td>
<td>636</td>
<td>10 per day</td>
<td>2.36%</td>
</tr>
<tr>
<td>QEII outpatient</td>
<td>128</td>
<td>192</td>
<td>10</td>
<td>7.81%</td>
</tr>
<tr>
<td>QEII inpatient (per day)</td>
<td>553</td>
<td>830</td>
<td>20 per day</td>
<td>3.61%</td>
</tr>
<tr>
<td>Private outpatient</td>
<td>128</td>
<td>154</td>
<td>30</td>
<td>23.44%</td>
</tr>
<tr>
<td>RSA referrals (per case)</td>
<td>5763</td>
<td>5763</td>
<td>0</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

24 Co-payments were set as flat figures on the basis of the government user charge policy, which renders these percentage figures in the right column.
Other variables: Reserves

- 4% of total SHI expenditure are set aside each year as reserves to protect the SHI scheme against uncertainties of lower than estimated revenues or higher than planned expenditure.
- It is assumed that 50% of each year's reserves will actually be used for unexpected (higher) expenditures. The other 50% of the previous year's reserves are therefore remaining and are considered as income in the following year.\(^{25}\)

6.2. Results and implications of Scenario A+

6.2.1. Equity and solidarity

Scenario A+ is designed with the goal of achieving universal coverage and assumes that the SHI can be extended to cover the entire population after a 10 year expansion period. It contributes in an important way to achieving equity in access and in financing (cf. WHO 2005) because

- Everyone is (eventually) covered with the same access to the same benefit package
- The poor are exempted from paying contributions nor co-payments.
- Contributions are related to capacity to pay. i.e. everybody pays the same share of one's salary, the only exception being the flat contribution amount for those informal sector workers that are not exempted.

As such, health financing is characterized by a strong element of solidarity, as those with higher incomes pay more (in absolute terms).

While out-of-pocket expenditure is relatively low in Lesotho, it may still afflict on certain population groups. A SHI would improve this only once these population groups are included in its coverage and to the extend that fees are waived for them. To afford this, their health service usage will ultimately have to be financed from the contributions of the formal sector and the MOHSW budget. This is in contrast to alternative insurance suggestions that would allow the better-off to purchase private health insurance (often referred to as “Medical Aid Scheme”). Such schemes would not improve equity in financing or financial risk protection to the poorest. Some of the key differences between PHI and SHI are outlined in Table 10 in Chapter 3.7.

6.2.2. Financial feasibility

Scenario A+ charts a way to universal coverage of all Basotho with one social health insurance that appears to be financially feasible at least in its initial years under the assumptions and requirements set out above. However, these should be examined closely:

As illustrated by Figure 3, Scenario A+ comes with a large surplus of the SHI in its first 7 years. Only afterwards would the insurance run into a deficit under these circumstances.

\(^{25}\) For SimIns technical reasons, the use of reserves for SHI income purposes is entered as "other contributions" to the SHI.
The explanation for the arising deficit after 7 years is that the SHI is covering increasingly more beneficiaries from the informal sector who do not pay as much in contributions as they cost to provide health services to. This is the financial manifestation of an equity effect inherent in social health insurance, whereby the better-off subsidize the poor, and the healthy subsidize the sick. The simulation thus helps to analyse the financial implications of such a system, including how much solidarity is financially feasible. This deficit would continue beyond the projection period, but it would not be expected to grow much wider since universal coverage has been reached by then. A way of balancing it needs to be found, however.

**Increasing contribution rates and using the accumulated surplus for balancing**

If formal sector members pay a constant 5% contribution rate, the deficit arising after around 7 years, could be funded by using the accumulated surplus of the initial years, assuming good savings management. Scenario A+ projects a cumulative surplus (including interest) of over M 550 million from the initial 7 years. With deficits growing to about M 70 million per year, this suggests that the SHI may be able to live off those savings for another 5 to 10 years after the deficit arises. While this is certainly an option to keep in mind, there are several caveats to consider. Firstly, it is only a temporary solution and sooner or later the SHI must find other options to remain financially viable. Secondly, it may be imprudent to raise funds from the population only to spend it on their health in the future. These people themselves are likely to be in a better position to use their incomes for more productive purposes. Finally, the danger of imprudent or illicit use of large sums in what is essentially a savings account cannot be dismissed.

Another option is to peg contribution rates dynamically to SHI expenditures so that they go up when expenditures rise and go down when expenditures decrease. This would avoid both a large surplus in the initial years and a deficit in later years, but it would make the subject of the level of contribution rates a much more contentious issue. International experience indicate that under such a system, contribution rates will usually increase and only rarely decrease. Whether several such increases are politically acceptable and feasible is a question for the policy makers to contemplate. Figure 4
shows the SHI financial feasibility with contribution rates set to balance out expenditure. They would start at 2% in Year 1, and then increase by a percentage point every two years, thus reaching 7% in Year 10 (always shared 50/50 between employee and employer). When the Government decides to introduce SHI as a new health financing scheme, it may well prefer to set a higher contribution rate rather engaging in a political process and negotiations every two years. Furthermore, the question is whether the formal sector workers are willing to pay contributions at a rate of 7%.

Figure 4: Increasing contribution rates from 2% to 7%

Financial Feasibility of the Health Insurance Fund
NGU (in thousands), constant prices

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Income</th>
<th>Total Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>43327</td>
<td>9976</td>
</tr>
<tr>
<td>2009</td>
<td>49910</td>
<td>23016</td>
</tr>
<tr>
<td>2010</td>
<td>85827</td>
<td>61457</td>
</tr>
<tr>
<td>2011</td>
<td>93419</td>
<td>71954</td>
</tr>
<tr>
<td>2012</td>
<td>131563</td>
<td>112353</td>
</tr>
<tr>
<td>2013</td>
<td>137041d</td>
<td>140783</td>
</tr>
<tr>
<td>2014</td>
<td>183066</td>
<td>171537</td>
</tr>
<tr>
<td>2015</td>
<td>196031</td>
<td>202820</td>
</tr>
<tr>
<td>2016</td>
<td>243440</td>
<td>234466</td>
</tr>
<tr>
<td>2017</td>
<td>261096</td>
<td>266499</td>
</tr>
<tr>
<td>2018</td>
<td>315798</td>
<td>308162</td>
</tr>
</tbody>
</table>

Other options for balancing the budget
Using accumulates savings in the medium term or dynamically linking contributions to expenditures are two options to achieve a balanced SHI budget. What follows is a list of other alternatives to choose from, namely by either increasing the revenue of the SHI or decreasing its expenditure.

Expenditure can be decreased by:
(a) Lowering provider remuneration (i.e., lower unit costs) or reducing the benefit package:
   Unless better data on how much health services cost to deliver becomes available, it would not be prudent to assume that the cost used in the simulation could be lowered. As a primary objective of SHI is to raise funding that can be used to improve services, reducing provider remuneration or the benefit package would be inconsistent with this goal.
(b) Lowering provider remuneration via increased co-payments:
   Co-payments and user fees have a negative impact on equity and increase the risk of catastrophic expenditure. Therefore, this option is discouraged. Also, given the low

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26 As outlined in Chapter 4, a 7% contribution rate (i.e. 3.5% for the employee and 3.5% for the employer based on 50/50 sharing) is still within the acceptable range as revealed during the stakeholder consultations with potential beneficiaries.
income levels of the population, the additional amount that could be generated through co-payments would be negligible.

Revenue can be raised by:
(c) Increasing the contribution rates of the informal sector or exempting fewer of them from payment:
Small adjustments may be possible, however, overall there is little scope for extracting more payment from the informal sector. This is because the predominant characteristic of this population group is that they do not earn much. Requiring higher contributions or exempting fewer people from payment will at a certain point simply lead to more persons defaulting on their contribution payment and being exposed to catastrophic expenditure when falling ill.
(d) Providing government subsidies to the SHI (e.g. by introducing earmarked sin taxes):
Subsidies from the government budget could come from tax revenues and/or donor funding.

Importantly, the alternatives are not mutually exclusive and can be combined to differing degrees to find the optimal solution. For example, contributions could be lowered in the initial years, but when they are increased only up to a maximum ceiling. Above that subsidies would be needed. The solution that is chosen is ultimately a political decision.

6.2.3. Government employer contributions to SHI

Apart from possible subsidies to the SHI, the government is expected to pay half of the contribution for public service officers in its role as their employer. This amounts to roughly M41 million in 2008 and increases to M54 million in 2018 (in constant prices) (see Table 16). The increase in constant prices is due to an assumed rise in the number of government employees.27 The cost to government for paying the employers’ half of SHI contributions for public service officers amounts to about 0.63% of total government revenue.

Table 16: Government contributions to SHI in its role as employer of public service officers, in ‘000 Maloti, constant prices

<table>
<thead>
<tr>
<th>Year</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments</td>
<td>40 652</td>
<td>41 871</td>
<td>43 129</td>
<td>44 420</td>
<td>45 754</td>
</tr>
<tr>
<td>Year 6</td>
<td>47 128</td>
<td>48 539</td>
<td>49 998</td>
<td>51 497</td>
<td>53 043</td>
</tr>
</tbody>
</table>

27 The assumed increase in government employees is 3%, as indicated by Central Bank of Lesotho 2007
6.2.4. The structure of health expenditure

Figure 5 below shows the resulting structure of total health expenditure in Scenario A+.

It can clearly be seen that health insurance expenditure (in red) takes up an increasing proportion of total health expenditure over the simulation period, owing to the increasing coverage. However, the expenditure on health by the MOHSW (in green) remains the dominant pillar of health financing throughout. In this figure, preventive and promotive health care expenditure is part of the MOHSW funding share. It is assumed that the budget for preventive and promotive health care is maintained at least, and hence the overall MOHSW budget increases due to inflation and population growth.

6.2.5. Resource flow

Another concern is where health insurance resources go to. It was emphasized during the first mission that additional resources mobilized through social health insurance should mainly flow into the GOL and CHAL facilities in order to finance the required quality improvements. In Scenario A+, an important part of the additional funds for health from SHI flow to the private sector. This is because a large share of health care provided at GOL and CHAL facilities is funded via the MOHSW budget. When looking at the total health care funding for curative health care, the funds flowing into the private sector constitute a smaller share. In fact, under the assumptions in Scenario A+, over 90% of total health care costs are incurred in GOL and CHAL facilities.
This is also explained by the higher co-payment for private services (30 Maloti), which is assumed to maintain a utilization rate that is skewed towards the formal sector who can afford the higher co-payments. Should the informal and rural population’s utilization of private services increase rapidly, i.e. if the co-payment rate of M30 for outpatient care at private sectors would not constitute a barrier, then larger amounts of the health expenditure from SHI would flow into the private sector.

6.3. Variants for Scenario A+

6.3.1. Decreasing MOHSW budget for curative care

As stated before (see 6.1. and Figure 2), the previous financial projection is built on the assumption that the budgets currently disbursed by the MOHSW to DHMTs and to hospitals remain in place and continue to fund a large share of curative health care provision at GOL and CHAL facilities. Taking account of possible changes in the economic and financial environment of the country, we provide the results of a modified projection. Under this variant, it is assumed that the MOHSW budget for curative care decreases by 15% (in constant prices). One factor influencing the governments spending abilities may be changes in the Southern African Custom Union (SACU), on which some of the Lesotho Governments’ income relies. It is assumed in this variant that these changes would lead to a reduction in government tax revenues.

Figure 6 below illustrates the consequences for the SHI fund, should government budgets to health facilities decrease by 15% while at the same time the quality and cost increases that form part of Scenario A+ are implemented.
Figure 6: Funding shares from decreasing MOHSW budget, SHI and co-payments (in constant prices)

Figure 7: SHI financial feasibility with a declining MOHSW budget

Under these assumptions SHI expenses grow faster and to higher levels thus amounting to a larger deficit (see Figure 7). The deficit would occur in Year 7, and by the end of the 10 year projection period, accumulate to almost M 350 million versus a deficit of less than M 150 million under Scenario A+, as outlined in Table 17. Assuming that contribution rates are fixed at 5% for the formal sector, the accrued savings may be
enough to balance that deficit until the end of the projection period. However, afterwards, one or several of the adjustments outlined in Chapter 6.2. would have to be implemented. To cover the deficit from member contributions only, for example, would mean increasing them to 9% of salaries (shared between employer and employee).

Table 17: SHI balance under declining MOHSW budgets versus Scenario A+

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scenario A+ with declining MOHSW budgets:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current year SHI deficit (Maloti)</td>
<td>-10.2 m</td>
<td>-37.3 m</td>
<td>-67.1 m</td>
<td>-94.5 m</td>
<td>-137 m</td>
</tr>
<tr>
<td>Scenario A+:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current year SHI surplus/deficit (Maloti)</td>
<td>+11.5 m</td>
<td>-6.8 m</td>
<td>-26.3 m</td>
<td>-41.7 m</td>
<td>-68.5 m</td>
</tr>
</tbody>
</table>

6.3.2. Including inpatient care at private providers into the benefit package.

During the second mission, it was asked whether inpatient care (IP) of private providers could be included into the benefit package and what financial implications it has. This section provides a revised financial scenario that projects financial feasibility of a SHI scheme with a benefit package that includes private sector inpatient care.

Currently, there is one private hospital in Maseru town called Maseru Private Hospital. The new QEII Referral Hospital may equally provide some beds in private wings, as suggested by Bicknell et al. (2002). No private inpatient care facilities are currently available outside Maseru in District towns. It is questionable whether additional private hospitals for inpatient care will enter the market, at least during the next 5 years. In the absence of more detailed data on utilization rates and unit costs of IP at private providers, we have to extrapolate from the available information as presented in Chapter 3.4.4. For the financial projections, the following assumptions are made:

Utilization rate:
The utilization rate for IP at CHAL and GOL was already assumed to increase from 0.02911 to 0.03719 due to lowered co-payments.

There are currently around 960 IP cases at Maseru Private Hospital (based on staff estimates, see Table 4). It is assumed that the inclusion of IP at Maseru Private Hospital in the SHI benefit package may further increase by 33%. Assuming that only the contributing members use Maseru Private, this results in a utilization rate of 0.00282. This utilization together with the above IP utilization rate is still below that of many other countries and hence appropriate.28

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28 The overall increase could be explained as follows: Informal sector workers in rural areas may start to use more IP of GOL and CHAL hospitals due to lower co-payment rates, whereas some contributing SHI members from both District towns and Maseru will switch to Maseru Private Hospital, access to which was facilitated due to co-payments that are only a proportion of the former user charges from OOPs. Alternatively, some may choose private wing facilities at QEII.
Unit costs:
Unit costs for Maseru Private Hospital are set at the same level as those for QEII IP, i.e. M 533 in Year 1 (2008).
No higher unit costs (and hence provider remuneration rates) are set for QEII private wings. It is assumed that additional expenditure for private wing facilities at QEII will be paid for through higher co-payments (see next paragraph).

Co-payments:
Co-payments at Maseru Private Hospital are set at M50 per bed-day, i.e. 9% of the unit costs. For private wing facilities at QEII, co-payments would equally increase to M50 per bed-day (instead of M20 per bed-day in a non-private ward at QEII). The higher co-payments serve two purposes:
On the one hand, they serve to control the utilization rates for IP at private providers. With no co-payment, most insured members would prefer and use IP at private providers rather than at district hospitals, if other opportunity costs (time and money to travel) are affordable. The second rationale of co-payments for IP at private providers is economic in order to ensure financial feasibility. As only the better-off would be able to afford these co-payments, it can be assumed that about two thirds of these admissions occur in the formal sector, and one third in the informal sector.  
These assumptions need to be discussed and reviewed once more precise information and data is available. Further aspects that may change the financial projections on the additional costs of including private IP into the benefit package include the following points:
- Unit costs for Maseru Private Hospital and services provided in QEII private wings may be higher or lower.
- Utilization of private sector IP services may be higher than assumed.
- It must be clarified whether there is a role for private top-up insurance for inpatient care. If there is still a market for such top-up insurance plans for inpatient care (see Chapter 5.1.5.), the costs for inpatient care of such insurees would not be incurred by the SHI.

Figure 8 shows the estimated financial feasibility of Scenario A+ with added expenditure for providing private sector inpatient services to the contribution paying insurance members only (in red). Other expenditure of the SHI is marked blue and SHI revenue is represented by the green line.

Among the paying SHI members, about two thirds belong to the formal sector, and about one third to the informal sector, which is thus in line with the above assumption.
Figure 8: Expenditure increase if private inpatient services are offered to the formal sector (in ´000 Maloti, constant prices)

It must be emphasized again that these are estimates only, as there was not enough data on the cost of these services or the expected uptake of them. Overall, the inclusion of private sector IP does not change the overall financial feasibility, although it does slightly increase the deficit in later years.

In the discussions during the second mission, some stakeholders raised the concern whether the better-off in Basotho society would be willing to accept a system where everyone receives the same services but the better-off contribute more to its financial upkeep. In principle, the contributions within the formal sector are proportional, i.e. everyone contributes the same proportion of their income. With the inclusion of the informal sector and the poor who cannot pay, the cross-subsidization from better to worse-off is strengthened. The argument voiced was that formal sector members, who contribute more to the insurance, should be offered a better service package. There is no categorically right or wrong stance on this argument. However, providing extra services to the better-off would result in a less equitable system.

6.3.3. HIV/AIDS care as part of the benefit package

HIV/AIDS presents an immense challenge for Lesotho, which has the world’s third highest prevalence rate. An additional calculation was made to get an idea of the financial implications if full care and treatment for people living with HIV/AIDS (PLWHA), including antiretroviral therapy (ART), was included in the SHI benefit package (without copayments). The data available is limited and several generalizing assumptions had to be made for this rough calculation. They are made following an article by Cleary et al. (2007) and are as follows:

- the HIV+ prevalence rate of the whole population stays at a constant 15%
- HIV prevalence and need of treatment is spread evenly across the entire population
- 15% of PLWHA are in need of ART in the first year
- people survive for 6.5 years on average after commencing ART
- every year 10% of the PLWHA not yet on ART commence with it
- for both pre-ART care and for ART, 80% of need is met
- pre-ART care costs M 100 and ART cost M 1000 per year and PLWHA (in constant 2006 prices)

Under these assumptions, the cost to the SHI fund of providing pre-ART care as well as ART to its members is estimated to start at M23m and rise to M138m over the projection period. Figure 9 shows this additional expenditure (in red) on top of the other SHI expenditure from Scenario A+ (in blue) versus SHI revenue (green line).

Figure 9: Additional expenditure for HIV/AIDS care

These additional costs represent well over twice the expenditure under Scenario A+ in the initial years, and still over 40% of them in the second half of the projection period. This suggests that burdening the SHI with these costs would require massive increases in its revenue (be that from contributions or subsidies). It is therefore advisable to continue to seek funding for care and treatment of PLWHA from external sources rather than through a potential SHI.

It is important to point out the uncertainty of these projections, as the data they are based on is limited and the assumptions are very static. E.g. much depends on whether such care and treatment has an effect on the overall HIV prevalence rate, which is assumed to stay constant here. If it goes down, so will the associated costs.
6.4. Sensitivity analysis for Scenario A+

Annex 3.1.3 provides a detailed sensitivity analysis for the results of the previous reports’ Scenario A. In it, the following variables were increased and decreased to see the effect this would have on the results (see Table 18).

Table 18: Variations in variables for sensitivity analyses

<table>
<thead>
<tr>
<th>Variation relative to Scenario A values</th>
<th>High variant</th>
<th>Low variant</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1+: administration costs</td>
<td>+13%</td>
<td>-33%</td>
</tr>
<tr>
<td>A2+: health care costs</td>
<td>+5% for public, +10% for private facilities</td>
<td>-10%</td>
</tr>
<tr>
<td>A3+: utilization rate</td>
<td>+20%</td>
<td>-20%</td>
</tr>
<tr>
<td>A4+: faster quality increase</td>
<td>Quality increase within 5 years instead of 10</td>
<td></td>
</tr>
<tr>
<td>A5+: fewer gov’t employees</td>
<td>Growth rate of number of government employees halved</td>
<td></td>
</tr>
<tr>
<td>A6+: no private services for exempted</td>
<td>Members exempted from payment are not covered for private OP services</td>
<td></td>
</tr>
<tr>
<td>A7+: cumulative administration, health care costs and utilization rate</td>
<td>Variants A1, A2 and A3 put together</td>
<td></td>
</tr>
</tbody>
</table>

For more details on the variant scenarios, please refer to Annex 4.4.1.

The key result of this analysis was that changes in utilization rates had the largest effect on the outcomes. As Scenario A+ is based on, and structurally the same as, Scenario A, this also holds true for Scenario A+. As implementation draws nearer and also while it is under way, continued observations should thus be made of changes in the utilization rate in particular. Should they be markedly higher than estimated here, the financial feasibility of the SHI will suffer.

6.5. Conclusion for Scenario A+

In conclusion, this scenario is assumed to achieve universal coverage over a period of 10 years, where all people have access to the same comprehensive benefit package. As the poorer part of the population is exempted from contribution payments and co-payments (i.e. no out-of-pocket payments for the SHI benefit package), the likelihood for a Musotho to experience catastrophic illness expenditure, which constitutes one of the greatest risks of being impoverished, is substantially reduced. Furthermore, in this scenario, the Basotho would have access to better health services than currently, if the additional resources mobilized through SHI are adequately turned into quality improvements in health care services.

Achieving universal coverage requires government spending on health: The MOHSW budget needs to be maintained to pay for curative health care services at GOL and for parts of CHAL services (in constant prices); in absolute terms, the MOHSW budget for curative health care would increase in line with inflation and population growth. Once a deficit occurs, subsidies (either from tax revenue and/or potentially from donor funds) into SHI may be required unless contribution rates are then increased.
It is also important to note that with respect to the average out-of-pocket household expenditure on health, which was M55 in 2003 (projected to be M72 in 2008, current prices), a large majority of formal sector employees and civil servants (Grade A-D) will not pay more for health care than before (see Table 13 in Chapter 5.1). However, most of their current out-of-pocket expenditure would be turned into prepayment with the introduction of a SHI scheme, except the OOPs for the lower co-payments. Since SHI relies on prepayment, households will no longer be forced to pay important sums out-of-pocket when illness strikes.
Table 19: Comparison between Scenario A+, A and B

<table>
<thead>
<tr>
<th>Key characteristics</th>
<th>Scenario A+</th>
<th>Scenario A</th>
<th>Scenario B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population coverage through SHI</td>
<td>All Basotho: Informal sector to be included gradually, but not in the initial years</td>
<td>All Basotho: Informal sector to be included gradually from Year 1</td>
<td>Only the formal sector employees: Public service officers; private sector employees; pensioners; income tax-paying self-employed</td>
</tr>
<tr>
<td>Benefit package</td>
<td>Once everybody is covered, everybody accesses the same benefit package; Differentiated benefit package, if OP private providers can only be accessed by the paying members.</td>
<td>Once everybody is covered, everybody accesses the same benefit package; Differentiated benefit package, if OP private providers can only be accessed by the paying members.</td>
<td>Insured members have better benefit package; danger that non-insured members get health care services at lower quality.</td>
</tr>
<tr>
<td>Financial protection</td>
<td>Those in the informal sector who are unable to pay are exempted from SHI contributions and co-payments</td>
<td>Those in the informal sector who are unable to pay are exempted from SHI contributions and co-payments</td>
<td>Those in the informal sector who are unable to pay are not financially risk protected.</td>
</tr>
<tr>
<td>Catastrophic expenditure</td>
<td>Risk of encountering catastrophic expenditure minimized (although low-income formal sector employees may struggle to pay co-payments)</td>
<td>Risk of encountering catastrophic expenditure minimized (although low-income formal sector employees may struggle to pay co-payments)</td>
<td>Risk of facing catastrophic expenditure remains among the poor (50% of population)</td>
</tr>
<tr>
<td>MOHSW budget for curative care</td>
<td>Needs to be maintained at its current level (in constant prices!)</td>
<td>Needs to be maintained at its current level (in constant prices!)</td>
<td>Needs to be maintained at its current level (in constant prices!)</td>
</tr>
</tbody>
</table>

Key implications

<table>
<thead>
<tr>
<th>Contributions by government (as an employer)</th>
<th>Year 1 (2008): M 40.6 million/year</th>
<th>Same&lt;sup&gt;30&lt;/sup&gt;</th>
<th>Same&lt;sup&gt;31&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in MOHSW budget for curative care</td>
<td>None</td>
<td>The quality increase is financed by the additional resources collected through SHI.</td>
<td>The quality increase is financed by the additional resources collected through SHI.</td>
</tr>
<tr>
<td>Government spending on health as % of total gov’t spending&lt;sup&gt;31&lt;/sup&gt;</td>
<td>Year 1: 11.28%;&lt;sup&gt;32&lt;/sup&gt; Year 11: 14.38%</td>
<td>Year 1: 11.25%;&lt;sup&gt;32&lt;/sup&gt; Year 11: 13.82%</td>
<td>Year 1: 12.36%; Year 11: 13.35%</td>
</tr>
<tr>
<td>Equity in health care access</td>
<td>All Basotho have access to health care and the same benefits</td>
<td>All Basotho have access to health care and the same benefits</td>
<td>If not monitored well, a two-class health care system may evolve.</td>
</tr>
<tr>
<td>Equity in financing across the whole population</td>
<td>Household health care expenditure is based on the principle of ability-to-pay.</td>
<td>Household health care expenditure is based on the principle of ability-to-pay.</td>
<td>Less progressive than in Scenario A and A*</td>
</tr>
<tr>
<td></td>
<td>The actual degree of equity in financing also</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>30</sup> Calculations for Scenarios A and B were based on a lower number and average salary for public service officers, which is why the data presented in Annex 3 differs.

<sup>31</sup> In line with NHA standard classification, this includes both MOH expenditure and SHI expenditure in government spending on health.

<sup>32</sup> Given small differences in the assumptions between Scenario A+ and A (see Annex 3.2.1.), these figures differ, although government spending is the same for these two scenarios.
Feasibility considerations require flat contribution payments in the informal sector, against the strict application of the ability-to-pay principle.

<table>
<thead>
<tr>
<th>Key trade-offs</th>
<th>Labour costs</th>
<th>Employment effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase through the employer's contribution share 50% x 5% = 2.5%</td>
<td>Employers may try to shift employment into the informal sector. Increased labour costs may be considered as a threat to competitiveness</td>
<td>Employers may try to shift employment into the informal sector. Increased labour costs may be considered as a threat to competitiveness</td>
</tr>
</tbody>
</table>

Increase through the employer's contribution share 50% x 5% = 2.5%.
7. Conclusions

7.1. Feasibility of Social Health Insurance

Universal coverage for all Basotho – entirely or partly through SHI – appears to be feasible and financially sustainable in principle, if the current funding levels provided by the MOHSW budget to GOL and CHAL health facilities are maintained (in constant prices), and increased in line with population and inflation. Such a scheme is thus much more comprehensive and equitable than earlier concepts of a medical aid scheme for civil servants only. In fact, the proposed scheme is able to offer better quality services to all Basotho, while increasing equity in access and equity in financing.

Furthermore, Scenario A+ may require that the SHI agency receives extra financial support (government subsidies), depending on the contribution rates, the level of care and coverage provided as well as the level of use of accumulated surplus. This is equally the case for Scenario A and B. Any government subsidies could come from tax revenues or from other sources.

However, the financial feasibility as projected with the SimIns tool goes hand in hand with sound institutional design of the SHI:

- There must be no contradictions in the institutional design features (Chapter 5.1.-5.5.).
- These institutional design features must be properly implemented
- An appropriate regulatory framework must be in place (Chapter 5.6.).

Foremost, the vision of extending coverage to all Basotho needs to be built into the key design features right from the beginning, otherwise it is likely that the key design - i.e. the architecture of the SHI scheme - will turn out to incorporate institutional contradictions that make the scheme more prone to fail. To meet these requirements, sufficient time for planning and preparation is required. Likewise, the necessary resources to meet these conditions need to be available. In general, a slower pace of introducing SHI is therefore preferred over a quick process in order to ensure better design and implementation. This is because there are still many issues that require careful thinking, planning, preparation, before SHI can work. Also, unless the legislation and regulatory framework as outlined above is in place, it would be difficult to get a SHI scheme running successfully.
7.2. Key decisions to be taken by Government

The government is advised to take key decisions in the following areas:

- The type of health financing, i.e. the decision to favour social health protection via social health insurance, but with continued and direct financial support from Government to CHAL and GOL facilities, rather than a pure tax-based system;
- The type of SHI, i.e. a SHI that tends to go in direction of Scenario A+ ("Phased SHI for All"), or variants of it, versus other types of scenarios;
- The type of governance structure of the SHI fund;
- The type of management structure of the SHI fund.

Once these key decisions are made and if the government opts for a SHI, the government will also have to take decisions with respect to critical key design issues and to negotiate with the respective stakeholders:

- The rate and speed of extension of SHI coverage to the informal sector
- The level of exemption from contribution rates
- The contribution rate, i.e. the percentage of payroll deductions
- The contribution rate for specific population groups, such as pensioners and informal sector workers
- The type of provider remuneration mechanism, i.e. the way providers are remunerated by the SHI fund
- The provider remuneration rates, i.e. the funding providers receive for their services
- The co-payment levels, i.e. the amount of money SHI members have to pay directly
- The level of exemption from co-payments
- The maximum rate of administration costs and the level of reserves

As such, the government also needs to be explicit and find a consensus regarding the financial feasibility assumptions and whether these are low-cost or high cost (compare Annex 3.1.3).

Finally, the government needs to develop and agree upon an implementation schedule to establish step by step the SHI scheme and the agency with personnel. This could ideally translate into an explicit "Implementation Project". There are substantial costs involved in setting up the scheme, such as investments in infrastructure and administration and training of staff in the various management and administration skills. Donors could also provide financial support for these start up costs or for covering specific diseases in the benefit package.

7.3. Further success requirements

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One of the key assumptions and success factors for SHI to be feasible in Lesotho is that quality of services in GOL and CHAL facilities improve substantially, and that health workers are motivated. Furthermore, the following aspects are critical:

- A dialogue on SHI needs to take place in order to build widespread consensus
- All stakeholders need to become more familiar with the principles of SHI
- There must be a strong lead actor who is in charge of SHI design, planning, preparation and implementation
- All key stakeholders need to be involved in the design, planning, implementation, monitoring of SHI; for example the SHI TGW could be enlarged.
- The SHI requires a well-functioning PPP for the new QEII.

### 7.4. Challenges and open questions

It is important to be aware of a number of challenges with respect to realizing a SHI scheme. While these challenges are not insurmountable, they require careful reflections and planning on the design and implementation of SHI.

- High unemployment rate and job instability
- Low incomes limiting the ability to contribute
- Large extended families
- Registration of informal sector and farmers
- Collection of contributions from informal sector, and how to assess their incomes
- Weakly organized informal sector
- Fragmented trade unions and professional associations
- Administrative capacity of the purchaser
- Administrative capacity of providers (with respect to contracting, claims management)
- Trust among the various stakeholders
- Lack of or inadequate infrastructure, limiting access to health care, especially in rural areas

Again, donor support could contribute to overcoming some of these challenges.

Furthermore, the following critical questions need to be addressed:

- How to increase rather quickly the quality of health care services to make SHI contributions attractive?
- What to do over the next 2-3 years until the new PPP QEII is fully functional?
- Will the abolishment of user fees/co-payments at health centre level lead to a tremendous influx of patients at that level, and if so, how can that service level be kept functional and being availed with the necessary resources (staff, equipment, drugs and medical supplies)?

### 7.5. Summary of recommendations on key design issues for a planned SHI scheme

This section summarizes again the recommendations on key issues for a SHI scheme (see Box 3). As noted above, these are based and derived from the stakeholder views gathered
during the consultations, on the discussions held with the Ministry of Health and other ministerial stakeholders as well as on the feasibility assessment and reflections by the mission team.

Box 3: Key Recommendations for establishing a "SHI for all Basotho" scheme

Recomendations for establishing a "Phased SHI for all Basotho" scheme:

**Resource collection:**
- The MOHSW budget for curative care is maintained (in constant prices).
- Resources mobilized through SHI do not replace but complement existing government funding.
- SHI resources are based on contributions by members.

(Chapter 5.1.1)

**Contribution rates:**
- The formal sector (public service officers, formal sector employees and pensioners) pays a uniform contribution rate based on their salary, which is linked to SHI expenditure.
- Contributions are shared between employees and employers at 50/50.
- Informal sector workers pay a flat contribution amount.
- The poor are exempted from contributions, namely 75% of informal sector workers, as they are unable to pay contributions.

(Chapter 5.1.2.)

**Extension of coverage:**

**Formal sector:**
- All public sector officers become SHI members in Year 1.
- Private sector employees join the SHI scheme over the first 3 years.
- All pensioners join in Year 1.

**Informal sector:**
- Informal sector workers start joining the SHI scheme in Year 3 in a pilot scheme.
- The detailed extension schedule and modalities need to be further developed, based on further stakeholder negotiations between the respective groups and civil society actors.
- Initial suggestions for the extension schedule:
  - Year 3: first 10% (pilot)
  - Year 5: next 10% (pilot)
  - Year 7: next 15%
  - Year 8: next 15%
  - Year 9: next 15%
  - Year 10: next 15%
  - Year 11: final 20%

(Chapter 5.2.1.)

**Membership:**
- Membership is mandatory, i.e. all population groups will eventually join the SHI scheme.
• Membership is family based, i.e. children below 18 and other adult dependents (first
grade relatives living in the same household without their own income) are covered.
(Chapter 5.2.1.)

Pooling:
• The GOL establishes one SHI agency that pools contributions for public service
officers, private sector employees, pensioners and at a later stage from informal sector
workers.
(Chapter 5.2.3.)

Benefit package:
• The benefit package comprises of all essential outpatient care at GOL and CHAL
health centres, GOL and CHAL hospitals and private providers, as well as inpatient
care at GOL and CHAL facilities including the QEII tertiary hospital.
• Specialized care for specific cases could be obtained in RSA on the basis of referral
through QEII.
(Chapter 5.3.1.)

Provider payment mechanism:
• Health care providers could be remunerated on the basis of a combination of capitation
and flat case payments, the latter serving for high cost services.
• It is noted that a fee-for-service remuneration is not advisable.
• The detailed payment structure and managerial proceedings need to be elaborated to
ensure that health facilities receive their facility income through both the existing
channel of MOSHW budget transfers and the new capitation/flat payment system in
parallel. This includes establishing or strengthening clear accountability channels for
heads/managers of health facilities.
• There may be an element of better payments for increased performance.
(Chapter 5.3.2.)

Provider remuneration rate:
• Based on more detailed unit cost information, the government sets capitation-based
remuneration rates and flat (case) payment rates for health providers.
• These same rates should be negotiated with CHAL facilities.
(Chapter 5.3.3.)

Contracting:
• The SHI scheme could offer contracts to all accredited health care facilities that
provide services to SHI members to clearly spell out rights and obligations of both
sides.
(Chapter 5.3.4.)

Accreditation and quality management:
• The existing accreditation scheme could be extended to all health care providers.
• Accreditation could become a precondition for contracting.
(Chapter 5.3.5.)

Governance and management of the SHI agency:
• Governance and ownership of the SHI fund can be semi-public or autonomous.
• The supervisory board should encompass a wider range of different stakeholders representing various ministries and government institutions, professional associations/trade unions, provider associations as well as other civil society representatives.
• The management of the SHI agency could be undertaken by a parastatal or contracted out to a private company.  
(Chapter 5.4.)

Legislation:
• Given that SHI is not only for the workforce, but for all Basotho, it is recommended to develop a freestanding SHI Law, jointly with MoL, MoPS and MoF.  
(Chapter 5.6.)

**Specific recommendations for the SHI TWG:**

• The SHI TGW should be extended to include:
  - Representatives from the MOL (social security experts)
  - Representatives from the MOF (macroeconomist/fiscal experts)
  - Resource persons with expertise in specific issues, including actuarial analysis.
• The SHI TGW should be strengthened institutionally and technically to be better prepared to the tasks ahead such as policy discussions, preparing policy documents for decision-makers, assessing, the financial feasibility study, overseeing further financial projection activities.
• Development partners should be involved in future consultations and discussions on SHI to get their support.
• Small sub-groups of the SHI TWG, with additional resource persons representing non-government stakeholders could be set up to work on specific issues and questions.
• An awareness raising campaign needs to be developed, which is tailored to the specific information needs and group interests of the various target groups, namely:
  - Potential beneficiaries from the formal and informal sector
  - Providers
  - Government stakeholders,
  - Other non-governmental actors
  - The very high-income earners and those with a private health insurance plan.
• The existing household survey data should be analysed to gather more detailed information on household health expenditure per quintile as well as on the percentage of Basotho households facing catastrophic expenditure and impoverishment. This information may contribute to strengthening the argument and objective of the MOHSW to introduce a SHI.
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on Social Health Insurance: http://www.who.int/health_financing/mechanisms/