Social Security in Africa

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Social health insurance: how feasible is its expansion in the African region?

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A DUAL CHALLENGE: IMPROVED ACCESS TO BETTER HEALTH CARE

In most economically advanced countries, adequate social security laws are basically taken for granted. However, it often took many decades for social security systems to benefit all or major parts of the population in those countries. In the area of social health protection, for example, it took Japan 36 years to move from the enactment of the first health insurance law to the final law establishing nation-wide social health insurance. In the United Kingdom, a similar time period was needed to achieve its universal tax-based system.

A key question now is whether African countries can take shorter routes to universal health coverage, rather than going through a lengthy transition period. Universal health coverage means that all of the population has access to appropriate health care when needed and at an affordable cost. Leapfrogging will be far from easy, as many African countries face the dual challenge of enhancing their overall health expenditure level and of drastically improving access to and quality of health care. First, noting that a basic set of health services would cost at least $34 per capita, many of the 46 WHO member states in the African region fall short of this objective. In 2005, 29 countries spent less than this amount. Secondly, problems of access to health care are pervasive and are linked to the level of households’ out-of-pocket payments for health care: high out-of-pocket payments deter people from seeking care. In Kenya for example, out-of-pocket payments represented about 50% of total health expenditure in 2003. The results from a Kenyan household survey in the same year showed that 24.9% and 24.7% of patients did not use outpatient (ambulant) and inpatient (hospitalized) care, respectively, although they needed it. About 40% of these patients reported they could not afford the out-of-pocket payments charged for these categories of care.

THE POTENTIAL ROLE OF SOCIAL HEALTH INSURANCE

The challenge is: how to achieve both a higher level of expenditure and a lower level of out-of-pocket payments? There has been the call by African heads of state to allocate at least 15% of annual government budgets to the health sector, referred to as the Abuja Declaration. In addition, if the existing international commitments are fulfilled it is expected that this financial support would indeed increase substantially over the next decade. Both enhanced domestic and external funding for health would boost health systems, not only in terms of improved quality of health care, but would also shift away from out-of-pocket payments to ‘prepayment of health care’. Health financing via prepayment implies that people are not deterred from seeking care and at the same time are protected against the financial risks of falling ill, as the burden of patients to pay out-of-pocket will be eliminated or substantially reduced.

There are a number of alternative ways to achieve universal health coverage via prepayment. When governments are the only responsible financing agents for the transition to universal health coverage, one usually speaks of a tax-based health care system. Another mechanism is social health insurance (SHI), which in its mature form involves compulsory membership among all of the population. Principal funding is via earmarked contributions by employees and their employers, civil servants and government (as their employer), and the self-employed from the formal and informal sectors of the economy. The base for the contributions of employees, civil servants and employers is usually the employees’ or civil servants’ salary. The contributions of the self-employed are often either flat-rate or based on estimated income. However, hybrid forms of SHI are also quite prevalent, with government paying contributions for those, such as the unemployed and the poor, who would otherwise have difficulties in contributing. Another important characteristic is that health care provision financed by SHI is often mixed, based on both the public and private health care sector. Furthermore, for its management functions (such as member registration, collection of contributions, contracting with and reimbursement of providers), SHI may also be organized by parastatal or non-profit organisations such as sickness funds.

AFRICA’S RECENT INTEREST IN SOCIAL HEALTH INSURANCE

SHI is not a widely adopted health financing mechanism in Africa. While there are many countries that
operate a health insurance scheme for civil servants and/or private sector employees only some of these include features of a SHI, its appeal to cover larger parts of the population has been growing. Countries including Ghana, Nigeria and Rwanda have passed SHI laws. Earlier on, Kenya investigated the feasibility of SHI and Lesotho and Swaziland are doing so now. What could explain its attractiveness? One distinct feature is that it does not call exclusively on public finance, but instead spreads the responsibility of health care financing among households and the private sector as well. From that point of view, tax-based systems in Africa are particularly challenged: the overall tax base may need to be strengthened, tax compliance may require improvement, and then a sufficient allocation towards health would have to be called for. Still, social health insurance is not a panacea either. It requires that an important organizational apparatus be put in place and that many actors in society shoulder critical responsibilities, such as the willingness and ability to contribute to the SHI scheme and then to comply with its regulations, thereby accepting a certain degree of financial solidarity.

FEASIBILITY ANALYSES OF SOCIAL HEALTH INSURANCE

Since 2002, the WHO has been involved in technical advisory work especially on assessing the feasibility of SHI in Kenya, Lesotho and Swaziland in collaboration with national experts from those countries. In each country we analysed the financial, organizational and political feasibility. Below we present some of the highlights of this work that should help us in formulating general guidance.

In Kenya, one basic financial scenario was that of gradual implementation of universal health coverage: coverage by a possible National Social Health Insurance Fund (NSHIF) would reach 62% of the population after 10 years, with further expansion in the second decade of SHI implementation. An important feature is that such a scenario would only be conceivable with sizable government subsidies. Without such subsidies, access to health care among low-income households would be jeopardized, as the contributions from formal sector employees and civil servants would be insufficient to cross-subsidize the needed health care of the poor. External donors’ financial support, however, could alleviate this extra financial burden on government. In fact, a variant of the basic scenario assumes that external donors would finance the provision of antiretroviral therapy, which would reduce the required government subsidies by about 20%.

As far as the organizational aspects are concerned, it was studied whether the existing National Hospital Insurance Fund, a mandatory hospital insurance scheme for the formal sector with a small part of voluntary insurance for informal sector workers, might be transformed into the NSHIF. The latter would then be governed by a Board of Trustees with representatives from civil society. It is also interesting to note that the proposed NSHIF would include a Department of Fraud and Investigation in order to check the fund’s financial activities. Civil society groups and enterprises such as the Post Office would also be given a role, especially in the collection of contributions from households in the informal sector.

Concerning its political feasibility, consultations were held with a great number of stakeholders and interest groups, and most were supportive of the proposed NSHIF. Only Kenya’s private Health Maintenance Organizations were very critical and had doubts about NSHIF feasibility. Finally, in 2004, the Kenyan Parliament passed a law on the NSHIF. However, President Kibaki judged it still needed amendments and returned it to Parliament for further debate that is still ongoing. Nonetheless, with a long-term vision, the existing National Hospital Insurance Fund is undertaking a number of institutional changes to increase membership and extend benefits so as to be better prepared should SHI take off.

Lesotho’s priority concerns are to improve the quality of and access to health services, especially to the poorer half of the population. To this end, the country wants to raise the amount of money it can spend on health through SHI and decrease user charges to reduce out-of-pocket expenditure. Of the several financial scenarios discussed, stakeholders found the one that aims to extend SHI coverage across the whole population most attractive. This scenario envisions a rapid implementation of SHI for the formally employed, while gradually extending this to the rest of the population over the course of a decade. Almost half the population would be exempt from having to pay owing to poverty. Current spending on health from tax sources would be maintained and supplemented with SHI funding. The combined funding would allow a substantial investment in improved quality health services.

As coverage increases and more poor people join, the financial balance of the SHI would tip towards deficit after some seven years. This would require subsidies and/or a raise in contribution rates for the formal sector.

Lesotho’s stakeholders, including the government and civil society, are debating whether or not to go ahead with such a system. The implication that needs to be accepted first is that a SHI would institutionalize a cross-subsidy from rich to poor. Today, those who can afford it usually purchase health services in neighbouring South Africa, but a SHI would only allow a select number of medically essential referrals. Services over and above what the Lesotho SHI system is scheduled to offer would still need to be paid for privately. Everyone would, however, be contributing to the SHI, so that the cost of providing and improving services would be spread between households, enterprises and government. How exactly the money would be best spent to achieve these goals would be the next question to tackle.

Similarly in Swaziland, given the concern about the poor quality of care in the government sector, the feasibility assessment of a SHI served to provide alternative options to the existing private medical aid scheme now under discussion for civil servants (a private health insurance scheme). Another challenge of the current health financing system is the high expenditure on and the insufficient organization of medical referrals to South Africa. Thus, the Ministry of Health’s objective of introducing SHI is to ensure universal access to health care by mobilizing additional resources to finance quality improvements, particularly in the public sector, as well as to build up tertiary, specialized care within Swaziland.
With a small population of about one million, the key stakeholders preferred a scenario in which gradually all population groups would join the SHI scheme to achieve universal access after six years. About a fourth of the population would be exempted due to reasons of inability to pay contributions. A key assumption for this health financing system is that the government's budget for health care would be maintained and increase in line with GDP growth. The SHI scheme would then mobilize approximately another 50% of the government's budget for health. With these additional resources, significant quality improvements and increased utilization by the population could be financed.

The key challenge now being debated is implementation feasibility: can quality of health care at government facilities be improved within a few years to such a level that the population finds it acceptable to make contributions of around 6 to 7% of salaries? Another political challenge is that many representatives of the stakeholders and negotiating parties, as part of the upper middle class, have a strong interest in receiving access to the private health sector, with universal health coverage and solidarity appearing to follow as secondary objectives. It is now upon the government to take a decision, which also strongly depends on which financing scheme - a private health insurance or a SHI - the civil servant unions prefer.

**IMPLEMENTING SOCIAL HEALTH INSURANCE POLICIES: THE CASE OF RWANDA**

Aiming at universal health coverage for its 9.5 million population, Rwanda has spearheaded the development of a number of schemes that together constitute its SHI system. The three most important ones are the Rwandaise d’assurance maladie (RAMA), the Medical Military Insurance (MMI) and the Assurances Maladies Communautaires (AMCs). The RAMA social health insurance is compulsory for government employees and voluntary for private sector employees. Its contribution rate is 15% of basic salary (shared equally between employee and employer). MMI covers all military personnel, who pay a contribution rate of 22.5% of basic salary (5% paid by employee and 17.5% by government). AMCs are community-based health insurance schemes whose members are mainly rural dwellers and informal sector workers in both rural and urban areas. They make up the majority of the population; by the end of 2007 about 5.7 million Rwandans were covered by AMCs. Members usually contribute 1000 Rwandan Francs (1.85 US$) per person per year which is matched by the government (with external donor support).

An important innovation has been the launch and extension of the AMC. Despite its voluntary character, the AMCs have benefited from a steady increase in membership. One of the principal factors of this success has been the collaboration among all stakeholders, and especially the financial support from government and external donors. Still, the AMCs face many challenges including making contributions more affordable to the poorest and improving financial management capabilities.

In general, there is the challenge to further reduce the fragmentation in this SHI system, but overall progress is steady. Rwanda has developed a legal framework for governing social health insurance and continues with its expansion. In particular, a recent law (April 2008) stipulates the future requirement of compulsory health insurance for every Rwandan.

The results of Rwanda’s efforts in building up a SHI system can also be seen from the improvement in several health financing indicators, which include a greater availability of financial resources for health (34$ per capita in 2007 vs. 13$ in 1999), an increased coverage of the rural and informal sector population by the AMCs (from 1.2% in 1999 to 75.6% in 2007), and a lower burden of out-of-pocket payments (from 24.7% of total health expenditure in 2000 to 15.9% in 2005).

**WHITHER SOCIAL HEALTH INSURANCE IN THE AFRICAN REGION?**

The feasibility studies summarized above indicate that there is a certain potential for social health insurance in the respective countries. This reflection is reinforced by the positive outcomes from the social health insurance policies in Rwanda. However, we can not merely generalize this assessment to the African region as a whole. Indeed a number of conditions for adequate implementation of SHI need to be satisfied. The prerequisites for success are vital and should once more be emphasized. First, financially speaking, with contributions from all stakeholders, sometimes including external donors, SHI can indeed be a vehicle for universal health coverage. The assumption here, however, is that countries’ overall income level and income growth are sufficient, enabling households, enterprises and government to make contributions commensurate to their legal obligations. Secondly, sustained external donor financial support would strengthen the revenue base of the SHI schemes. Furthermore, sustained efforts would be needed to build new SHI-related organizations and reinforce administrative capacities to manage them. Crucially, progress with implementation will depend on political consensus and effective collaboration between stakeholders. In particular accepting a minimum degree of solidarity involving pooling of contributions and risks from all groups in society is a must.

Fulfilling all prerequisites may be a tall order, and it stands to reason that a transition period to a mature social health insurance system may last a decade or more. Having said all this, one should not forget that SHI is not the one and only method for reaching universal health coverage. Quite a number of possible paths exist with mixes of SHI, tax-based funding, community-based and private health insurance. Each country will have to decide what is most optimal in its own context. Should SHI be adopted, there is no doubt that implementation will be accompanied by various challenges of a political, organizational and financial nature. These should not discourage countries, however. A perfect road to universal health coverage does not exist. In fact, international experience shows that the development of SHI in the now high-income countries was far from smooth. In the meantime, the experience of countries such as Rwanda is noteworthy and promising.