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Seminar Equity in Health:

Challenges for Social and Community Insurance Schemes

Sofitel The Hague, Tuesday 27th June 2006

Seminar Program

12.00	Sandwiches
12.30	Opening: Lilianne Ploumen, CORDAID
12.30	Introduction: Anno Galema, DSI/SB
12.45	The Background: Beyond the user fees debate: What are the consequences of abolishing user fees and what role could insurance systems play. Speaker: Leon Bijlmakers, ETC
13.00	Questions
13.10	Setting the stage: what are the perspectives and opportunities of different risk sharing arrangements in health financing in low-income countries Speaker: Alex Preker WB
13.40	Experiences with Community based health insurance schemes: successes and constraints Speaker: Bart Criel, Institute of Tropical Medicins, Antwerp
14.10	Discussion
14.50	Coffee break
15.10	Possible synergy between CBHI and (district) Social Health Insurance, case of Ghana Speaker: Grant Rhodes, Ecorys
15. 30	Hospital based insurance scheme: financial sustainability in vertical linkages with sub-district level: experiences from Uganda? Speaker: Pontius Mayunga, Mutolere Hospital, Uganda.
15.50	Discussion
16.30	Short break
16.40	Closing discussion Discussion on needs, ways and opportunities for further synergy between activities of Dutch actors in the area of CBHI and SHI
17.30	Closure
	Drinks

INTRODUCTION

On Tuesday 27th June 52 people of various organizations and institutions, that are active in the area of health insurance in low income countries or intending to do so, participated in the seminar ***EQUITY IN HEALTH: Challenges for Social and Community Insurance Systems.***

The move in several SSA countries to abolish user fees has intensified the search for alternative fair financing strategies. Increasingly, DGIS directly or indirectly will have to address this issue in support to the health sector. Similarly, a recent evaluation of the health programs of several Dutch Co-financing organizations has brought forward the need to invest more in sustainable options for health care financing, including health insurance systems.
The **aim** of the seminar was as follows:

- Stimulating the debate on a comprehensive perspective on health insurance
- Strengthening networking in The Netherlands on issues of socially oriented health insurance in low-income countries
- Strengthening the basis for complementary work at country level

For this seminar a variety of speakers was invited: Mr Leon Bijlmakers (ETC), Mr Alex Preker (WB), Mr Bart Criel (Institute of Tropical Medicine Antwerpen), Mr Grant Rhodes (Ecorys), Mr Pontius Mayunga (Mutolere Hospital Uganda). Each of them highlighted experiences from their perspective on the topic of the afternoon.

OPENING WORDS

In her opening speech, Mrs Ploumen, Director of CORDAID, took the audience back in the history of health care systems and health reforms in Africa. Cost recovery was put on the agenda during the Bamako Initiative resulting in the introduction of user fees in many SSA countries: programmes showed some success particularly in improving access to drugs and quality care, however, the effect on equity overall has been far less positive.
In many African countries we now see that governments move away from user fees. At the same time they are looking for alternative health financing schemes that do assure access of the poor to basic health services (equity); contribute to quality; are efficient and acceptable. Alternatives, like community health insurances schemes have been launched.
It is important according Mrs Ploumen, to share the experiences with different alternative financing schemes. She hoped the seminar would provide an opportunity to lay a basis for a network of Dutch organisations involved in health care financing that would allow for exchange, discussion and learning.

A word of introduction was then given by the Chair of the afternoon Mr.Galema from BuZa, DSI. Health insurance is a complicated issue. It is not only about complicated matters as risk analysis, premium calculation, re-insurance mechanisms but also about practicalities like the collection and administration of premiums. With the story about a second hand clock found at a local Portuguese market he illustrated this.

> *Years back insurance societies in Portugal provided their members with a clock. The owner had to put in coins to make it run. These coins were collected on a regularly basis by somebody from the insurance company, who had a special key to open the clock. The amount collected was taken as payment of the insurance premium.*

The current thinking and practice on health financing and health insurance is fragmented and there is an absolute need for more coherence and synergy in implementing these systems in low income countries. This fragmentation is also among the Dutch organizations and

institutions active in this area while at the same time the available information and knowledge offers a opportunity for more collaboration.
As part of the work on health financing, DGIS commissioned an inventory of experiences with user fees and various social and health insurance schemes, a study that was done by ETC. The outcome was presented at the seminar as background for the insurance debate.

BACKGROUND
by Leon Bijlmakers, ETC
Beyond the user fees debate; the implications of abolition. What are the alternatives?
We see:
- an evolution in thinking about user fees: from cost coverage and cost efficiency towards additional income for health care workers, or an administrative burden. .
- a strong position of some INGOs , eg SCF, donors (DFID) and world leaders (Jeffrey Sachs) against user fees. So far 4 countries in SSA have abolished user fees.
The Government's role is to make health systems work and to increase overall health systems performance. Combining the criteria equity and efficiency and the 3 components of health financing (revenue collection, risk pooling and purchase of services) the arguments against and in favor of user fees can be found in the attached presentation of Bijlmakers.

In conclusion: User fees do increase inequity and inefficiency of health care, but play an important role in sustaining health institutions.

The real equity debate should focus on protection of poor to the catastrophic event of sudden high health expenses. Abolition of user fees does not necessarily support the transfer of public resources to the poor who need it most. Health systems are structurally inequitable. Free PHC services do not automatically overcome this barrier. In combination with widespread calls for greater involvement of the private sector, user fees abolition could trigger even a total sell-out of public health services.
Also in terms of efficiency there are effects of abolition of user fees (on quality, ownership, accountability towards patients, collaboration between public and private providers).

In conclusion, user fees abolishing is not necessarily good for the poor and especially not in the short term. HCF strategies need to be assessed on their contribution towards the overall health systems performance. There does not exist a blueprint for national HCF strategies but most likely an appropriate mix is required, based on a country's financial capacity and the contribution and constrains of public and private sector.

Discussion:
- The reality in all low income countries is that vast majority of expenditures on health is through Out of Pocket Expenditures (OPE), including indirect costs. Hence, the debate on user fees is a fake debate. In South Africa for example, where user fees were abolished, still 85% of the population has to pay for care.
- top down-bottom up: *What do people want, and what are they willing to pay for?*

SETTING THE STAGE
by Alex Preker, WB

Mr Preker states that the MDGs are not realistic, for instance U5 mortality stagnates since the 1990s (reduction during SAP). Would increased spending on health care improve this? Not by itself, you also need more investment in other sectors notably water and sanitation and education, Preker states.
Economic growth is important as there is almost a linear relation between growth and health indicators. But growth alone is not enough, because a better targeting of the spending is required to realize better health outcomes.
So far, government commitments have not yet translated into improved indicators. There is a tendency in the World Bank to go back to infrastructure financing rather than giving loans for health projects. There is in fact little proof that increased government spending on health improves health indicators.
Increased international donor budget support doesn't necessarily increase the total health spending in the country, as the Ministry of Finance can decide to substitute (part of) the health budget and for instance spend it on defense. Donors are therefore less inclined to spend in pooled funds without earmarking, because governments can spend it freely and often do not spend it on health.

The prospect of reaching the MDGs is rather "depressive". Many countries do not spend the 35US$ per capita on health that has been defined as an average needed to reach the MDGs. But even if this amount is spent, governments would fail. Some governments would have to spend 100% of GDP! In other words, we should set a more realistic time frame, since the formulation of the MDGs for 2015 are impossible to reach.

For health spending the role of the private sector is important. You can just not ignore the 80% of total spending on health which goes to the private sector. We must find a constructive way to use these resources better rather than focusing on abolition of user fees. Make people get better quality service for the money they are spending anyway (whether through UF, OPE or any other accompanying expenses).

EXPERIENCES WITH CBHI
by Bart Criel, Institute of Tropical Medicine, Antwerpen

The experiences in CBHI are mostly from Africa, in particular West Africa. We can find different models: from a community-run scheme (common in West Africa) to a provider-run scheme with all mixed models in between. The legal institutional framework varies from country to country.
In general: size of the schemes remains small; packages of benefits differ; contextual conditions under which CBHI programs are implemented are influencing the development of the schemes (ability and willingness to pay, recognition of the importance of insurance by the target group, the technical and political support of the government etc.)
Further research is strongly recommended to measure results on e.g. risk pooling, participation, transparency. Scaling up of CBHI, managing programs through establishing a federation of CBHI is needed to steer the process.

Less positive CBHI results: high overhead due to low enrollment; low accessibility for the chronic poor due to too high premiums. There is a need to use subsidies for chronic poor. But

who decides exemption criteria? Volunteers role: important asset in setting social priorities. Complexity of managing CBHI requires professionals (not volunteers), which is costly and requires attaining economy of scale.

Lessons from Europe's health insurance developments are useful: systems started with small initiatives, gradually growing into larger and later national systems.
Challenge: how to link small scale CBHI with other health care financing arrangements (integration). CBHI is complex and needs support, technically and analytically. Some good examples of regional/national support are La Concertation, Community Health Financing Association for Eastern Africa. In Belgium a Platform Micro Health Insurance & Mutual Health Organizations (MASMUT) was founded. There is also a role for academic organizations, NGO's and church organizations to play to aim for a synergetic effect: strengthening of demand side and supply side.

Discussion:
The "chronic poor" are referred to as those in need of subsidies. They lack money, a social network to access money and are completely dependent. About 5% of the population can be defined as chronic poor. Meanwhile the "intermittent poor" are a diverse group: they might fall in poverty at some point in time, but recover relatively easy afterwards; they can contribute to premiums during a certain period of the year. Difficult to define which individuals can (partly) contribute and who cannot, the so-called cut-off point. The local community itself and volunteers will provide the most valid decision. We have to be cautious not to apply our western values to these destitute groups.

Special groups like elderly and chronically ill are part of the households, and are therefore included in the insurances.

Link between Community Health Insurance schemes and public health system is complex: policy makers themselves are often not quite clear. Only few countries started developing a framework but the majority of these are poorly planned. Social security systems for the formal sector are artifacts and seldom function properly. An example of combining CBHI with a public national system we find in Ghana.
Dilemma: CBHI schemes cannot function without subsidies, however when government gets intensively involved it's "the kiss of death". Illustration: In Eritrea small community schemes were destroyed due to the involvement of huge banks.

What can other actors and donors do to support:

- Take lessons at hart from evolutions in Europe: slow pace, gradual involvement of subsidies etc. Give time to grass root level to adapt and support from bottom up instead of supporting huge macro programs. In Europe we started with risk pooling on a small scale. The chronic poor were not included. Control was easy but the need to expand to cover running costs made management more complex. The chronic poor came only in when government started supporting these schemes.
- Collaborate with Government and build consensus in developing initiatives.

POSSIBLE SYNERGY BETWEEN CBHI AND SHI
by Grant Rhodes, Ecorys

Rhodes presents the case of Ghana, where the National Health Insurance Act states that "The provision of basic health care services to people resident in the country shall be done through mutual and private health insurance schemes".

PETS (Public Expenditure Tracking Survey) in Ghana have indicated that only 20% of non-wage public expenditures are getting to first line services. For non-wage expenses, health care providers depend on contributions from the population (mainly out-of-pocket), CBHI schemes have emerged to manage this risk.

Social Health Insurance (SHI) differs from CBHI as it is supposed to have universal coverage and a comprehensive benefit package. CBHI schemes are often very small and therefore appear to be saving schemes (or even "post offices") with limited risk pooling. Social capital ensures that people from the same social network are all included, reducing adverse selection since people with different levels of income or health risks will be included as well. In addition, social capital also ensures that the system is monitored effectively, since social pressure from the group may withhold individuals from excessive use of health care services. On the other hand, both SHI and CBHI offer opportunities to:

- 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

The National Health Insurance Act 650 was established to provide basic health care services through mutual and private health insurance schemes. The role of the National Health Insurance Council is to:

- Register license and regulate schemes
- Accredit (quality) health care providers
- Administer 'risk equalization' funds

Now, CBHI Schemes are being absorbed into District Mutuals, and different government levels and departments are competing to set up schemes, this may sometimes be opportunistic. All schemes are still small

Survey among CBHI schemes found:

a) 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

b) Beneficiaries:
- –Persons individually ID'ed (fotos) (97%)
- –9% enjoyed benefits
- –No real 'marketing' plan for beneficiary enrollment (target groups)

c) Organization and Management of Schemes:
- –Financially volatile

–Weak or no financial management

The government of Ghana aims at 40% population coverage by 2008 under national health insurance, but so far only 1-2% is covered. The danger exists of government over-regulating on premiums, beneficiaries, benefit package (crushing the egg).

Discussion
Role of donors is complicated by lack of understanding of health insurance because of its complexity. Adverse selection may cause problem at start but will reduce over time when coverage increases. This would require role of donors to support schemes during start-up phase. Problem of adverse selection in Ghana was contained. Donor money through CBHI schemes may be more effective compared to top-down financing but whether it is more difficult to control is not clear yet.

Difference between Community Health Insurances and Micro Finance Insurances is that they look at different markets; insurance covers negative risks, micro credit looks at positive opportunities.

HOSPITAL BASED INSURANCE SCHEME IN UGANDA
by Pontius Mayunga, Mutolere Hospital

Mr Mayunga presented the micro-level experiences of Mutolere hospital based scheme in Uganda. Founded in 1999, initially supported by DFID the objectives were to improve access to health care for the local community and to provide a stable source of funding for the hospital. The principle of risk-pooling was not new to the area; traditionally they have their own "ingobyi groups" for carrying patients to and from health facilities.
Positive: scheme gets full (moral) support of authorities; hospital can deliver all health services required
Challenges: limited capacity (human resource, management, equipment, budget) and coverage
CBHI's programs in Uganda are member of the Community Based Health Financing Association, a non governmental body supporting and guiding the initiatives.

Uganda has announced launching Social Health Insurance (SHI) for the formal sector (2006). Consequences for Mutolere Scheme or how to realize link between both systems is not yet clarified.

Future plans Mutolere pre-payment scheme:

- Expansion to lower level units, in order to reach more people.
- Building capacity of the scheme and ascertain financial and technical support
- Strengthen collaboration with other actors (local and national authorities and CBHFA remains an important point to work on, in particular in relation to tuning the new SHI and the prepayment scheme).

FINAL DISCUSSION

Observations:

- High turn-out of this afternoon indicates increasing interest in the topic of health insurance.
- How can we improve linking of the many initiatives we are working on, which are fragmented up to know?
- What can we learn from MASMUT Belgium and the Micro Finance platform? The experiences of the Belgium platform MASMUT: The agenda for a platform should not be too broad and a choice should be made whether its purpose is information sharing only or also a forum to work together. Joint activities will strengthen the felt usefulness and commitment
- How to convince donors, who have their own agenda? Would it be possible to interest them through linking insurance with AIDS programs?
- Can a platform lead to more coherence in the Dutch field and to less competition between different interests, e.g. on concept of insurance?

COMMITMENT FOR FOLLOW UP:

TPO/Healthnet shows interest to contribute to the Platform by sharing experiences.
KIT, Ecorycs and Interpolis are interested to commit thinking and time. Important is not adding another network for sharing experiences only but to develop a common approach and translate this in a clear action plan (providing services and stimulating joint action).
Cordaid supports the idea of creating a Platform for linking, learning and joint action and is willing to assist in formalizing this. Sees it as melting pot of experiences and expertise of broad variety of actors, where each member can contribute and tap knowledge. In relation to Cordaid's role in capacity building of southern health partners, this platform would be extremely useful. The experiences of Cordaid's network of partners could also provide input for the platform (for example through linkage and through participating in pilot activities).
BuZa is interested to contribute to the platform. Firstly for learning and knowledge sharing. Moreover, although BuZa has moved more and more into SWAPs, there is certainly a need for technical assistance in the context of sector programs and linked up with local opportunities. An expertise network could be instrumental in this. In the days following this seminar an International conference will be held in Copenhagen for Multilateral and Bilateral donors where the initiative will be worked out for an consortium in social protection in health, including a TA component. It could be seen how a Dutch platform could benefit from this initiative.

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