The development of health financing systems in low-income developing countries

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References in www.who.int/health_financing/
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I. TOWARDS SUSTAINABLE HEALTH FINANCING AND UNIVERSAL COVERAGE
WHA Resolution on 'Sustainable health financing, universal coverage and social health insurance' (2005)

• The further development of health-financing systems is necessary...
  – *In order to guarantee access,*
  – *and provide protection against financial risk*

• Basic principles are ...
  – *revenue collection (prepayment)*
  – *pooling (of revenues and risks)*
  – *purchasing*
• The choice of a health-financing system is to be made within the particular context of each country

• Health financing reforms may involve a mix of public and private approaches, including the introduction of social health insurance

• Importance of the role of State legislative and executive bodies in further reform…with a view to achieving universal coverage
What about the transition to universal coverage?

• Transition to UC generally has generally taken years, with co-existence of
  
  – Community-, cooperative-, enterprise-based health insurance
  – Other forms of private health insurance
  – Compulsory SHI-type coverage for particular population groups
  – Tax-based funding
Stages of coverage and organisational mechanisms

- **Universal Coverage**
  - Tax-based financing
  - Social health insurance
  - Mix of tax-based financing and various types of health insurance

- **Intermediate stages of coverage**
  - Mixes of community-, cooperative- and enterprise-based health insurance, other private health insurance, SHI-type coverage for specific groups and limited tax-based financing

- **Absence of financial protection**
  - Out-of-pocket spending for health care
II. COMMUNITY-BASED HEALTH FINANCING
II.1 Performance criteria

1. Revenue collection

   Enrolment

   » low membership is warning for adverse selection

   » broad membership makes the scheme viable over the longer run

   » membership to be accessible for vulnerable groups
Ratio of prepaid contributions to health care costs

- the higher volume of prepaid contributions
- the more the financial consequences of treatment costs can be avoided
2. Pooling

Practice of risk pooling across groups in the community

so that transfers can be ensured between low-risk and high-risk members
3. Purchasing

Practice of strategic purchasing

is a search for the best health services to purchase, the best providers to purchase from, and the best payment methods and contracting arrangements

... in order to contribute to more rational and cost-effective health care
II.2 OVERVIEW OF EARLIER EMPIRICAL FINDINGS CONCERNING PERFORMANCE
### TABLE 1 Key characteristics of selected non-profit health insurance schemes

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Scheme</td>
<td>GK(^1)</td>
<td>Grameen Health Plan</td>
<td>Bwamanda Health Plan</td>
</tr>
<tr>
<td>Eligible population (number of households)</td>
<td>37,200</td>
<td>37,500</td>
<td>19,400</td>
</tr>
<tr>
<td>Population coverage rate(^2) (%)</td>
<td>27.5</td>
<td>41.0</td>
<td>60.0-65.0</td>
</tr>
<tr>
<td>Insured services</td>
<td>Community-based facility and hospital level</td>
<td>Community-based facility level</td>
<td>Hospital-level IP</td>
</tr>
<tr>
<td></td>
<td>OP and IP(^3)</td>
<td>OP</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

1. GKK=Gonoshashthya Kendra
2. Population coverage rate= ratio of insured population to eligible population
3. OP and IP stand for outpatient care and inpatient care, respectively
II.2.1 Performance criteria

**Enrolment**

- WHO 1998 study: median of 24.9% (44 schemes)
- Rwanda Project study: 7.9% by end of first year of operation
- Thiès study (Senegal): average enrolment of 68%

**Concern**: enrolment across different income groups
Prepayment ratio

- WHO 1998 study: prepayment ratio in the range of 30% to 60%

- Insurance scheme of Self Employed Women’s Association (SEWA-Gujarat, India): 76% of hospital costs
Practice of risk-pooling

- Many CHI schemes are small and have single pools

- China’s Rural Cooperative Medical Schemes: possibility of separate funds for workers and farmers

- ILO 2002 study: CHI as entry point to larger pooling arrangements, supported by other financial sources (governments, donors)
Practice of strategic purchasing

• WHO 1998 study: previously weak definition of benefit packages (some exceptions: UMASIDA scheme in Tanzania, SEWA)

• increasing attention to strategic purchasing: E.g. Rwanda Project, CHIs in Guinea
II.2.2 Factors that influence performance
Revenue collection

Prepayment ratio

Practice of Risk-pooling

Practice of Purchasing

* Affordability of contributions
* Unit of membership
* Distance
* Timing of collection
* Trust

Mix of contributions by households government donors others

* Trust
* Mechanisms for enhanced risk-pooling

* Contracting
* Provider payment methods
* Referrals
* Waiting period
II.3 SPECIFIC CASES
SEWA community-based health insurance in Gujarat, India

Sources: Kent Ranson, Bulletin of WHO, vol.80, 2002; Tara Sinha et al., Health Policy and Planning, December 22, 2005
Key characteristics

- Health insurance as part of the Self-Employed Women’s Association (SEWA) Integrated Social Security Scheme, established in 1992

- Focus on women (between 18 and 58 years old); however they can insure their spouses and children
  - Membership in 1999-2000: 23,214 members

- Annual social security premium is 72.5 rupees ($1.67)
  - Of which 30 rupees earmarked for health insurance
  - Coverage up to 1200 rupees ($28) in case of hospitalization
    - Exclusion: chronic tb, certain cancers, diabetes, hypertension, diseases caused by addiction

- Cost-recovery (excl. Administrative cost): between 119 to 309%
- Administrative cost: between 10.2 and 22.9% of expenses
Key findings with respect to access to health care

• Women who made claims were poorer than the general population
  – 27% of claimants fell below the poverty line

• Mean rate of reimbursement for reimbursed claims (89% of claims submitted): 76.5%

• Impact on catastrophic health expenditure (>10% of income):
  – For all claimants: reduction of % households with catastrophic care from 35.6 % to 15.1 %
  – For poorest claimants: reduction of % households with catastrophic care from 72.4% to 24.8%
**Further challenges**

- Need to enhance financial protection: further **lower barriers** to effective access
  - Direct reimbursement from SEWA to hospital providers
  - Issue of distance (rural vs. Urban): cost of transportation and loss of income and time
- Expansion of the **benefit package**
  - Financial feasibility could be enhanced by subsidies from government and donors
- Making the insurance also more attractive to the **non-poor** by offering new packages
  - With the potential for better risk-pooling and cross-subsidization
Grameen Kalyan Health Program

Source: Letourmy & Letourmy, AFD, Notes et Documents, nr 26, december 2005
Key characteristics

- GK-HP developed by the Grameen Trust in August 1997
  - Its objectives:
    - Provide primary health care services (19 health centres since 1996)
    - Develop health insurance with community participation
    - Self-sufficiency

- Health insurance is voluntary

- Two types of contributions
  - For Grameen Bank members: 120 Tk per year per family
  - For non-Grameen Bank members: 150 Tk per year per family

- Contributions are paid to a Grameen Bank credit agent
  - But micro-credit loans do not serve to finance the contribution
Key findings with respect to access to health care

- **Health insurance benefits:**
  - Free vaccinations & yearly health check-up
  - Consultation with co-payment in health centres
  - Reductions on drugs, exams and consultations in reference health facilities

- **Poor non-members** of Grameen Bank (ultra poor) receive free treatment
  - Financed via Grameen Welfare Fund
  - About 10% of health centre patients benefit
Key findings with respect to membership and cost-recovery

- **Beneficiaries**
  - November 2001: 198,000
  - February 2003: 261,800

- **Cost-recovery**
  - Health centre income is from:
    - Revenues from lab tests, drug sales, consultations of non-members
    - Health insurance contributions from members
    - Subsidies from Grameen Welfare Fund
  - Cost-recovery evolution
    - 1996: 38%
    - 1999: 72%
    - 2002: 81%
New ways to protect the poor

Health equity funds: the case of Cambodia

Focus on the poor

- Local and independent NGO to be contracted that
  - identifies the target group of the poor population
  - manages the Health Equity Fund
  - acts as a 'third party payer'

- Level of financial support to patients
  - on case-by-case basis

- from partial payment of admission fee to full coverage of total cost of hospitalization, including transport, food and basic items
Cost of the Health Equity Fund (HEF)

- **Support to 1437 patients (1-9-2000 to 30-9-2002) or 30% of all patients in 3\textsuperscript{rd} Q of 2002**

- In 2001, running cost of district hospital cost was US$152,000 or $53 per admission
  - 62% funded by government
  - 21% by user fees
  - 17% by MSF and UNICEF

- **Cost of HEF for one year around $13,000**
  - 8.6% of running cost
  - $0.06 per capita per year
**Effects on households**

- Health equity fund (HEF) supported nearly all extreme poor
  - 87% were identified and supported for 50% of their total expenditure

- **Effects on financial constraints:**
  - Informal payments stopped
  - But, user fees (7 to 10$ per admission) continue to be major obstacle to the poor
  - Besides, hospitalization itself is not the only cost: higher spending on transport and food
III. SOCIAL HEALTH INSURANCE
III.1 Basic principles

• Ensure **access to a benefit package** of health services among **all population groups**

• The provision of benefits needs to be ascertained through **sufficient and stable financing** of SHI
  
  – involving contributions by the **stakeholders**: employees, employers, self-employed, government

  – contributions are normally based on **ability to pay**

  – in principle membership is (or will eventually become) **compulsory**
III.2  Key Design Features
Population coverage

INDICATORS

• Percentage of population covered by SHI

• Coverage by target group
  – employees of private and public enterprise
  – civil servants (incl. teachers, military personnel)
  – casual workers, migrants and other self-employed
  – retired civil servants and employees
  – non-working population (incl. students, unemployed, disabled)
FURTHER CONSIDERATIONS

• ‘Inclusion’ of groups depends upon national financial resources and government stewardship
  
  – government financial support for those who cannot afford to pay
  
  – pooling: cross-subsidies between target groups
Extent of prepayment

**INDICATORS**

- Ratio of prepaid contributions to total health care costs
  - whole population
  - by target group

- Percentage (%) of households with ‘catastrophic’ spending
  - whole population
  - by target group
FURTHER CONSIDERATIONS

• Issue of equity: income/wage related contributions vs. flat rate contributions
  • considerations of administrative efficiency
  • degree of solidarity

• Sufficient and stable contributions
  • government financial support
  • other revenues (earmarked taxes etc.)
## Prepayment ratios in selected mature SHI systems, 2004

<table>
<thead>
<tr>
<th>Country</th>
<th>Prepayment Ratio (%)</th>
<th>Country</th>
<th>Prepayment Ratio (%)</th>
</tr>
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<tbody>
<tr>
<td>Austria</td>
<td>69.3</td>
<td>Israel</td>
<td>69.2</td>
</tr>
<tr>
<td>Belgium</td>
<td>71.7</td>
<td>Japan</td>
<td>77.9</td>
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<tr>
<td>Costa Rica</td>
<td>68.5</td>
<td>Luxembourg</td>
<td>89.9</td>
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<td>France</td>
<td>76.0</td>
<td>Netherlands</td>
<td>63.3</td>
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<tr>
<td>Germany</td>
<td>74.9</td>
<td>ROK</td>
<td>44.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Switzerland</td>
<td>57.1</td>
</tr>
</tbody>
</table>
Fragmentation in pooling

**INDICATOR**

- Multiple funds? YES/NO

If YES, what is the level of risk equalization?

*Risk equalization arranges for transfers across different funds such that each fund can offer the same benefit package to its members.*
Risk-equalization: example with 2 funds

FUND 1

Initial Revenue

Expenditure

FUND 2

Initial Revenue

Expenditure
Risk-equalization: example with 2 funds (cont.)

FUND 1

Initial Revenue

Expenditure

FUND 2

Revenue incl. transfer

Expenditure

Solidarity fund
Risk-equalization: example with 2 funds (cont.)

FUND 1

Final Revenue
Expenditure

FUND 2

Final revenue
Expenditure

Solidarity fund
Composition of pools

**INDICATORS**

- Is membership compulsory?
- Are dependants covered?

**FURTHER CONSIDERATIONS**

- Registration of the household or the individual?
- Registration of migrants?
The benefit package

**INDICATORS**

- Do members have full information on their ‘rights’?
- Do monitoring mechanisms exist: internal and external quality reviews?

**FURTHER CONSIDERATIONS**

- Criteria used in the design of the benefit package
- Design of contracts and renewal of contracts
Administrative efficiency

**INDICATORS**

- Maximum percentage of expenditure on administrative costs?
- Maximum percentage of reserves?

**FURTHER CONSIDERATIONS**

- Paying the providers: advance payment, proper timing
- Management of risk-equalization
III.3 Country experiences with Social health insurance
Comparative data on countries *with or intention to move* to social health insurance

<table>
<thead>
<tr>
<th>Country</th>
<th>GDP per Capita</th>
<th>THE per Capita</th>
<th>THE %</th>
<th>GHE %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japan</td>
<td>37,282 USD</td>
<td>2,908 USD</td>
<td>7.8</td>
<td>76.7</td>
</tr>
<tr>
<td>Rep of Korea</td>
<td>9733 USD</td>
<td>584 USD</td>
<td>6.0</td>
<td>44.1</td>
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<tr>
<td>Thailand</td>
<td>1,919 USD</td>
<td>71 USD</td>
<td>3.7</td>
<td>57.4</td>
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<tr>
<td>Colombia</td>
<td>1,938 USD</td>
<td>186 USD</td>
<td>9.6</td>
<td>55.8</td>
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<td>Viet Nam</td>
<td>404 USD</td>
<td>21 USD</td>
<td>5.2</td>
<td>25.8</td>
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<tr>
<td>Indonesia</td>
<td>741 USD</td>
<td>20 USD</td>
<td>2.7</td>
<td>23.7</td>
</tr>
<tr>
<td>Kenya</td>
<td>337 USD</td>
<td>28 USD</td>
<td>8.3</td>
<td>22.2</td>
</tr>
</tbody>
</table>

*Source: World Health Report 2002*
Transition to social health insurance:

the case of the R. of Korea
Timeline of social health insurance development

- **1977**: Start of implementation of Health insurance Law with *gradual* approach…universal coverage by 1989
- **1997**: 373 Health insurance funds
  - issue of *administrative cost* (8.5% on average)
  - issue of *different contributions*, even for insured with same income
- **1998**: Law of National Health Insurance Corporation (NHIC)
- **2001**: Pooling of insurance funds of government and school employees and industrial workers
- **2003**: Pooling with health insurance fund of the self-employed
IV. A WAY FORWARD:
Connecting community-based schemes to social security schemes
IV.1 Government’s role

- adviser and regulator on the design of community based schemes (enrolment, size of pools, benefit package etc.)
- monitor basic performance and trainer
- co-financier
IV.2 The role of the Community-based schemes

- sharing available evidence and know-how
- sharing monitoring protocols
- collaboration in training
IV.3 Perspectives

- connection-scenario feasible if there is trust and credibility

- complementary role of Community-based schemes, their role being defined by government as steward
Linkage between social security and community based social protection

the case of Lao P.D.R

Source: A Ron, ILO/ISSA/AIM study on linkages between statutory social security schemes and community based social protection mechanisms to extend coverage, September 2006.
I. Introduction

• 1975-late 1990s: health care funded by government and provided for free in public health facilities

• Introduction of user fees in 1997 and expansion of Revolving Drug Funds (fees for drugs set at cost + 25%)

  – Important impact on out-of-pocket spending (10$ per person per year)
II. Social protection schemes

- Civil Servants Scheme (CSS)

- Social Security Organization (SSO) for private sector workers

- Voluntary Community-based health insurance (CBHI) developed by the MOH
  - 5 local schemes now operational
  - Policy set by Health Insurance Committee of the MOH
  - Local management with the CBHI District Management Committee
III. Legal framework for CBHI

- All schemes follow the same core design as defined by the MOH

- Four manuals need to be respected:
  - Work plan preparatory phase and report on community consultation
  - Regulations for the pilot project
  - Guidelines and comments on regulations
  - Forms, registers and letters used in the administration of CBHI
IV. Challenges

- Expansion of coverage
  - Currently the total insured proportion of the population is only 2.3% of the 5.9 million population

- Stressing harmony between the different schemes rather than competition

- Long-term strategy
  - Extension of SSO to all provinces and all enterprises
  - Merging of CCS with SSO
  - Enrolment of self-employed formal and informal sector workers in SSO
  - Legislation for the stages to reach universal coverage
CONCLUDING REMARKS

• There is no unique prescription on how to reach universal coverage:
  
  – Important to assess the role of Government as direct financier
  – Mixed systems may be indicated in the transition phase

  community-based health insurance and social health insurance belong to the various options...
  but, once selected, merits substantial preparation, and institutional and managerial capacity
References to case studies


References to case studies (cont.)


- **RWANDA**:
References in www.who.int/health_financing/

- WHA Resolution
  http://www.who.int/health_financing/HF%20Resolution%20en.pdf

- Community-based health insurance

- Social health insurance
  http://www.who.int/health_financing/issues/mechanisms/en/index2.html

- Catastrophic health expenditures
ANNEXES
Proportion of households with catastrophic expenditures vs. share of out-of-pocket payment in total health expenditure
Percentage of households with catastrophic expenditure and impoverishment (SEAR)
Composition of out-of-pocket health payment in Nepal (WHS 2003)
Out-of-pocket health expenditure as a share of total health expenditure in SEA region (2003, NHA)
CBHI in Rwanda

- CBHIs + government intervention
- Objectives:
  - universal coverage + local accountability
  - increased risk pooling + subsidy to cover the poor (much from donors)

- First CBHI initiatives in mid-1960s
- Gov pilot projects 1998, rollout since 2001
- 2006: about 40% of population registered with a CBHI
- True coverage probably lower (failure to pay recurrent contributions, other barriers to access e.g. continued user fees)

Source: Ministry of Health, Rwanda. Photo by Bart Lippens
**CBHI** (mutuelle de santé / MS) at local sector level with health centres

Elected locally

Collection of contributions
CBHI unions
Contributions pooled at district level in CBHI union
Administration & reimbursement
Mobilisation & sensitization
Federations of CBHI unions at province level
National solidarity fund
Supervision of activities
Facilitate exchange of experiences

Possible future roles:
Aggregated risk pooling
Reimbursement for "out-of-district" service utilization
National solidarity fund

National confederation

together with formal sector insurance

Defend interests of CBHIs

Be involved in policy making
Technical Support Cell

Confederation
- MMI
- RAMA
- CBHI

CBHI Federation
- CBHI Union

National Level

Province Level

District Level

Technical support cell
- Under MoH administration
- Policy making
- Monitoring
- Training
- Research

National solidarity fund
National solidarity fund

Contributions from CBHIs as well as the formal sector insurances, some tax and donor fund

Functions as "Re-insurance"
1. What is SimIns?

A tool to analyze the basic mechanism of health insurance
2. Principal uses of *SimIns*

- **Illustrate** different policy options with respect to key health insurance variables (not setting policies)

- **Facilitate** search for financial equilibrium: which sets of contributions and/or utilisation patterns and/or health care costs are compatible with this goal

- **Examine** the impact of health insurance on
  - the overall structure of national health financing
  - The structure of general government health expenditure
3. Examples of policy issues

- What **benefit package** can a health insurance offer given specified contributions?
- What is the required funding from different sources to **expand the benefit package**?
- Different combinations of contributions from government employees, employed workers and the self-employed, along with government subsidies can ensure **financial equilibrium while extending coverage**?
- What are the financial implications of providing **exemptions**?