The Social Health Insurance (SHI) initiative in The Gambia

Report of WHO scoping mission on health financing options, 18-21 November 2019

Summary

1) The NHI initiative is the creation of a one universal scheme for all Gambians.

2) It is aimed at serving mostly the poor and reduce out of pocket expenditures.

3) The Ministry of Finance proves to be willing to lead the initiative. The Ministry of Health leads in terms of technical discussions.

4) A law is being drafted but important issues are yet to be clarified, especially:
    a. The scope of the law. It should be enought to have a law that created the scheme & its implementation Agency
    b. The Agency line Minister
    c. The Agency oversight set up
    d. The replacement of targeted exemptions by household income-based exeptions

5) New taxes are considered to supplement contributions. They should be progressive ones. They can be earmarked.

6) The Ministry of Health has a very important responsibility in ensuring the availability and quality of services, especially drugs.

7) Granting health facilities with bank account and support their capacity in financial management should be considered. Adapted public financing management should prevail.

8) The initiative would better start with the poor.

9) It should start as soon as possible, possibly with a pilot. But it will have to go slow in terms of expansion.

10) NHI should be implemented with a national dialogue for ownership and sustainability as it is a society project.

Origine and rationale of the SHI proposal

Findings:

- Possibly originally a proposition of the Ministry of Finance: to reduce OOP, to improve access to health facilities, for health expenses accountability, to increase in health funding, for justice, human right, prevention (all this mentioned by his Excellency the Minister of Finance)
- Rationale of of Department of Planning / MoH is to reduce OOP, & for strategic purchasing.
- Rationale for other stakeholders are: to adress equity (Member of Parliament), a general buy-in (President office), a financial mechanism for the health sector (hospital).
- Other opportunity according to us: to reduce exclusion (that is not captured in NHA).

⇨ *Consensus on the main objective that is to reduce OOP especially for the most vulnerable.*

Recommandations:

- To look carefully where the money comes from (not only who pays how much in contribution but also the progressivity of possible new taxes) and where the money goes (who it serves in terms of target population and what system it supports, public or private health system) for the iniative to meet the objective of equity and health system strenghtening.
- To include some existing fee exemption mechanism in the benefit package (eg: MCH, free services for the poor) to serve as a financial mechanism

Scope of the SHI proposal

Findings:

- Clearly universal: the initiative is consensually seen as a initiative to serve all gambian.
- It was never challenged that it shall be one scheme, ie one pool. This means one benefit package for all, cross-subsidies, one institutional set-up, one set of procedures and tools for all gambian.

Recommandations:

- Having said it is universal, the real question is *whom to start with*. Right from the beggining signs must be given that it is for all and that it is one pool. The conditions to cover the different categories of population differ a lot. Recommandation is to start with the most vulnerable for strategic but also technical reasons (cf infra, appendix 1).

Financial sustainability

Findings:

- Understanding from everyone that funding sources shall be a mix of contributions & taxes.
- Existing discussions on news taxes under MoF lead. WHO can provide other suggestions[1].
- Questions around earmarking or not: MoF in favor in consideration of Treasury issues.
- WHO position is that earmarking is not more a guarantee of sustainability than budget lines; also that sin tax are good but do not necessarily need to be earmarked for health. But it is true that acceptance of a new tax is greater when it is for a national social project, and general treasury constrains can indeed be taken into consideration to secure the scheme cashflow needs.

Recommandations:

- To introduce new tax(es) for the SHI initiative but also to acknowledge that the top-up to contributions is a governement commitment (by law), from out of budget or budget likewise.
- To base the financial sustainability also on a national buy-in: to initiate a national dialogue on the SHI initiative.

Health financing system

Findings: (RBF, RDF & PFM)

- A donor (WB) supported RBF (Result-Base Financing) initiative has started but there is no guarantee that it will be taken over by the governement (this usually being referred to as « instiutionnalization »). Several take-aways from the RBF can be considered in the pespective of the NHI initiative, such as providers' autonomy, support of basic healthcare provision conditions prior to introducing a new financial mechanism, information system support, health facility financial support; but there is no general buy-in but serious questions about the quality-based incentive rationale & the financial sustainability.
- There are important issues of drug availability that question the opportunity of the SHI initiative. In the existing system (with drug shortage) SHI will either not work (no drug to be served) or will be expensive (obligation to contract the private pharmacies).
- Today the decentralized facilities do not have a bank account nor financial autonomy. This is limiting their capacity to develop strategies to provide healthcare adapted to their direct environment. It will also limit SHI opportunity to be a leverage in healthcare availability & quality improvement.

[1] Cf. studies in Togo, Mali & Benin.

Recommandations:

- To separate institutionnaly the RBF initiative from the SHI initiative. RBF project may continue and look at the capacity of the PCU to absorb it. The NHI agency should be created for NHI only taking into account that strategic purchasing is fully part of the health insurance work anyway, and that incentivizing quality will naturally and progressively be part of the NHI agency propositions.
- To concentrate efforts in improving the question of drug availability in the public health system. And to make it clear that the current drug shortage in public facility is a no go for the SHI initiative.
- To analyze the drug exemption policy possible effect on their availability and the opportunity to revise it or not with the introduction of SHI: is there a link between this policy and the shortage? Should the introduction of NHI come together with the reduction or even the end of this subvention policy?
- In parallel with the SHI initiative, to introduce a PFM (Public Financial Management) reform probably in line with the RBF experience that will give more financial autonomy to the health service providers including a bank account.

Other health system issues

Findings:

- The health system has some other weaknesses that could limit the opportunity of the SHI initiative. Especially apparently there are important issues with the availability and quality of the Human Ressources for Health (HRH) and in the geographical access to healthcare.

Recommandations:

- SHI should be rolled out slowly, i.e scaled up very progressively so that the demand-side conditions improve together with the supply-side ones.

Institutional set up

Findings:

- The Ministry of Finance is leading the iniatitive and does not imagine the SHI to be under the MoH. Now the alternative seems to be that the Ministry of Finance itself be the line Minister.
- The capacity of The Gambia to create a valuable institution capable of managing a SHI has not been challenged (though this is usually a very important concern in many Western African countries). Still the main condition of success for the initiative is that the Agency in charge proves to have an exemplary governance. This include: accountability, board's role and independance, internal management, external control.
- Decentralization of the institution is sometimes considered. But a difference should be made between decentralized payment (cf. above mentioned PFM issue), possible decentralized functions (such as information, control and possibly contribution collection) and deconcentrated offices.
- Regulation of the SHI initiative is key, especially (1) in the dialogue with the MoH, especially the eligibility of goods and services in the benefit package, the payment conditions (mechanism and amount), the norms and standard for the information system and the quality control and (2) in monitoring & evaluating that the strategic choices are in line the legal provisions and that proposed changes of legal provisions are based on valuable reasons.

Recommandations:

- To pay a lot of attention in the governance structure of the Agency taking into account the State Own Enterprise (SOE) regulations but also the national experiences in all sectors.
- To ensure a transparent and accountable contracting and/or appointing of the in-charge (Board and Direction).
- To create or use an existing intersectoral body in charge of regulation (Authority or permanent commission).

Conclusions

- **Major settings (bill)**

A certain consensus has been heard regarding what is usually the essence of law on SHI. This is a very good news:

- SHI will be obligatory
- SHI will be universal with one (scheme) for all
- Fundings will come from a mix of contributions and taxes
- An Agency will be created to manage both the finances and the risk

This is not yet quite enought to send the bill to the Parliament. Few more questions have to be discussed for the law to be consensual:

- What should be the Agency line Minister ? It could be MoH or MoF. The important thing is that the line Minister does not give instructions to the Agency, but gives recommandations. We also believe the provider-purchaser split is important. The current leadership assumed by the MoF is also interesting to consider.
- What should be the regulatory / oversight institution / body of the Agency ? The Health Service Commission to be (from the draft Constitution) is an option. Otherwise, the Council of Ministries and Parliament could play the role.
- Should we really have the law explicitly exempt some categories of people apart from an income level perspective (under five, pregnant woman, etc…)? This may not be a good idea and we recommand to acknowledge the change of paradigm: the notion of « universal » means that exemption should only be considered under an income basis. Moreover we know that at least 48% of the population will have to be fully subsidized (the « poor »), and probably another part of the population with limited income will also need to be at least partically subsidized. So why should under five, elders or pregnant woman from high income quintile be exempted?
- To what extend earmarked taxes should be agreed upon and included in the bill? How much should be said in the bill regarding financing sources of subsidies? Probably the bill needs to mention some decisions when they reach a consensus, but not pretend to clarify the all sources.
- Should the bill also deal with the regulation of the private and communautary insurance? This is currently in the draft bill. But why the Agency in charge of implementing the NHI scheme should be a regulatory body to the private insurances when the Agency itself needs a regulatory body? And private insurance have nothing to do with the NHI scheme, so putting this together is confusing?

Then discussions will continue on the technical issues, especially on benefit package & the funding, and these issues will be clarified in the regulations

- **Progressivity**

On 5th December the Ministry of Finance will announce the SHI initiative officially, but at best the services will start for a very limited proportion of the population by the end of 2020. The main reason why is that the law has to be promulgated, the regulations adopted, the agency created, the board nominated, the Director appointed, its team recruited, the SOP (standard operations and procedures) manual in place, and a basic information system, registration system and financial management system ready.

The SHI initiative can start sooner or later, and the sooner the better. But lilkewise it is of utmost importance that it'd be progressive. SHI will have to go slow to go far, because it will have (1) to make sure the health services are available, (2) that the funding is available, (3) because i twill need to learn from its own lessons, and (4) to ensure that the all country is participating in this *national* project.

Appendix 1: why starting with the most vulnerable?

1. The experience shows that when NHI starts with the formal sector, it becomes more and more difficult to tackle the informal sector including the poor. Mostly because the formal sector expects more and more benefits and turns out to be reluctant to pool its funds.
2. Covering the poor is not difficult, because there is no contribution collection. The major challenge is on targeting.
3. Covering the poor is very good for a start, because the system can be tested on all the other functions of insurance (information, registration, contracting, monitoring, financing, risk management, claim processing including control & payment) with beneficiairies that are relatively less demanding.
4. Starting with the poor means to increase coverage on the basis of the funds available. For example if the premium is 700 dalasi and the budget for claims in 2021 is 70 millions, the Agency can cover 100.000 people as a start; and if the budget is increased to 350 millions in 2022, i twill be able to cover 500.000 people. If one starts with the public sector, the governement has to pay 50% of all premium of all civil servant straight away the first year.
5. Starting with the poor allows to start in a geographical area, as a pilot or test before rolling out to all the country. On the opposite, starting with the civil servant means being ready all over the country.
6. Politically, this target is very relevant.
7. This is a target for which the partners are more willing to support in various ways.

Appendix 2: 2020 draft implementation plan

This is basic and ambitious workplan for services to start at the end of 2020.

TYPE OF WORK	MAJOR & MINIMUM TASKS	1	2	3	4	5	6	7	8	9	10	11	12
Legal provisions' preparation and adoption	Law drafting												
	High level discussions (on line Minister, oversight & exemptions)												
	Law adoption process												
	Regulations developement and adoption												
Institutional set up	Creation of the Agency												
	Appointment of the Agency Board and Direction												
	Constitution of the teams												
Technical preparation	Consultancy on the benefit package												
	Financial simulations and decisions on steps for coverage												
	Refinement of the benefit package												
	Basic information system development												
	Identification & registration of the poor												
	Contracting: negociation of payment mechanism and amount												
	Development of standard operations and procedures manual												
National dialogue	Information on the law												
	Sensitization of the Health Workers												
	Consultations (on the benefit package & conditions of access)												
	Communication on the benefit package and conditions of access												
	Discussions on the choice of possible pilot zones												
Supplier-side preparation	Improvement of the drug system												
	Discussions on adapted PFM for the health facility												

Appendix 3: interviews

1. Director of Planning, MoH
2. Director of Policy Analysis Unit, Dpt of Strategic Policy & Delivery, Office of the President
3. Honorable Chairperson, National Assembly Select Committe on Health, Women, Children, Disaster Humanitarian Relief and Refugees
4. Excellency the Minister of Health and Permanent Secretary
5. UNFPA officers
6. UNICEF offices (health & social protection)
7. Kanifing General Hospital administrator, health financing and medical doctor
8. WB consulatnt on the bill
9. Ministry of Health legal Advisor