

# HEART

HIGH-QUALITY TECHNICAL ASSISTANCE FOR RESULTS



## Social Health Protection in low- and middle-income countries: the practical challenges

A brief discussion paper

## Executive Summary

A seminar organised by Oxford Policy Management in June 2017 brought together practitioners and policy makers to exchange insights on practical challenges for the implementation of social health protection (SHP) programmes, and social health insurance (SHI) in particular. Kicked-off with a presentation of recent experiences from Bangladesh and Pakistan, the discussion touched on a range of issues, including how to reach and incorporate the poor and non-poor in the informal sector, working with private providers and moving towards strategic purchasing.

There was agreement that SHI means far more than raising contributions, as it is sometimes construed, and reaches into deep health sector reforms. These require careful staging, sustained political commitment and a focus on good governance, but also a continued engagement with core principles of universal health coverage (UHC), primarily equity. Nevertheless, some of the implementation challenges faced today are not new. Investing further in the existing health system learning mechanisms, formal and informal, will be key to avoid repeating implementation failures of the past.

## Introduction

The pursuit of UHC has become a top global health priority and an increasing number of low- and middle-income countries (LMICs) are explicitly aiming for it.<sup>1</sup> In most of them, however, progress must happen against the backdrop of a severely resource constrained health care system, the inefficient and inequitable use of available resources, a heavy burden of out-of-pocket payments (OOP).

Making tangible gains towards UHC often requires substantive reforms across the health system. UHC is also costly<sup>2,3</sup>, so the extent of health financing sets limits for UHC and is a natural starting point for reform. Growing evidence shows that increasing the share of pre-pooled contributions, as opposed to OOP, helps to enable UHC and also improves population health.<sup>4</sup> Some form of SHI is one way to reduce the burden of OOP, usually in combination with tax-funded health expenditures. Current examples of SHI expansion include Kazakhstan, Bangladesh and Pakistan.

The theoretical foundations of SHI are not new and the pitfalls and transitional issues are also well known from a host of country experiences<sup>5</sup> – collecting contributions in large pools to avoid fragmentation, focusing on equity by incorporating the poor from the onset, and acting as a strategic purchaser. Where to start? Preoccupation for sequencing of steps is rising<sup>6</sup>, but there is no consensus about implementing SHI in a highly resource constrained environment or how to account for country context. Policy makers need robust responses quickly in order to advance reform in what often turns out to be a complicated and multifaceted exercise across health system pillars.

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<sup>1</sup> Cotlear, D., Nagpal, S., Smith, O., Tandon, A., & Cortez, R. (2015). *Going Universal: How 24 Developing Countries are Implementing Universal Health Coverage from the Bottom Up*. The World Bank.

<sup>2</sup> McIntyre, D., Meheus, F., and Røttingen, J.A. (2017), 'What level of domestic government health expenditure should we aspire to for universal health coverage?', *Health Economics, Policy and Law*, 12(2): 125–137

<sup>3</sup> Stenberg, K., Hanssen, O., Edejer, T., Bertram, M., Brindley, C. et al (2017) Financing transformative health systems towards achievement of the health Sustainable Development Goals: a model for projected resource needs in 67 low-income and middle-income countries. *The Lancet Global Health*, 5(9): e875-e887.

<sup>4</sup> Moreno-Serra, R., Smith, P. (2016) Broader health coverage is good for the nation's health: evidence from country level panel data, *Journal of the Royal Statistical Society: Series A (Statistics in Society)*, 178:1, 101 – 124

<sup>5</sup> Carrin, G., James, C. (2005) Social Health Insurance: Key Factors Affecting the Transition Towards Universal Coverage. *International Social Security Review*. 58:1, pp. 45–64.

<sup>6</sup> Josephson, E. (2017) National Health Insurance in Low and Middle Income Countries: A suggestion for a component-based sequencing. Accessed here: <http://www.healthfinancingafrica.org/home/national-health-insurance-in-lics-and-lmics-a-suggestion-for-a-component-based-sequencing>

At a seminar organised by Oxford Policy Management on the practical challenges to the implementation of SHP programmes (June 2017), practitioners and policy makers exchanged insights on some implementation questions of SHI. These included how to reach the poor and informal sector, how to engage private providers and how gradually to shift from passive to strategic purchasing and the necessary government capacity for implementing SHI. How have some countries addressed these issues, and what challenges remain?

## Reaching the poor and informal sector

The composition of the population in LMICs makes it difficult to reach and incorporate the entire population. Because of the size of the informal sector and the level of poverty, relying on payroll deductions excludes the poor and the non-poor in the informal sector. Including these groups is essential for UHC, but comes with specific challenges.

Incorporating the poor and vulnerable (people living just above the poverty line) often requires fully subsidizing their membership from general tax revenues. A pilot health protection scheme in Bangladesh, known locally as ‘Shastho Surokhsma Karmasuchi’ (SSK), targets people living below the poverty line in three sub-districts, whose premiums are fully subsidised by the government. Identification is conducted by local level committees and one health card is issued per household. In Pakistan’s SHP programme, the government and KfW initially paid the premium for the poorest 21% of the population, as identified through the Benazir Income Support Programme (BISP), which was later expanded to the poorest 50% of the population in Khyber Pakhtunkhwa province in Pakistan. The international experience illustrates challenges with different methods of targeting – community-based targeting (formerly used in Indonesia and Turkey) and demographic targeting (according to age, as in Ghana) identify many non-poor people as poor and exclude others who are actually poor, while means-based testing leads to registries which may require substantial administrative costs to maintain. Pakistan’s example is a case in point: the SHP programme uses BISP household lists, however these are not up to date and targeting is sub-optimal. Considering such costs and their likely evolution over time in the decision making process on SHI is paramount.

Reaching the non-poor in the informal sector – sometimes referred to as “the missing middle” – comes with other challenges.<sup>7</sup> Significant investments in information technology (e.g. unique or linked identification numbers), communication (e.g. building awareness of the available insurance products) and outreach (e.g. particularly rural and difficult to access areas) may well be required, with significant frontloading. In terms of enrolment, voluntary enrolment is often ineffective even when subsidised, e.g. about 7% among informal sector households in Vietnam despite intensive promotion and a 25% premium subsidy.<sup>8</sup> Mandatory enrolment with contributory payments is attractive, but difficult to enforce or replicate at scale. Irrespective of the mix of mechanisms for payment, the global move appears to be shifting towards increasing reliance on government subsidies.

More broadly, the seminar discussion touched on the importance of delinking entitlement to health services from employment status. With equity at the centre of UHC, it is essential to invest in identifying country-specific coverage approaches that do not “lock in” existing inequities and provide comparable benefits between the formal and informal sectors – particularly to those just above the poverty line, who are also extremely vulnerable. The search for the most suitable approach in a given context is iterative, as the multiple attempts of reaching the poor in Bangladesh illustrate, but needs to remain guided by this essential UHC principle.

<sup>7</sup> Bonfert, A., Özaltın, A., Heymann, M., Hussein, K., Hennig, J., Langenbrunner, J. (2015) Closing the Gap: Health Coverage for Non-poor Informal Sector Workers. Joint Learning Network for Universal Health Coverage.

<sup>8</sup> Wagstaff, A., Nguyen, H.T.H., Dao, H., Bales, S. (2014) Encouraging Health Insurance for the Informal Sector: A Cluster Randomized Trial. *The World Bank, Policy Research Working Paper 6910*, pp. 1–18. Accessed here: <https://openknowledge.worldbank.org/handle/10986/18768>

## Engaging the private sector

Private sector actors can play a role in the delivery (as service providers) or financing (as purchasers) of SHI schemes. For example, the Government of Pakistan works with private insurance companies in SHP: the government covers the premium for the poor and vulnerable (for 50% of the poorest income quintile) to enrol in private schemes, whereas the schemes cover the costs of the healthcare services accessed. The private insurance companies are also required to cover 50% of the total population of the target districts, incentivising them to tailor to a previously unserved section of the population by offering new and more affordable insurance products. In service delivery, accrediting private sector providers (for profit or non-for-profit) can help meet the growing demand for healthcare of predictable quality as enrolment in SHI increases. For example, for the SSK pilot in Bangladesh, the government has accredited private sector hospitals to meet the increased demand for hospital beds.

How the government should engage with private providers for UHC will depend on the composition of this sector: are providers of low quality and underqualified, are they non-profit, formal, small-to-medium sized or corporate and commercial?<sup>9</sup> For such arrangements to work effectively, government stewardship is essential through policies, incentives and regulations, and building this capacity is not easy. The Pakistan example illustrates this: in Khyber Pakhtunkhwa there was initially only one civil servant to oversee the relationship with the private insurance companies.

How a country embarking on SHI opts to include (or not include) the private sector can create long-standing effects on the healthcare system. In Bangladesh, increased utilisation resulting from the introduction of SSK strained the capacity of public providers and determined the government to consider contracting private providers to cope with demand, an initially unplanned development. In Pakistan, one of the objectives of SHP was to incentivise private insurance companies to develop insurance products for non-subsidised populations. However, the programme's mid-term evaluation identified difficulties in motivating the private insurers to develop this direction.

The discussion at the seminar stressed the importance of anticipating, as much as possible, potential long-term dynamics in engaging the private sector in SHI schemes. While there is clear potential in working with the private sector to advance UHC, a deep understanding of the nature of the private sector in a given country in relation to system-level objectives and capabilities should feed into policy design options. Furthermore, sufficient time needs to be allowed between engagement phases in order to allow mid-course adjustments in response to roll-out developments.

## Towards more strategic purchasing of health services

Moving from passive to strategic purchasing involves a shift from the reactive payment of bills or following a predetermined budget to a proactive, continuous and evidence-based approach to deciding which services and products should be purchased, how and from whom. If done correctly, strategic purchasing can promote quality, efficiency, equity and responsiveness in health service provision and facilitate progress towards UHC.<sup>10</sup> Doing so is not straightforward, as it is multifaceted and requires an overhaul of the regulatory framework.

Although no LMIC has achieved strategic purchasing across the board, many countries have successfully established some elements of it. In sub-Saharan Africa, Nigeria's National Health Insurance Scheme (NHIS) has a regulatory framework for provider accreditation, regularly checks providers' accounting departments and performs audits, though its limited capacity hinders its

<sup>9</sup> McPake, B., Hanson, K. (2016) Managing the public-private mix to achieve universal health coverage. *The Lancet*, vol 388, pp. 622 – 630. Accessed here: [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(16\)00344-5.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)00344-5.pdf)

<sup>10</sup> Factsheet by the London School of Hygiene and Tropical Medicine (LSHTM) (2014) "Strategic Purchasing Factsheet." Available here: <http://resyst.lshtm.ac.uk/sites/resyst.lshtm.ac.uk/files/docs/reseources/FactsheetWEB.pdf>

effectiveness. In South Africa, despite relatively stronger reporting and accountability systems, line-item budgets do not encourage the efficient use of resources or quality improvement<sup>11</sup>. A better example of this component of strategic purchasing is Ghana, as the NHIS progressed from a fee-for-service system to a standardized itemized fees system for medicines and Diagnostics Related Grouping (DRG) for clinical services – reducing arbitrary price fluctuations.<sup>12</sup> Thailand's example demonstrates which prerequisites might be necessary to progress towards strategic purchasing: a single, large purchaser that can negotiate lower prices; multi-stakeholder governing board managing the relationship between the purchaser and government, citizens and providers; and institutional capacity to secure an adequate budget and make strategic purchasing decisions.<sup>13</sup> However, as is evident from these limited country examples, strategic purchasing remains an area where many practical questions remain with limited examples of best practice from LMICs.

The seminar discussion touched on the fragmentation of care arising from the way in which benefit packages are constructed. The schemes in both Bangladesh and Pakistan included inpatient care but not medication, leaving non-hospitalised patients with chronic diseases exposed after an acute episode. Furthermore, continuity of care becomes problematic when patients require specialised care available outside the service providers participating in the scheme – following referral patterns correctly and still having to travel large distances to a tertiary hospital without insurance covered may well prove to be the “push” below the poverty line.

## The steps ahead

As the above discussion on reaching the vulnerable, working with private providers, and moving towards strategic purchasing has pointed out, SHI means far more than raising contributions – as it is sometimes construed. By way of conclusion, we outline below several broad points that came through in the seminar discussion:

- **Introducing SHI requires a pragmatic, holistic, long-term view over health system priorities and objectives.** It has implications for quality of care, training and retaining the health workforce, adjusting or reforming models of care, making use of and developing health infrastructure, reforming public financial management practices – to name just a few aspects. There are many ways of running a health system and they are context-specific, but SHI cannot hope to solve all issues.
- **But who will provide and take on such pragmatic, holistic advice?** Consultancies are usually asked to conduct analytical studies and “provide policy recommendations” on a narrow set of questions or policy perspectives, which somehow paradoxically limits the robustness and usefulness of their recommendations. This raises a number of unanswered questions: are the current analytical tools fit for purpose? Are health sector reform or support programmes structured appropriately to deliver tangible progress towards UHC? Do governments have the capacity to synthesise, meaningfully engage with and act upon provided recommendations?
- **From a functional perspective, governance is essential.** A focus on improving governance is paramount for ensuring trust among the many stakeholders involved in the reform process. Without trust in the health system, the public will not respond favourably to reform attempts.

<sup>11</sup> Research brief by the London School of Hygiene and Tropical Medicine (LSHTM) (2016) “Strategic Purchasing for Universal Health Coverage: a Critical Assessment. The South African Integrated Public System.” Accessed here: <http://resyst.lshtm.ac.uk/sites/resyst.lshtm.ac.uk/files/SA%20purchasing%20brief%20integrated%20public%20system.pdf>

<sup>12</sup> Agyepong, I., Aryeetey, G. C., Nonvignon, J., Asenso-boadi, F., Dziku, H., Antwi, E., Arhinful, D. K. (2014). Advancing the application of systems thinking in health: provider payment and service supply behaviour and incentives in the Ghana National Health Insurance Scheme – a systems approach. *Health Research Policy and Systems*, 12(35), 1–17.

<sup>13</sup> Research brief by the London School of Hygiene and Tropical Medicine (LSHTM) (2016) “Strategic Purchasing for Universal Health Coverage: a Critical Assessment. Universal Coverage Scheme and Civil Servant Medical Benefits Scheme in Thailand. Accessed here: <http://resyst.lshtm.ac.uk/sites/resyst.lshtm.ac.uk/files/Thailand%20purchasing%20brief%20.pdf>

Governance is to go beyond regulation and legislation, and include the relationship with civil society actors and the private sector.

- **From an implementation perspective, careful staging is essential.** A careful, systematic approach to assessing the appropriateness and feasibility of introducing SHI has supported policy decisions in both Pakistan and Bangladesh before proceeding with pilots and scale-up. In other cases, like Malawi, the assessment can identify a more suitable time in the future and produce a pathway to sustainable change, e.g. first establish a purchaser agency and take a gradual approach to developing capacity.<sup>14</sup>
- **The implementation challenges for SHI today are not new, even for LMICs.** The key SHI design features identified in early 2000s<sup>15</sup> – population coverage, method of financing, level of fragmentation and composition of pools, the benefits package, payment mechanisms, and administrative efficiency – remain essential design components. Today, however, much more evidence and country experiences accumulated since gives policy makers a better chance at “getting reforms right” compared to the wave of SHI adoption in the early 2000s.
- **Leveraging insights from the country experiences and systematically adapting them to local contexts does not come spontaneously.** Undergoing such deep health system transformations requires time and systematic learning, both across countries and within countries, across different stakeholders, including policy makers, researchers, and global health practitioners. Investing further in the existing health system learning mechanisms, formal and informal, will be key to avoid repeating implementation failures of the past.

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<sup>14</sup> Assessing the feasibility and appropriateness of introducing a National Health Insurance Scheme in Malawi. Oxford Policy Management, 2016.

<sup>15</sup> Carrin, G., James, C. (2004) Reaching universal coverage via social health insurance: key design features in the transition period. *World Health Organisation Discussion Paper, number 2*.