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Can CBHI be a precursor to SHI?

Seminar: Equity in health: Challenges for Social and Community Insurance Systems
Grant Rhodes
27 June 2006, The Hague

Contents

- Where are we coming from?
- Does it make any difference if the destination is:
  - Community Based Health Insurance?
  - Social Health Insurance?
  - Is there a passage between them?
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- How long will it take to get there?
- If we go; what preparations do we need to make?

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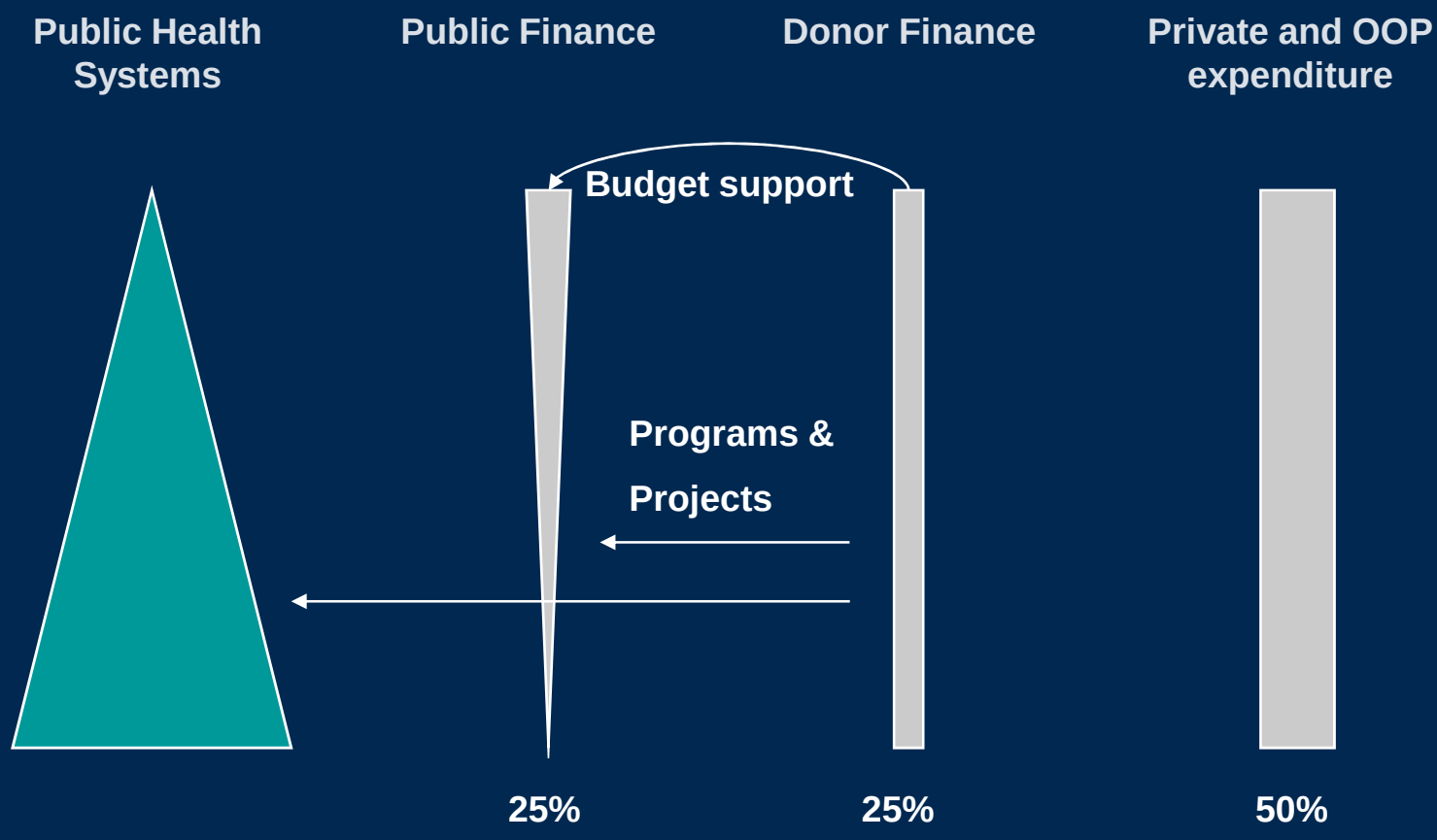
Where are we coming from?



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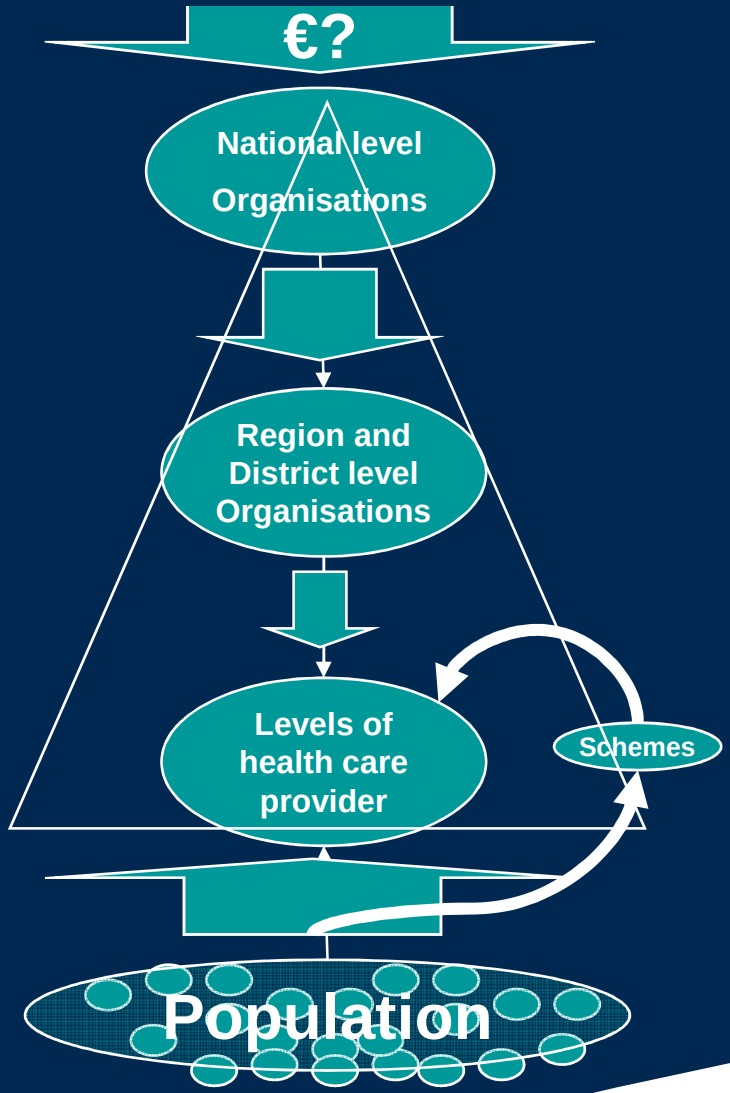
The Emergence of CBHI



- PETS in Ghana have indicated that only 20% of non-wage public expenditures are getting to first line services
- At the provider level ((non-)wage) expenses are being met OOP
- The population faces real financial risk in using health care
- Schemes have emerged to manage that risk

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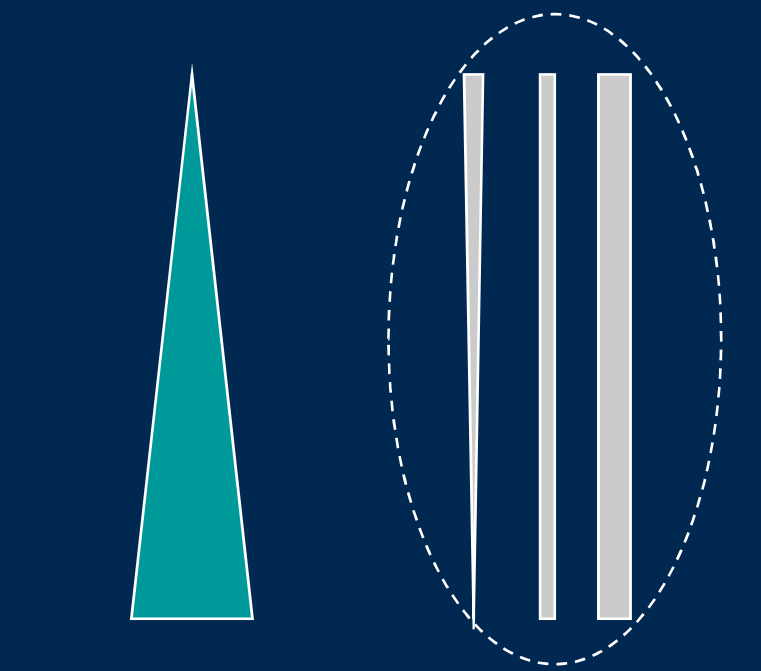
What are the differences between CBHI and SHI?

- What is CBHI:
  - Is it insurance? (group risk 'pool')
  - Is it a saving scheme? (own risk over time)
- What is SHI
  - Is it universal?
  - Is the benefit package comprehensive?
- What do they have in common!?
- Key questions
  - What are we paying for?
  - Who runs the scheme(s)?
  - What is the risk profile?
    - Benefits
    - Beneficiaries
  - What is the impact on health care provision and providers?
  - What does all this mean for the regulator(s)?



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Does it make a difference which LICs choose ?

- Neither will:
  - Widen or deepen the tax base
  - Affect labour market conditions and secondary benefits
  - Change the fact that debt relief doesn't create more cash for services
- Both can:
  - Increase the predictability of finance and bring it 'on-budget'
  - Be brought into national strategic development frameworks
  - Separate the finance of medical care from its provision allowing:
    - Providers to focus of provision
    - Financiers to focus on risk management (health care expenses)
    - (MOH) Regulator to focus on public health!!
    - (MOF) Regulator to focus on better use of public funds

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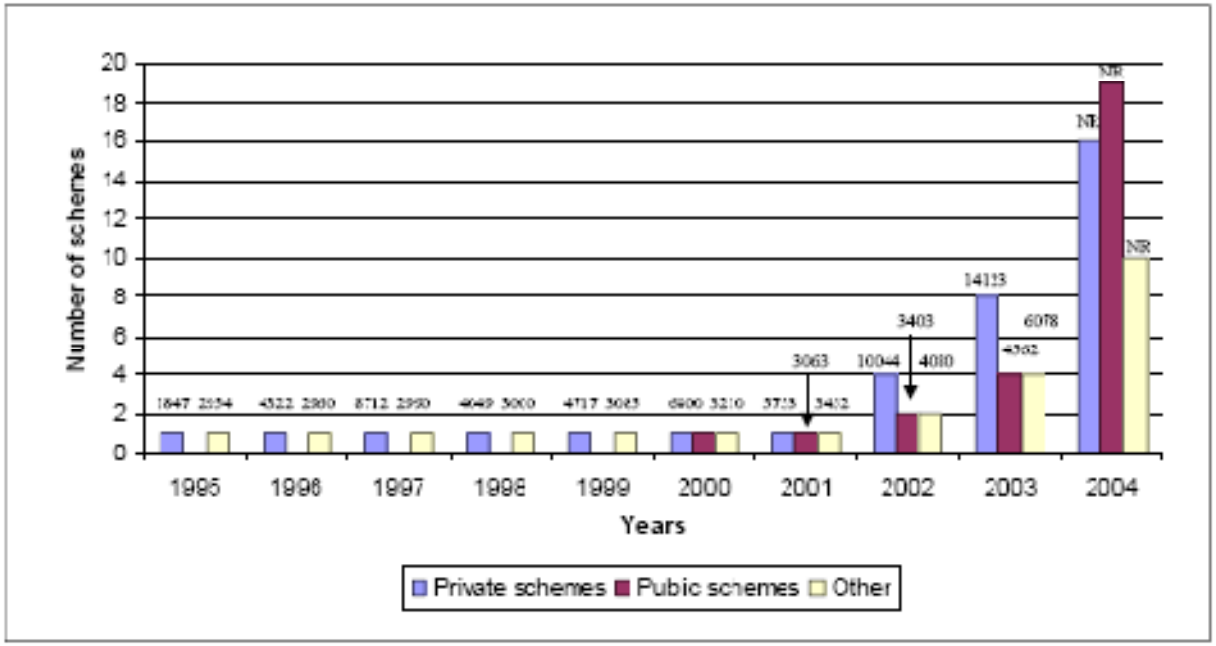
Not just theory: whither Ghana?

Figure 1: Average enrollment in surveyed schemes in Ghana 1995-2004*

* In 2004, enrollment was available only for a few schemes and is not reported here.



Source: Baltussen et al. Management of Mutual Health Organisations in Ghana. TMIH Vol II (2006)

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The National Health Insurance Act 650

- "*The provision of basic health care services to persons resident in the country through mutual and private health insurance schemes*"

- District Mutual Health Insurance Schemes
- Private Mutual Health Insurance Schemes
- Private Commercial Health Insurance Schemes

- National Health Insurance Council
  - Register licence and regulate schemes
  - Accredit (qual) health care providers
  - Administer 'risk equalisation' funds

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What did we find?

		Nature of scheme[#]		
		Private scheme (n =16)	Public scheme (n=19)	Other (n=10)
Organisational structure				
Ownership	members have ownership of scheme	100%	100%	100%
	MHO is independent of provider	100%	95%	100%
	MHO can set premiums	69%	42%	70%
	MHO can define benefit package	69%	37%	80%
Community participation	community participate more than once per year in meetings	81%	58%	80%
Financial management				
Moral hazard	use of co-payment to reduce moral hazard	25%	21%	10%
Adverse selection	the existence of probation periods	75%	95%	90%
	family registration required and enforced	19%	16%	20%
	limited acceptance of chronic diseases	31%	47%	40%
Fraud and abuse	use of membership card with photo	94%	95%	90%
Cost control	require referral letters to refund patient' hospital invoices	88%	90%	70%
	enforcement of essential drugs list for reimbursement	81%	84%	60%
	use of a maximum refundable sum for services	38%	16%	40%
	negotiating lower tariffs for members	69%	74%	90%
Capacity of management staff	the administrator has received formal training	81%	90%	50%
	paid staff is involved in the day-to-day adminstration of the scheme	75%	95%	90%
Financial position	use of actuarial methods when setting premiums and benefits	31%	5%	10%
	presence of reinsurance	6%	37%	10%
	financial stability (2003)	5.7 (1.5-58.8)	6.0 (0.7-48.6)	8.0*
	operating balance (2003)	1.2 (1.0-7.9)	1.0 (0.4-1.6)	1.0 (0.7-1.2)
	ratio of administration cost to expenditure (2003)**	0.7 (0.2-1.0)[##,**]	0.9 (0.1-1.0)[##]	0.5*

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What does this mean?

- Market Structure:
  - CNHI Schemes are being absorbed into District Mutuals
  - Different gov.t levels and departments are competing to set up schemes
  - Alls schemes are still small
- Benefits:
  - Considerable variation in benefit packages
  - District Mutuals don't really know what package they offer
  - Local Schemes are negotiating discounts
  - Strong links to (limited) local providers
- Beneficiaries:
  - Persons individually ID'ed (fotos) (97%)
  - 9% enjoyed benefits
  - No real 'marketing' plan for beneficiary enrollment (target groups)
- Organisation and Management of Schemes:
  - Financially volatile
  - Weak or no financial management

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In Practice: Will it make a difference which option LICs Choose ?

	Strengths	Weakness
Social Health insurance	• central government support • better funded (access to subsidies) • economies of scale and scope in operations • negotiating power with providers • …	• used as subsidy channel to prop up public sector service providers • political interference in operations: – beneficiaries – benefits – pricing • Lack of trust at local level • Untried and unproven in LIC • …
Community Based Insurance	• Local support and social entrepreneurship (civil society) • Good relations with providers • Variable benefits responsive to local needs • Variable pricing and payment terms responsive to client capacity •…	• small scale • tops up subsidized services does fully develop purchasing function • unstable • to small to support skilled administration • …

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Can CBHI be a precursor to SHI?

- Certainly, however…

- If:
  - Schemes remain more or less saving schemes to top up finance to mini local (public provider) monopolies…
- If:
  - Schemes pursue an underwriting function to represent beneficiaries financial interests in getting health care and dealing with health care providers…

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Is the question not how long do we want to take ?

- How long do we have?
- 2015 is only 9 years away
- Most of sub-Saharan Africa is way off track for the MDGs
- A non-distortionary channel for increased international finance for health with long-term potential (after 2015) will be needed
- Are there economic benefits (outside health care coverage) to developing insurance and financial market capacities?
- Can trade vertical for horizontal equity for however long this might take?

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If we go; what preparations do we need to make ?

- The market for health care (the health care system) will change, are actors prepared for there new roles?
  - Can the **Public** be made to understand the issue
  - Can **Providers** focus on the quality of their services and price them transparently?
  - Can **HI Schemes**:
    - Transparently communicate benefits to clients and build client confidence
    - Contract value for money services for providers
  - Can **Ministries of Health** focus on public health gains without (+/-) running public health care monopolies
  - Can **Ministries of Finance** focus on steering the health sector towards universality through flexible control of:
    - the health insurance market
    - the health care provider market
  - (Can MOHs and MOFs work together?!)
  - Will **Donors** need to change?

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Supporting preparations

- Improving communications between MOF/ MOEcon and MOH
- Capacity building in practical insurance operations
- Development of tools
- Marketing (in LIC) research
- And don’t forget the providers!

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