

Workshop Report

No. 1

**Social Health
Insurance
Working Group
Meeting in
Zimbabwe**

**January 28–30,
1998**

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Partnerships
for Health
Reform



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Partnerships
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- ▲ *better informed and more participatory policy processes in health sector reform;*
- ▲ *more equitable and sustainable health financing systems;*
- ▲ *improved incentives within health systems to encourage agents to use and deliver efficient and quality health service; and*
- ▲ *improved organization and management of health care systems and institutions to support specific health sector reforms.*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

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Abstract

This report captures the essence of the outputs of the Social Health Insurance Working Group Meeting in Zimbabwe, held at the Holiday Inn, Mutare on January 28–30, 1998. The objective of the meeting were to—

- ▲ *Reach consensus on the structure, provision, and other technical details for social health insurance, including an examination of nationwide implementation of cost recovery, reimbursement mechanisms, hospital reforms, private sector interaction/regulation, and means testing/equity;*
 - ▲ *Develop a draft social health insurance framework; and*
 - ▲ *Develop a draft action plan.*
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Acronyms

EMCOZ	Employers Congress of Zimbabwe
GOZ	Government of Zimbabwe
MAS	Medical Aid Societies
MOHCW	Ministry of Health and Child Welfare
NHIS	National Health Insurance Scheme
NSSA	National Social Security Authority
PHR	Partnerships for Health Reform
SDU	Strategic Development Unit
SHI	Social Health Insurance
USAID	U.S. Agency for International Development
ZCTU	Zimbabwe Congress of Trade Unions

Executive Summary

The purpose of this report is to summarize the final products of the Social Health Insurance Working Group Meeting in Zimbabwe, held at the Holiday Inn, Mutare on January 28–30, 1998. The report is not intended to provide a narrative of meeting proceedings but to give the reader a sense of the issues that were discussed and the plan for social health insurance that was proposed. The objectives of the meeting were to—

- ▲ *Reach consensus on the structure, provision, and other technical details for social health insurance, including an examination of nationwide implementation of cost recovery, reimbursement mechanisms, hospital reforms, private sector interaction/regulation, and means testing/equity;*
- ▲ *Develop a draft social health insurance framework; and*
- ▲ *Develop a draft action plan.*

Each session was organized around a particular health care financing or social health insurance theme or set of issues. Zimbabwean participants opened most of the sessions with a presentation or structured discussion. The purpose of each session opening was to enable the participants to articulate their visions, goals, and concerns regarding health care financing issues and social health insurance in Zimbabwe. An open discussion followed each presentation. Each session concluded with a synthesis of the discussion. (See Annex for a list of workshop participants.)

At the conclusion of the workshop, three additional meetings were necessary to complete the proposed model for the National Health Insurance Scheme (NHIS), formulate the first draft of the action plan, and discuss an outline of the presentation to policymakers and ministry officials. These meetings were held in Harare on February 2, 3, and 5 at the Meikles Hotel.

Next steps include providing continued assistance on refining the proposed model for NHIS and developing the presentation package, after obtaining further clarification from counterparts.

1. Agenda

ZIMBABWE SOCIAL HEALTH INSURANCE RETREAT AGENDA JANUARY 27–30, 1998

1. Session One: Goals, Objectives, Context, and Political Realities
 - a. Presentation on goals, objectives and expected outputs of the meeting
 - b. Discussion by individual participants
 - c. Presentation of major health care problems
 - d. Discussion by participants
 - e. Presentation of major health care financing problems
 - f. Discussion by participants
 - g. Discussion of current political climate
 - h. Synthesis of discussion

2. Session Two: Possible Solutions
 - a. Presentation of possible solutions to health care financing problems
 - b. Discussion by participants
 - c. Discussion
 - d. Synthesis

3. Session Three: Social Health Insurance in Zimbabwe
 - a. Presentation on proposed form of Social Health Insurance
 - b. Discussion by participants
 - c. Presentation on pros and cons of Social Health Insurance
 - d. Pre-requisites for Social Health Insurance
 - e. Mock debate by participants on Social Health Insurance
 - f. Discussion
 - g. Synthesis

4. Session Four: Next Steps
 - a. Presentation on desired next steps from participants
 - b. Reaction
 - c. Discussion
 - d. Synthesis

5. Session Five: Next Steps Continued

2. Discussion Questions

I. Session One: Goals, Objectives, Context, and Political Realities

- ▲ *What are the major features of the health sector, (i.e., size, scope, distribution) for both the private AND public sectors?*
- ▲ *What are the achievements of the health sector in terms of coverage, performance (data on key indicators)?*
- ▲ *What are the major problems of the health sector in each of the following areas:*
 - △ Service delivery,
 - △ Administration/management/supervision,
 - △ Manpower, human resources, and
 - △ Financing?
- ▲ *What are the problems that could/would be resolved by SHI?*
- ▲ *What is the impact of current political and economic developments on health sector performance (e.g., devaluation, inflation, food price increases, etc)?*
- ▲ *What other health sector reforms have recently been implemented, or are underway, or are being proposed/considered for the near future?*

II. Session Two: Possible Solutions

- ▲ *Is the health system adequately financed?*
 - △ Contribution of National Budget.
 - △ Contribution from local governments and municipalities.
 - △ Private financing:
 - △ User fees
 - △ Private insurance
 - △ Employer financing
 - △ Health maintenance organizations
 - △ Donor financing.

- ▲ *Are resources optimally allocated?*
 - △ Curative versus preventive (esp. HIV).
 - △ Personnel versus other inputs.
 - △ Enforcement of the referral system.
- ▲ *Are resources/services equitably distributed?*
 - △ The urban/rural distribution of resources and services.
 - △ Existence and enforcement of protection mechanisms (targets, means tests).
- ▲ *Institutional issues:*
 - △ Relationship between the public and private sectors.
 - △ Governance, decentralization, autonomy.
 - △ Incentives for effective and efficient performance.
- ▲ *What is the role for SHI in the above points.*
- ▲ *What is the likely impact of SHI on private MAS (Medical Aid Societies).*

III. Session Three: Social Health Insurance in Zimbabwe

Questions 1:

- ▲ *Benefits packages.*
- ▲ *Contribution mechanisms, how much, how to collect.*
- ▲ *Target groups.*
- ▲ *Provider payment mechanisms.*
- ▲ *Control systems.*
- ▲ *Administration and management of fund.*

Questions 2:

- ▲ *Initially, five studies were to be undertaken to determine the feasibility and design of the SHI, but so far only the two undertaken by KPMG have been completed. IN this context can you proceed without the other crucial studies such as suppliers' response and financial management?*
- ▲ *Will current and future growth of the economy permit higher allocations to the health sector via tax or insurance contributions?*

- ▲ *What is the current level of payroll taxes, and what is the likely impact of increased taxation on incomes and employment?*
- ▲ *Cost explosion is one of the greatest dangers that can result from health insurance. What technical, administrative, and financial skills are in place or envisaged in order to deal with this issue?*
- ▲ *Does the infrastructure exist to provide the services to which people are entitled under insurance? Have you considered that urban and rural people may resist paying for a service which brings no additional benefits (quality) and was moreover free to the rural people prior to the introduction of health insurance?*
- ▲ *Is a pilot study of the proposed SHI envisaged?*

Questions 3:

- ▲ *Does SHI respond to the health care and health care financing priorities that were previously identified?*
- ▲ *What are the principal advantages of SHI?*
- ▲ *What are the principal disadvantages of SHI?*
- ▲ *What are the implementation issues that need to be considered?*
- ▲ *How will SHI be structured? Who will be in charge?*
- ▲ *What other policy reforms in the health sector are necessary for SHI to succeed?*
- ▲ *Do people want SHI? If so, who does? Who doesn't? Why?*
- ▲ *If SHI just means a new tax on people with no improvement or change in service, isn't that just taking something from someone? How would you convince "the person on the street" that this is a good idea? What kinds of reforms would you want to implement to make sure that people value SHI?*
- ▲ *How will providers be paid? Will a central agency pay providers individually? Will the funds just go straight to the MOH or will a separate agency be set up to reimburse providers?*
- ▲ *What will happen to private MAS's under SHI? What kind of outcome would be good for them? What kind would be bad? Why?*

IV. Session Four: Next Steps

- ▲ *If consensus building is necessary, what stakeholder groups are the most important to target?*
- ▲ *What are the messages that are most likely to reach these groups?*
- ▲ *What are the roles and responsibilities of each of the core participating groups in next steps? What resources are necessary for each of these actors to carry out their assigned roles?*
- ▲ *What information gaps, if any remain? Which are the most important ones?*

- ▲ *Who will take the lead in keeping the coalition together in order to maintain momentum?*
- ▲ *Do we need to consider other health reforms prior to/along with SHI? If so, what are they? Which ones are of greatest priority? Do there exist some reforms that are necessary precursors to SHI?*
- ▲ *Are the resources (both financial and human, including managerial) adequate to ensure sound implementation of SHI? If not, which are the most crucial resources that are needed?*

3. Discussion Notes: Session One

1. Objectives/Expected Outputs
2. Agenda
3. How broadly do we want to look, i.e., how much of the health care financing environment do we want to bring into the discussion of Social Health Insurance (SHI)?

Parking Lot

1. Review previous material to determine impact on current discussion.
2. Get background information to each participant so that everyone understands issues on the same level.

OBJECTIVES/EXPECTED OUTPUT:

1. Too many objectives, need more focus.
2. Identify steps to develop a draft SHI framework.
3. Develop draft, not identify steps to draft a SHI framework.
4. What is a framework?
Model of implementation of SHI scheme.
Framework plan versus implementation/action plan.
5. Define process steps from here (where we are) to SHI.
6. Gain clearer understanding of the SHI concept.
7. Action plan describing details of SHI model and how it will be implemented.
8. As per Terms of Reference, i.e. develop draft framework, (implicit agreement).
A framework is a description of broad features of a solution that could work and steps necessary to implement it.
9. Develop a draft implementation action plan.
10. Identify steps for future action/implementation.
11. Include what and how.
12. Employees:
Agree: Something needs to be done vis-à-vis health care.
Disagree: What (i.e. what has already been proposed)?

AGREEMENTS REACHED:

1. Agreed to meet.
2. Agreed something needs to be done regarding finance of health care.
3. Consult, ensure there is consensus.
4. Result of this workshop will be disseminated to broader group of stakeholders.
Proceedings are not binding.
Just recommendations to stakeholders.
First step in serious consultative process.
5. Need to broaden stakeholder groups.

AGENDA:

1. Need to consider costs of inaction, i.e. not doing anything.
2. Time use:
Need for time to discuss formulation of action plan.

- 3. Need to discuss management, efficiency of health sector reforms, etc.
Reorganize suggested session 3.
Item D goes first and then the remainder of the items follow.
- 4. Add experience from other countries in the region.

PROBLEMS:

(Presentation by Mr S. Chihanga)

- 1. Facilities have deteriorated: there is no equipment, and drugs are in short supply due to inefficiency, quality.
SHI - YES
- 2. Inadequate staffing of peripheral facilities.
NO/YES, IN PART/INDIRECT
- 3. Problems with referral system, e.g. 75 percent of patients at hospitals are walk-in patients.
YES, DIRECT
- 4. Administration centralized.
YES
- 5. Lack of accountability.
YES
- 6. (Mr S. Chihanga)
Problem is not shortage of money, it is rather:
Delivery system is inefficient.
Money should follow the patient.
Access.
Quality.
Consumer satisfaction.
YES
- 7. Complaints by patients.
Long queues.
Lack of drugs and supplies.
Rudeness of staff.
Lack of ambulances in the rural areas.
YES
- 8. Gross underutilization of primary health care facilities.
YES
- 9. Rational distribution of responsibilities (between public and households) not well articulated.
YES
- 10. System has a lot of waste.
YES
- 11. Inherent conflict in being both a provider and a purchaser of services.
YES
- 12. Weak policy environment; policymakers do not see the linkages between the various sectors; instead each sector seems to function on its own.
YES
- 13. Treatment and deployment of manpower.
Governmental departments are organized around professionals.
Those who make the most noise get the larger allocations.
YES, PACKAGES AND RESOURCES AVAILABLE ARE BASED ON NEED, NOT OTHER FACTORS

14. Overcentralization: e.g. money belongs to the Ministry of Finance; vehicles belong to the Ministry of Transport, etc.
YES
15. Simplistic perception of reform. There is a need for political commitment.
YES/NO
16. Shortage of managerial competence (i.e. posting of staff is not rational).
NO
17. Lack of incentive for manager/performance excellence.
YES
18. Negative moral of manpower.
Decline in earnings.
Risk of exposure to HIV.
Lack of staff development opportunities.
YES

COMMENTS:(input from the floor):

1. Government centralized to promote equity:
Can some of the problems be resolved by rearranging responsibilities?
Can some of the resource mobilization and responsibilities be delegated to local governments?
2. Lack of data on significance of some problems; need system evaluation.
3. How do you relate SHI to centralization?
4. Lack of representation from the Ministry of Finance in such policy forums, yet their role is vital.
5. SHI is often related to curative care. What do we do about preventative care?
6. Management and such problems may not be resolved by SHI. Something has to be done by the Ministry of Health to correct these problems.
7. How is the separation of the purchaser/ provider going to resolve the benefits going to the few after eliminating all those that will be exempted?
8. Appropriate incentives induce appropriate behavior
9. What is the objective and net yield of cost recovery?
Capacity and incentive to bill and pursue reimbursements.
Need multi-sectoral approach.
10. Develop systematic culture of evaluating what we do.
Develop clearly defined indicators.
11. Nationally agreed monitoring system to be tried in the Health Sector, Education Sector and the Agricultural Sector.
12. Need to balance quantitative and qualitative data.
Need to make data relevant to SHI.
Is Alma-Ata still a relevant policy?

HEALTH PROBLEMS:

1. Problems SHI can solve:
Efficiency, depends on how providers are paid (e.g. capitation)
Capitation:
Paying providers on a per person basis, i.e. “per capita.”
Incentive to keep patients healthy
Incentive to under treat?
Guarantee Ministry of Health standards.

- SHI would make sure resources to provide health care are available.
SHI can affect quality, i.e. queues.
2. How can SHI affect quality?
Related to budget support to hospitals (resources to provide adequate care will be available).
The process of ordering drugs to time of receipt is about 6 weeks.
Also need to recognize low income groups' ability to pay.
Should access to drugs be a question of money?
 3. With management and administration reforms, SHI can improve outcomes and performance. This addresses Mr. Chihanga's comment that the problem is not necessarily lack of money, but an inefficient delivery system.
 4. Focusing on overall framework may provide a way to understand the other associated complementary reforms.
 5. Which problems can be solved/addressed by SHI?
Distinguish those problems that are solvable by SHI.
 6. SHI - redistributive effect?
 7. What problems SHI can address depends *greatly* on the SHI model, i.e the SHI scheme that is actually implemented?
 8. Private sector does not have sufficient incentives; Government has all the advantages (monopoly).
 9. For SHI to work, need to create incentives for providers (both public and private).
 10. Need to focus on overall health problems and the reasons for them.
 11. Impact of current political and economic developments on health sector performance.
Price of cleaning materials has increased.
On average, 70 percent of hospital admissions are due to underlying HIV/AIDS.
Inflation has had an adverse impact on purchasing power.
Delay treatment.
Choose less reliable alternatives (e.g. traditional ones).
 12. The KPMG Study did not consider the cost impact of the HIV/AIDS epidemic.
How can we offset public perception of the burden of SHI tax versus the use of revenue to pay for treating HIV/AIDS patients?
 13. Need to make sure that resources collected via SHI are not eroded by inflation.
 14. How can we link SHI to public assistance program, i.e. some will not be able to afford the cost of SHI?
 15. Costs associated with seeking care have also increased, e.g. transport.
 16. What will be covered by SHI? (Who will be entitled to benefits?).
Subscriber/payer.
Payer and allowance for the poor.
Other?
 17. Coverage:
Currently social sector (NSSA) does not cover Civil Servants.
Same for SHI?
 18. Implementation of SHI may be perceived as yet another levy.
 19. Current political climate may not be conducive.
 20. Civil service not part of NSSA due to issue of the 3 percent employer contribution.
Need to reduce the workforce in order to be able to afford employer (Government) contribution to NSSA.
 21. Political climate may not be favorable, but need to focus on how to overcome this problem.
Focus on the benefits caused by the introduction of SHI.

22. Equity: SHI can improve equity.
23. SHI will treat providers as equals.
24. Private sector and SHI.
Not control private sector but set national standards.
25. Health financing.

4. Discussion Notes: Session Two

SOCIAL HEALTH INSURANCE

Social Health Insurance systems pay for health service through contributions to a health fund. The most common basis for contributions is payroll, with contribution from both the employer and employee. Contributions are based on ability to pay, and access to service is based on need. The health fund is usually independent from the Government, but works within a tight framework of regulations. It is usual under social insurance for entitlement to service to be listed in detail (i.e. defined benefits package), and for contribution rates to set at a level intended to ensure that these entitlements can be met (i.e. the fund is solvent).

[Social Health Insurance: A Guidebook for Planning, Charles Normand, Axel Weber, *ILO*, p13]

SOCIAL HEALTH INSURANCE GUIDELINES FOR PLANNING: SOLUTIONS

1. Overview

- ▲ *Objective of health finance is improved health status.*
- ▲ *Health finance is a means to an end.*
- ▲ *Resource mobilization:*
 - △ National budgets (taxes)
 - △ Donor
 - △ Employers
 - △ Cost Recovery
 - △ Insurance
- ▲ *Resource efficiency: Are available resources used as efficiently as possible?*
- ▲ *Mix of inputs (technical efficiency) is important, i.e. having the right amount of capital and labor.*
- ▲ *Equity: resources allocated equitably.*
- ▲ *Impact of SHI on Medical Aid Societies (MAS): how and will it affect them?*

2. Labor point of view regarding SHI
 - ▲ *Share of National Defense in budget is too large.*
 - ▲ *Propose that reductions in National Defense allocation should finance health care.*
 - ▲ *Offset reduction in corporate and individual taxes with income in SHI that net burden in labor stays the same but health care is financed.*
3. Lack precise knowledge of where health resources come from and where they go.
4. Planning process leads to more efficient use of resources?
5. Funds (e.g. Social Development Fund) more able to allocated their funds efficiently than Ministries?
 - ▲ *Ministry has less flexibility, less control.*
6. Why not consider two different health packages:
 - ▲ *Urban health package (entitled to all available resources).*
 - ▲ *Rural health package (entitled to available resources which usually only amount to primary health care).*

5. Proposed Model for a National Health Insurance Scheme

1. INTRODUCTION

Pursuant to section 3 of the National Social Authority Act (NSSA) chapter 17:04 and a decision by the Politburo, the following National Health Insurance Scheme is hereby proposed.

The proposed scheme will be a joint effort between the Ministries of Health and Child Welfare, Public Service, Labor and Social Welfare and the social partners: Employers Confederation of Zimbabwe (EMCOZ), Zimbabwe Congress of Trade Unions (ZCTU), and representatives of civic, community and non-governmental organizations.

The scheme will be administered by NSSA and the requisite health services shall be provided by the Ministry of Health and Child Welfare and by other accredited health providers.

The principles of the proposed NHIS are: equity, social solidarity, self-financing and accountability.

2. THE PRESENT SITUATION IN ZIMBABWE

In Zimbabwe, health services are provided through the following: Government, local authorities, the private sector, and Mission Hospitals at the primary, secondary and tertiary levels. Government has played a major role in the financing of health services. A proportion of employed persons take advantage of a system of pre-payment for medical services through contributions to medical aid societies.

There are 27 medical aid societies, covering approximately 567,000 persons of the active labor force and their dependants. These insured persons have better access to medical services and greater choice.

A user fee was introduced at health care facilities in 1991 and became operational in 1993. A Government exemption policy, paid for by the Social Development Fund, covers those who earn up to Z\$400.00 per month. The policy, which is subject to abuse, is currently difficult to administer. Due to the difficulties in implementing exemption policies for health in rural areas, the Government discontinued the user fee policy in rural areas in 1995.

The referral system, which stipulates that those requiring medical services should initially access the lowest and cheapest level of primary health care, is not working well due to shortages of drugs, equipment, and technical staff. Instead, patients utilize central hospitals for illnesses that could be treated at primary health care centers.

3. OBJECTIVES FOR THE NATIONAL HEALTH INSURANCE SCHEME (NHIS)

Due to escalating costs, the Government may be unable to meet its full financial commitments to existing and expanded medical services. A National Health Insurance Scheme within the

framework of social security will not only ensure the financing aspect of health services, but also will be a social program that legislatively grants individuals the right to health insurance.

- ▲ *A national health insurance scheme redresses the unequal accessibility to health services by redistributing accessibility in an equitable and progressive manner.*
- ▲ *NHIS is a means of enhancing social solidarity in health care.*
- ▲ *Economies of scale from the pooling of risks and resources could result in surplus funds to improve the system of health provision.*
- ▲ *NHIS provides funds for the financing of the current and expanded health services in an efficient and sustainable manner.*
- ▲ *NHIS is poised to operate in an environment where there is decentralization of the health services and accountability.*
- ▲ *NHIS will implement the principle of separating institutional responsibility for the functions of financing and provision of health care. This will be done so that providers can be given incentives to offer quality care that meets client needs in the most efficient manner.*
- ▲ *NHIS will preserve a role for private sector providers and medical aid societies (MAS).*

4. COVERAGE

- ▲ *The scheme will provide access to a basic package of health services for everyone in Zimbabwe, both employed and unemployed, and their dependents.*
- ▲ *NHIS will finance the basic package of health services. Those wishing additional benefits beyond the basic package will have recourse to other schemes that will complement the basic package.*
- ▲ *NHIS will be compulsory for workers employed in the formal sector but optional for those employed in the informal sector.*
- ▲ *A regulatory agency (TO BE DETERMINED) will work with MAS and other schemes to ensure that the insurance packages offered as supplements to NHIS are standardized to facilitate consumer choice and comparisons of comparable supplementary benefit packages.*
- ▲ *NSSA will be responsible for reimbursements to providers only for services delivered as part of the defined basic package of benefits.*

5. FUNDING OF THE SCHEME

- ▲ *There is no exemption in principle; everybody pays or is paid for.*
- ▲ *The Scheme shall be funded from contributions from both employee and employer.*
- ▲ *A separate fund shall be established into which the contributions will be deposited.*
- ▲ *Compulsory contributions of formal sector workers shall be payable to NSSA together with contributions for the Pensions and Other Benefits Scheme through the employer.*

- ▲ *Compulsory contributions of formal sector workers shall be a proportion of a members' earnings, plus set rates for dependents based on actuarial estimates.*
- ▲ *Workers employed in the informal sector, as well as others not qualifying as indigent, will be able to voluntarily enroll in NHIS by paying into the Fund. Those wishing to voluntarily enroll will pay a flat rate per person plus set rates for dependents based on actuarial estimates.*
- ▲ *The Government will pay a contribution to the Fund to cover the indigent and those who are unemployed or unable to pay for themselves at rates based on actuarial estimates. The determination of who is indigent and cannot pay will be carefully means tested to ensure only those without ability to pay are granted free access to services. Certification of indigent status will be done by a separate Government agency such as the Department of Social Welfare.*
- ▲ *All tax preferences for private insurance will be eliminated. The revenue generated from this change should be used to pay a portion of the Government contributions to the Fund for those who are indigent.*

6. RATES OF CONTRIBUTIONS

- ▲ *The rates of contribution shall be sufficient to cover the costs of the services provided under the defined benefit package for the enrolled population under the compulsory program as well as allowances for the costs of administration and provisions for reserves.*
- ▲ *Determination of the allowances for reserves will be set after further study.*

7. BENEFITS OFFERED

- ▲ *Benefits offered will cover the core health services offered at primary and secondary levels. The precise components of the package as well as the extent of covered access to higher level care will be determined based on further study of the benefits package.*
- ▲ *In all cases, patients will be required to access care initially at the primary level. Except in the case of emergency care, the Fund will cover secondary and higher level care only if it has been referred from the primary level.*
- ▲ *Coverage of prescription drugs will be limited to those that are on the National list of essential drugs. Where applicable, they shall be in generic form.*
- ▲ *The defined benefit package will provide access to the services of accredited providers only in both the public and private sectors.*

8. ENTITLEMENT TO BENEFITS

- ▲ *The benefits are receivable for as long as one is a member. At unemployment, the benefits will continue for a period of up to 3 months. After 3 months, coverage can continue in one of two ways: either the subscriber is certified as poor to qualify for a Government-funded NHIS card, or the subscriber can purchase continuing coverage voluntarily through payment of a contribution.*
- ▲ *Workers retiring with pension will have access to the benefits package through compulsory enrollment in NHIS. The amount they pay will be determined in relation to their pension, which reflects their earnings during employment. This contribution will be deducted from their pension to cover the cost of their enrollment. Further study is necessary to precisely determine*

what their rate of contribution will be. Further study is also necessary to determine if their contributions during employment will be adjusted to account for their eventual retirement.

- ▲ *Formal sector workers, for whom participation is compulsory, will have access to benefits immediately. Voluntary enrollees will be required to wait 90 days before being eligible for benefits.*
- ▲ *Benefit cards, clearly indicating members entitled to benefits under the plan, will be issued to all qualifying enrollees. Benefit cards will be renewed annually, with a proportion of cards renewable each month. The benefit card will carry a photo(s) of all covered persons.*
- ▲ *Those eligible for coverage under this plan are defined as:*
 - △ *enrolled and 1 spouse.*
 - △ *children under the age of 18 years or up to 25 years in age if still in full-time education or if disabled.*
 - △ *Other dependents including parents where these have been nominated.*
 - △ *Those entitled to benefits will be those who are actually paid for.*

9. ADMINISTRATION, INSTITUTIONAL CAPACITY AND INFRASTRUCTURE

To successfully implement NHIS, new skills and expertise will be required, and roles and responsibilities assigned, in the areas of:

Health care management:

- ▲ *Assessment/accreditation of providers*
- ▲ *Determination if payments to providers are justified*
 - △ *Legal and regulatory management*
 - △ *Health management information systems*
 - △ *Assessing the quality of care provided*
 - △ *Negotiating contracts with providers*

These skills are prerequisites for initiation of NHIS.

10. RESPONSIBILITIES OF NSSA

- ▲ *NSSA will be responsible for the collection of funds and administration of benefits, though this latter responsibility may be delegated to another organization or contracted out to private organizations such as MAS.*
- ▲ *NSSA will be responsible for efficient collection of funds and administration of benefits. To this end, incentives and/or regulations will be introduced to ensure administrative expenses incurred by NSSA to manage NHIS are as low as possible while maintaining customer satisfaction.*

11. COEXISTENCE OF MEDICAL AID SOCIETIES WITH NHIS

- ▲ *MAS will continue to provide supplemental packages to those who wish to purchase additional services.*
- ▲ *Recognizing that NSSA has the lead in implementation of NHIS, other options for administering the benefits may be considered. One of the options might be to contract out to MAS to administer benefits and pay providers.*

12. COST CONTAINMENT

- ▲ *Cost containment reforms are a prerequisite for successful implementation of NHIS.*
- ▲ *A fundamental principle of cost containment is to set incentives for clients to consume resources wisely and for health care delivery personnel to provide appropriate amounts of care.*
- ▲ *Additionally, how providers are paid has been shown to significantly affect the cost of providing health care. For example, worldwide experience has shown that paying providers on a fee for service basis leads inevitably to cost escalation.*
- ▲ *Accordingly, providers will be paid based on some form of capitation, i.e., paid a fixed amount per person based on the number of persons enrolled for primary care at their facility.*
- ▲ *Capitation will have the added benefit of rewarding providers who offer quality care as resources will follow clients in the form of the capitation payments to the preferred providers.*
- ▲ *To encourage efficient use of resources by clients, the following measures will be used:*
 - △ *Clients will access care at the primary level and seek referral from their primary level care giver before having access to care at higher levels.*
 - △ *Clients will pay co-payments for curative or elective services.*
- ▲ *To encourage efficient use of resources by providers:*
 - △ *Providers will be paid on a capitation basis.*
 - △ *Clients will be allowed to register with (i.e., seek services from) public or private providers.*
 - △ *Providers will be encouraged to use principles of managed care.*
- ▲ *To ensure quality services in a managed care environment are offered—*
 - △ *Consumers will have choices whenever possible. To this end, providers (both public and private) will be encouraged to band together to form provider organizations and recruit clients.*
 - △ *Customer satisfaction will be monitored and included as an evaluation criteria for any performance-based payments or assessments, particularly in areas where provider choice is limited.*

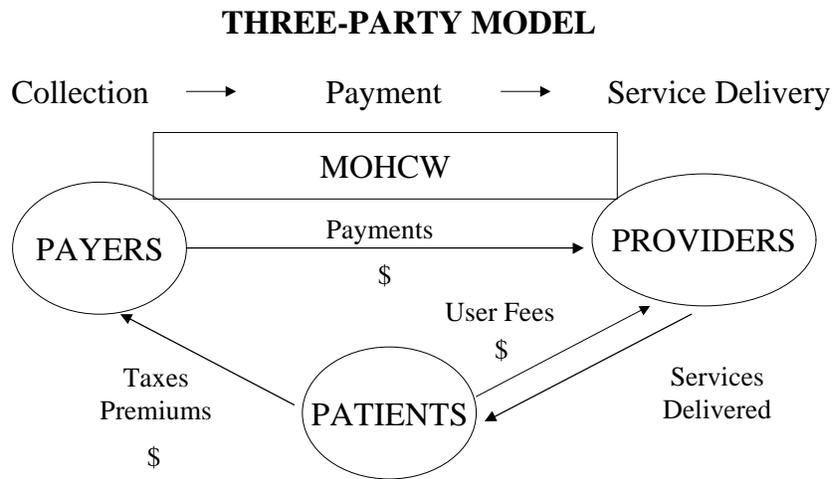
- ▲ *To ensure administrative expenses of running NHIS at NSSA are kept as low as possible, regulatory and incentive measures such as ceilings on administrative expenses and performance-based contracts will be used whenever possible.*

COMMENTS ON PROPOSED MODEL

1. Benefits

- ▲ *If illness is work related, there is a need to clarify where funding will come from to cover cost of illness.*
- ▲ *Work related illness covered under Workers' Compensation, SHI for other illnesses, i.e. not work related.*
- ▲ *Members should be able to purchase drugs from any source (private/public).*
- ▲ *Drugs are a very important issue for cost containment.*
- ▲ *There must be from Essential Drugs List (Generic).*
- ▲ *Need to evaluate potential response of private sector to request for Essential Drugs: legislation necessary?*
- ▲ *Means testing is difficult to do but necessary.*
- ▲ *Use associations to collect subscriptions, define: who is needy? (Experience in Ghana)*
- ▲ *Currently the Department of Social Welfare screens, identifies poor as follows:*
 - △ *Education: needy students are identified by the schools, assessed by social services*
 - △ *Health: direct targeting assure 20% of pupils are poor; remit 20% of clinic cost recovery revenues to clinic to cover cost of serving poor. Also poor referral from Primary Health Care (PHC) clinics are treated free of charge at hospitals*
 - △ *Locus housing concept used in urban areas (e.g. high versus low density). Not applicable for rural areas.*
- ▲ *Government grants to mission hospital also serve equity ends.*
- ▲ *Capacity limited to means testing at micro-level can target districts.*
- ▲ *Sixty-one percent of the current population is considered as being poor.*
- ▲ *Targeting (exemptions)- relevant only when user fees exist?*
 - △ *Geographic.*
 - △ *Epidemiological (i.e. HIV/AIDS).*

- △ Demographic (i.e. income, age).
- △ Means testing: (waiver).
- △ Discretionary, requires administrative capabilities.
- ▲ *Institutional response for deciding exemption waivers need incentive to certify carefully, otherwise costs will be increase (accumulate). Social security is not provided to civil servants as Government cannot afford to pay as employer of civil servants, i.e. taxes will increase.*
- ▲ *Civil servants are unsure of what happens to the 3 percent of employer's income after it is paid to NSSA – no proof of use for SHI.*



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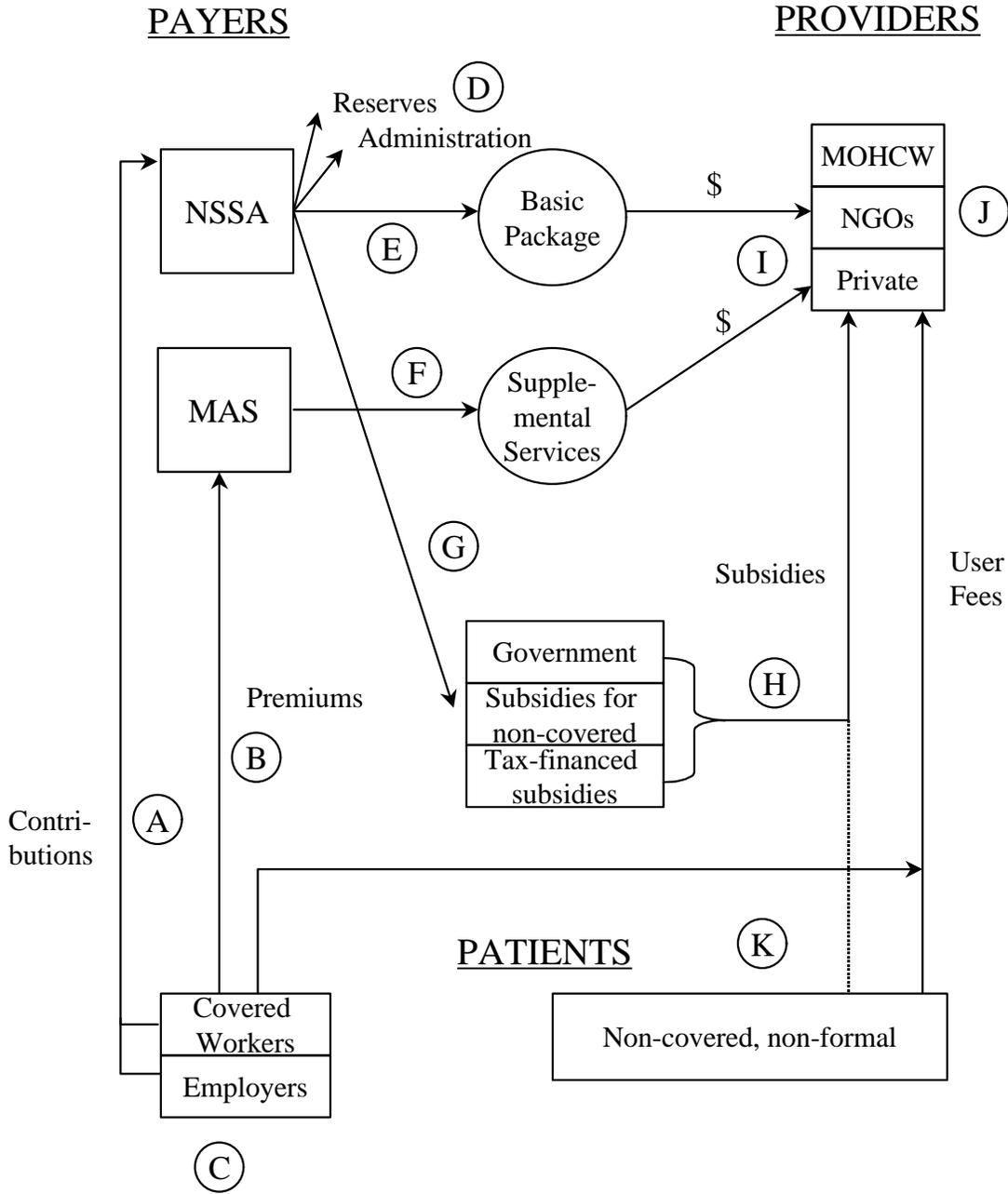
How do the incentives inherent in payment arrangements affect behavior of:

Patients? Payers? Providers?

For example:

- ▲ *Fee-for-service delivery: with insurance coverage and/or low/no user fees ⇒ rapid inflation in use and prices*
- ▲ *Budget-funded direct delivery by Government: with low/no user fees and constrained budgets, quality and access to services suffer*
- ▲ *Pre-paid capitation funding of a specific package of services: incentives to keep patients healthy and avoid unnecessary and wasteful.*

SCHEMATIC FOR ISSUE IDENTIFICATION



The diagram above provides a schematic for issue identification. A description follows the diagram.

A major goal for Social Health Insurance should be to improve incentives to bring desired cost-effective behaviours, with universal access to services of quality.

KEY FOR DIAGRAM

NSSA – National Social Security Administration

MAS – Medical Aid Societies

MOHCW – Ministry of Health and Child Welfare

NGOs – Nongovernmental Organizations

SUGGESTED QUESTIONS FOR SHI DESIGN: A POSSIBLE SEQUENCE WITH INTERRELATIONSHIPS NOTED FOR ITERATION

1. Costs, Contribution/Collection, and Benefits Specification

- ▲ *What should be in the basic package (i.e. both primary health care and hospital coverage), and which settings would be eligible for reimbursement? Should payment provide eligibility to receive private services and reimbursement? What actuarial methodology and assumptions are used to estimate the likely cost of the basic package? (Refer to I, J) Should there be different rates for rural/urban residents?*
- ▲ *What should be the contribution? Should it cover dependents? How? (Refer to A)*
 - △ Flat \$ amount
 - △ % of wages (all)
 - △ % of wages (up to certain limit)
 - △ Should contribution be compulsory? If so, for whom? (Refer to A)
- ▲ *How should MAS benefits and premiums be related to NSSA contributions and benefits? How should they be coordinated in provision and reimbursement?*
- ▲ *What would be the impact on profits, wages and the labor market of the new NSSA contribution? (Refer to B)*
- ▲ *Should reserves be set aside to ensure the fund is actuarially sound (to build up funds for future predictable cost increases) or should the amount of the reserves fund be just for immediate contingencies? What should the administration allowance be? (Refer to A, B)*

2. Financing Eligibility For Non-Covered Persons

- ▲ *Should the NSSA contribution include an amount dedicated to subsidize non-covered individuals? If so, how much should it be? (Refer to B)*
- ▲ *Should the contribution be compulsory? Should the insurance package be offered for sale to the non-covered? If so, at what rate? If so, for whom? (Refer to A) How should subsidies for non-covered be financed? How should subsidies to non-covered individuals be transferred by the Government to providers?*
- ▲ *What is the amount of budgetary offset (savings) from SHI implementation and how is this amount to be used? To reduce taxes? To finance programs?*

3. Restructuring the Delivery System and Defining Conditions for Reimbursing Providers:

- ▲ *How will providers be institutionally restructured and regulated? What are the principal cost-containment features? What choices among provider types will be made available for covered and non-covered individuals? (Refer to A,J)*
- ▲ *How should user fees be set (with and without insurance) and what should be their relationship to actual costs? (Refer to A) What should the reimbursement methods and conditions be for payment to providers? What should the rules and guidelines governing participation in NSSA reimbursement be?*

KEY QUESTIONS FOR BROAD CONSIDERATION:

- ▲ *How are incentives to patients/payers/providers changed?*
- ▲ *How are costs and benefits of changes relative to existing arrangements?*
- ▲ *To whom do such benefits and costs accrue?*

6. Action Plan for Implementation of a National Health Insurance Scheme

Below is an action plan for the implementation of a National Health Insurance Scheme.

Action Plan for Implementation of a National Health Insurance Scheme

	Responsible	1998				1999				2000				2001				2002				2003			
		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Consultation with Broad Group of Stakeholders Government Private sector providers MAS Public sector providers Other (donors, public, unions, etc)	Working group	/ / / /																							
Refinement of Proposed NHIS Model Further studies (benefits package, etc) Additional analyses	Working group	/ / / /																							
Pilot Test of Proposed NHIS Model Consultation Select pilot districts Grant autonomy to health care providers Train staff in accounting and administrative procedures Inform consumers Produce NHIS cards	Working group					/ / / / / / / /																			
Enhancement of Revenue Collection Revise rules for collection fees Implement improved billing procedures Assess/Collect/Write off past debts	MOHCW	/ / / / / / / /																							

	Responsible	1998				1999				2000				2001				2002				2003			
		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Revision of User Fees Consultation Legislation relating to fee retention Establish appropriate Fund(s) Information and Publicity Reintroduce fees at primary level Modify fees at hospital level	MOHCW, MOF																								
Organizational Changes in the Health Sector Consultation Implement cost accounting Enhance DHE role in managing primary care services Increase management autonomy for hospitals Improve management information systems Review funding mechanisms for primary care Modify fees at hospital level	MOHCW																								
Medical Aid Societies Consultation Introduce compulsory coverage for dependents Introduce levy	Working group																								

	Responsible	1998				1999				2000				2001				2002				2003			
		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Set up of Organization to Administer SHI Fund (NSSA) Consultation Design incentive structure to ensure low administrative expenses Review administrative, accounting and legislative framework Recruit staff Detailed planning Provide technical assistance for operational guidelines Develop pro forma constitution/operating guidelines Legislation Information and policy Start NSSA operations Collect fees	NSSA, MOHCW																								

7. Outline of a Presentation on a Proposed Model for a National Health Insurance Scheme

Proposed organization of presentation to permanent secretaries of Ministry of Health and Child Welfare and of Ministry of Labor, Public Service, and Social Welfare (tentatively scheduled for February 17, 1998)

A. PROPOSED OUTLINE

1. Rationale for the Program
2. Principles Underlying Program Design
3. Basic Elements of the Design of the Program (including Health Sector Reform)
4. Issues of Design and Implementation Needing Decisions
5. Benefits and Costs of the Program and Their Distribution

B. ISSUES

Issue: Many important details will no doubt be missing from the presentation. What minimum level of detail is required to proceed?

For example, information on costs of alternative packages of benefits will not be available, yet the burden of paying for those benefits is an important determinant of its feasibility. Rough guesstimates may be offered. However, these may serve to confuse people (to the extent they are off) or undermine support if they are made public. It is important to keep in mind the tradeoffs involved in making the benefits package richer or leaner. The more modest the benefits package, the lower the cost, but the higher the user fees/co-payments and/or the need for other sources of financing to make up the difference.

Issue: Should the presentation be designed in a way to offer policy choices to the policymakers, granting them their rightful role and responsibility to choose from among possible alternatives? Of course as reasonable as this approach may be (after all, it is the policymakers who make policy), sufficient information would need to be made available regarding the potential costs and benefits as well as implementation requirements of each alternative. This information, as well as detailed data on interactions of particular decisions with other policy dimensions, is unlikely to be readily available very soon. Also, the need for an overall baseline for various spending elements is essential for making meaningful comparisons of the cost and spending consequences of changing current policies.

Issue: As noted, much supporting information and many answers to critical policy questions are interrelated. That is, answers to some depend critically on answers to others. Moreover, incorrect answers to some will have serious consequences to the assumptions which may have been made about the way the design and implementation process will actually work, e.g., cost containment methods incorporated in the design. Therefore, should the presentation make an

attempt to put ranges on estimates and to identify the most critical areas where precision is either most important and/or is most problematic, or both?

C. PROPOSED ORGANIZATION OF THE PRESENTATION

Program being presented: How should it be defined?

Suggestion: Define NHIS as a critical/essential element of broad Health Sector Reform, but with many elements of reform being necessary preconditions or “policy conditions precedent” for promulgating national health insurance as a method of financing universal coverage and equity of accessibility in practice. In other words, there should be an explicit statement that certain policies and programs need to be in place AND need to be proven effective BEFORE a commitment is made to commence collection of a social health insurance levy.

1. Rationale for the Program

Suggestions:

- ▲ *enumeration of system’s problems*
- ▲ *identification of the root causes of those problems*
- ▲ *incentives are wrong, leading to inefficiency/inequity*
- ▲ *Government has multiple roles in health sector; they are in conflict*
- ▲ *average medical care costs/prices rise faster than general prices and*
- ▲ *wages, and the foreign exchange component is beyond Government control*

2. Principles Underlying Program Design

Issue: How broadly the sweep of principles enumerated would depend on whether broad Health Sector Reform were adopted as the “program”.

Suggestion: Integrate appropriate principles of health sector reform into principles underlying the program. Adopt and/or adapt from the basic proposal the principles discussed at the retreat, but emphasize need for health sector reforms as conditions precedent to NHIS implementation.

3. Basic Elements of the Design of the Program (including Health Sector Reform)

Issue: Each of the basic elements has important design issues needing explanation and assessment for the benefit of policymakers. These could be taken up here, as each element is discussed, or could be elaborated in the next section to emphasize the interrelationship of the issues. If taken up later, the listing of the elements here would lack more than elementary justification for the decisions implied by the element’s description, and, of course, would not enable initial understanding of the intricate interrelationships among the many policy variables being changed.

- ▲ *Benefits package (specify with Government provider base/capitation bias)*
- ▲ *Coverage (pilot, phase-in issues; formal/informal)*

- ▲ *Providers (accreditation; organization; management)*

- ▲ *Role of private sector (providers and insurers)*
- ▲ *Other elements named in basic proposal*

4. Issues of Design and Implementation Needing Decisions

Benefits Package:

How does raising user fees (to what relationship to full cost) relate (in distribution of cost, in timing, in justification) to specification of the benefit package? Will some level of nominal fee (at point of service remain)? If so, how much, how collected, how retained, for what? Shall there be deductibles? Should there be benefit limitations, in terms of days/visits/dollars of benefits/types of services? Should mental health services be included? Should benefit package be described in a way that would presume use of capitated plans? If so, how would the plan be reinterpreted in rural areas, where capitation would not apply? If both public and private providers will be eligible (accredited) providers, will payment/reimbursement to private providers be limited to some maximum based on cost of public services (otherwise, how can the growth of private services be controlled at the expense of public providers?).

Coverage:

Costing of benefits package for any group is determined by specifying which groups have coverage, or, in other words, what does the term “actuarial estimates” actually mean in practice? This is particularly important with respect to set rates for:

- ▲ *children/dependents*
- ▲ *the elderly*
- ▲ *persons with special health needs (are AIDS costs averaged across everyone’s costs?)*
- ▲ *those who are given the choice whether to join*

Two key points need to be emphasized:

- ▲ *Age (and gender) composition of a group determine use (and cost) for any particular benefit package.*
- ▲ *Actuarial rules of thumb are that, relative to the costs of the average worker, aged 18 to 45 years, other ages have average costs which are the following percentages of the cost for an average worker aged 18-45:*

Children:	70%
Ages 45-55:	200%
Ages 55-65	250%
Ages 65+	300%++

Private insurance companies typically price coverages to employers depending upon the age and sex composition of their employees, and often require a minimum proportion of employees join to validate the law of averages. Individual coverage, which is what voluntary coverage would be for informal workers, would actually be priced quite expensively in the private market, since

those choosing to buy it would be those who know that they need the insurance (likely to make claims in excess of the cost of the insurance). Even if user fees were set at full cost, the Government might lose money offering voluntary insurance at group (average) rates to those in the informal sector, simply because those buying would use services costing more than the amount of revenues from the insurance sold. Of course, this could well be the specifically desired policy; all that would be required is that the source of financing for the extra costs be identified and tapped.

Moreover, the above proportions (rising with age) point up the issue of whether and how to include the elderly in the scheme. If the coverage for retirees is to be included, the eventual increased cost should be factored into the total discounted cost to be collected now.

Of course, if total expected costs are merely to be collected through a progressive payroll levy, the main issue is not whether particular groups of consumers pay more or less than they cost, only whether they will pay now for entitlement to benefits after they stop working. Of course, who will pay (and how) for those currently retired from the formal sector (and the elderly in the informal sector) is a separate and large issue.

Provider arrangements (including treatment of the private sector):

- ▲ *Issues of reimbursement arrangements dominate considerations here. BEFORE any premiums/levies are begun to be collected, proven systems should be in place in the public facilities for identifying costs associated with particular services and cost centers, and systems for billing and collecting fees for those services need to be working. Under a capitation, this system could be much less complex, but no less difficult to set up. One would have to have data collection systems for identifying and recording service and transaction data (by visit/encounter) so that clinical and epidemiological data could be related to use patterns and to costs, and for the likely circumstance that some patients will not be covered under the conventional system of national health insurance. Instead they will either receive free services (for which the facilities will directly bill the Government or for which the Government will provide direct, lump sum subsidies to facilities). Tracking of use will be necessary for determining the amount of lump sums facilities will be eligible to recover.*
- ▲ *Treatment of organizational and reimbursement to private providers should be designed to support overall public health policy goals, namely, quality services at a contained cost, presumably pursued through capitation. This would require development of a market for benefit plans, which combine the processes of collecting the capitated fee and organizing and managing the services (under a variety of possible contractual arrangements) of various provider groups (outpatient and inpatient). Developing and regulating such a market is a time-consuming and laborious task which will be feasible only in large urban and suburban areas. Piloting such efforts would essential.*

5. Benefits and Costs of the Program and their Distribution

As indicated by the considerations enumerated above, precise identification of benefits and costs would require studies and analyses, particularly of the private market for health insurance and medical care; dummy tables and charts are available to show suitable formats which could be used.

6. Unanswered Questions and Important Assumptions about Program

Important interrelationships need to be highlighted, as in the retreat presentation, particularly on how gaps in information, when filled, may undermine the feasibility (both economic and political) of implementation. [Refer to the diagrams and list of interrelated questions presented above.]

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