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INTRODUCTION TO HEALTH INSURANCE POLICY OPTIONS IN BOTSWANA: IMPROVING EFFICIENCY AND SUSTAINABILITY THROUGH HEALTH INSURANCE

September 2016

This background paper was prepared by Jose Carlos Gutierrez and Carlos Avila on behalf of the Health Finance and Governance project.

The Health Finance and Governance Project

USAID's Health Finance and Governance (HFG) project helps to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. The five-year, \$209 million global project is intended to increase the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG supports countries as they navigate the economic transitions needed to achieve universal health care.

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DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.

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ACRONYMS

AFA	Associated Fund Administrators
BNHI	Botswana National Health Insurance
BPOMAS	Botswana Public Officers Medical Aid Scheme
BURS	Botswana Unified Revenue Service
CSMBS	Civil Servant Medical Benefit Scheme (Thailand)
DHMT	District Health Management Team
EHSP	Essential Health Services Package
FFS	Fee-for-service
GOB	Government of Botswana
HBP	Health Benefit Plan
HFG	Health Finance and Governance Project
HFTWG	Health Financing Technical Working Group
MAS	MAS
MOF	Ministry of Finance
MOH	Ministry of Health
NBFIRA	Non-Bank Financial Institutions Regulatory Authority
NHIS	National Health Insurance System (Ghana)
PHC	Primary health care
SSS	Social Security Scheme
UCS	Universal Coverage Scheme
UHC	Universal Health Coverage
VAT	Value-added tax
WHO	World Health Organization

Currency conversion: 10.2 BWP per USD

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The Health Finance and Governance Project (HFG), supported by the United States Agency for International Development (USAID), appreciates the commitment and strong support of the Ministry of Health, the Health Financing Technical Working Group, and many others who shared their insights and contributions in the development of this report and in the development of the Health Financing Strategy.



EXECUTIVE SUMMARY

The purpose of this report is to explore how insurance reforms could improve the efficiency and sustainability of the Botswana health system, and to offer specific policy recommendations to guide the development of a national health insurance reform proposal. The report builds on the Health Finance and Governance (HFG) Project's support to the Ministry of Health (MOH) and the Health Financing Technical Working Group (HFTWG), and is one output of HFG and HFTWG's joint development of a health financing strategy. Further, the report will inform HFG's future technical assistance, which includes more quantitative analysis related to financing an insurance system and a fuller exploration of the feasibility of insurance reform.

The report has two main sections: Part I provides an introduction to health insurance and the challenges facing Botswana's health system, while Part II presents a framework for designing a health insurance system and outlines policy recommendations for each insurance design element in the framework.

As described in Part I, the impetus for health insurance reform comes from the HFTWG's multiyear process of exploring the main challenges affecting the Botswanan health system in order to develop a health financing strategy to overcome them. Specifically, Botswana needs to increase and sustain domestic financing for health (especially the HIV response), improve efficiency throughout the health sector, and address persistent deficiencies in primary care that contribute to the country's serious under-performance in maternal and child care. Botswana failed to reach the Millennium Development Goals for maternal mortality and under-five mortality, and mortality levels remain unacceptably high.

Part I then outlines basic health insurance concepts. At its core, the purpose of health insurance is to protect people from unexpected, and sometimes unaffordable, expenditures on health care: it mitigates the financial risk of any single person by paying for health care from a pool of prepaid funds, thus spreading the costs among the population. A discussion comparing and contrasting health insurance and car insurance helps explain the basic mechanics of insurance and how health's special place as a human right entails objectives and considerations that distinguish health insurance from other insurance products.

Part I concludes with a brief discussion of the evidence underpinning health insurance reform. The literature documenting the impact of health insurance on financial protection and health outcomes is too vast for a full review; instead, this section provides a brief overview and provides readers with further lines of inquiry. Ultimately, insurance reform can provide a platform to increase transparency and accountability of the health system, to empower the population, and to improve consumer choice and foster competition.

Part II seeks to answer the question “if Botswana were to embark on national health system reform, what should that reform look like?” It opens by outlining a general vision for a Botswana health insurance reform proposal. Mapping the flow of funds across the health system illustrates how the proposed insurance reforms can modify those flows. Part II then presents a health insurance design framework based on Wang et al. (2012) and adapted for Botswana. The framework comprises six insurance design elements: a) revenue generation; b) population coverage; c) benefit plans; d) provider payment; e) operational processes; and f) insurance governance. Each element seeks to answer a basic question pertaining to the design of an insurance system:

- a. Revenue generation – Where will the money come from?
- b. Population coverage – Who will be covered?
- c. Benefit plans – What services will be covered?
- d. Provider payment – How will providers be paid?
- e. Operational processes – How will the system operate?
- f. Insurance governance – How will the insurance system be regulated and governed?

The discussion of each design element presents definitions and key issues before describing the specific challenges that the element presents in Botswana and proposing policy recommendations to begin narrowing to the decisions that policymakers face in the design of an insurance system. These policy recommendations are supported by lessons from other countries and include the following:

- Enrollment in health insurance (whether through a new national insurance scheme or through medical aid schemes) should be mandatory for all Botswana.
- The new insurance system should be financed by contributions from formal sector workers and firms, and from government subsidies for the poor and those in the informal sector.
- The insurance reform should create a purchaser/provider split, with a new insuring entity purchasing services from the MOH.
- Botswana should develop a comprehensive health benefit plan that is based in evidence, adequately costed, and financially sustainable.
- Botswana should invest in electronic information systems in district health management teams and cost centers to facilitate efficient operational processes.
- Governance structures to steward and regulate the insurance system must promote accountability to important stakeholders including government, beneficiaries, and employers.

Finally, this report presents conclusions and next steps. Recognizing that Botswana is still in the early steps of designing an insurance reform proposal, the discussion highlights next steps that will be key to moving from policy design to policy adoption and implementation. Ultimately, despite the many challenges to implementing large health sector reforms such as insurance reform, Botswana’s history of innovation and commitment to health as a human right indicate its very real potential for enacting ambitious reforms and improving the health of all Botswana.



PART I

I. INTRODUCTION TO INSURANCE AND THE BOTSWANAN HEALTH SYSTEM

I.1 Objectives

This report is intended to inform the development of a national health financing strategy for Botswana. Specifically, the report explores how adopting national health insurance could improve the efficiency and sustainability of the Botswanan health system to ultimately provide better services and improve population health outcomes. It describes the main reforms that will be necessary if the Government of Botswana (GOB) decides to pursue health insurance reform and provides specific policy recommendations to guide the design of a national health insurance reform proposal.

I.2 The Collaboration of HFG and the HFTWG

This report is part of the Health Finance and Governance project's (HFG's) ongoing support to Botswana's Ministry of Health (MOH) and its Health Financing Technical Working Group (HFTWG) in the development of a health financing strategy. It builds on the HFTWG's initial strategy development work between 2012 and 2014.

In February 2016, HFG Botswana began facilitating regular meetings of the HFTWG. At the February meeting, HFG presented a landscape analysis of the main health financing challenges facing Botswana's health system (Cali and Avila 2016). Based on the analysis and in the context of policy priorities that the group had previously identified, the HFTWG decided at the meeting to focus on two of the priorities: health insurance and efficiency. To explore these topics, HFG has produced this insurance policy report, and a policy brief identifying opportunities to improve efficiency (Nakhimovsky et al. 2016). HFG is also supporting the MOH in conducting a Health Accounts exercise (Cogswell et al. forthcoming 2016) to better understand national health expenditures, and with an actuarial analysis of Botswana's Essential Health Services Package (EHSP). Throughout this technical assistance, HFG has worked closely with MOH counterparts to ensure joint ownership and build stakeholder consensus around the strategy. Together, all of these products serve as inputs to the health financing strategy, which will be presented in October 2016.

I.3 June 2016 HFTWG Meeting and Insurance Policy Options Survey

The themes and policy recommendations in this report incorporate comments from a lively discussion on the merits of and challenges to introducing an insurance system in Botswana, which took place at the third HFTWG meeting facilitated by HFG, in June 2016. At that meeting, HFG presented on the basics of insurance systems, including the fundamentals of actuarial analysis and examples of country experience with developing national health insurance - particularly from Ghana - that are relevant to Botswana.

During the meeting, HFG also conducted an informal Health Insurance Policy Preferences Survey exercise to probe HFTWG participants about their level of agreement (and disagreement) to 11 statements related to key policy issues in the design of insurance systems. Participants were asked to consider these questions in light of how a potential insurance system should be designed in Botswana. The results of this exercise are integrated into this report throughout Part II, in the sections corresponding to the related policy recommendations. The exercise used a "vignette" methodology that has been used to measure consensus in the health economics policy community (Morrisey and Cawley 2008; Trujillo et al. 2015). For each question, participants were presented with a vignette regarding a key policy issue in designing a health insurance system, then with a statement voicing a position related to that policy issue. For each issue, participants were asked to indicate their level of agreement. An example vignette and statement are presented below, and the full questionnaire is included as an annex.

Sample Vignette from the Insurance Policy Options Exercise

A common challenge for insurance pools is adverse selection - the phenomenon where healthy individuals do not enroll in health insurance while the sick, or those who anticipate having greater medical needs, do enroll. This leads to a sicker and more expensive beneficiary population for the insurer, which can in turn result in higher premiums, further discouraging young and healthy individuals to enroll. One approach to limiting adverse selection in health insurance is to mandate enrollment in the insurance scheme.

Insurance enrolment should be mandatory for workers in the formal sector (with contributions collected through payroll deductions).

1. Strongly Agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly Disagree

Source: Authors

As this report will discuss later, the bolded statement in the box above achieved full consensus - all 20 participants agreed or strongly agreed with it. While these responses should not be taken as the HFTWG's final word on the policy issues, they provide important insights into the level of consensus around the policy insurance options covered and can help guide future discussion. Further, the responses have informed the policy recommendations in Part II of this report.

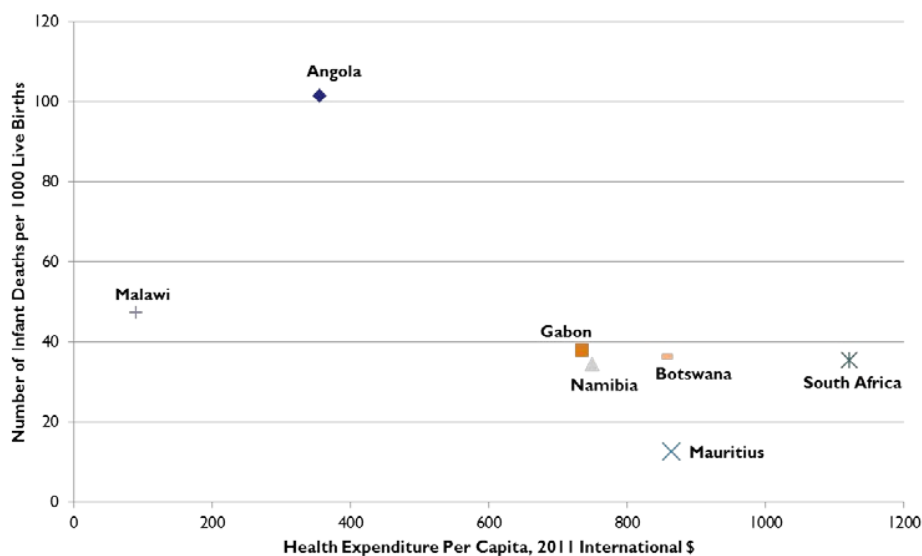
1.4 Botswana Health System Context

Botswana has made impressive improvements in health outcomes over the last few decades, particularly through its response to the HIV epidemic. Botswana has one of the highest levels of HIV prevalence, with 19 percent of the general population infected (Statistics Botswana 2013). In response, it has built one of the world's most successful HIV programs, which currently provides antiretroviral therapy to 64 percent of the HIV-infected population (Avalos and Jefferis 2016). But sustaining these coverage levels will be difficult. In June 2016, President Khama announced the launch of Botswana's "Treat All Strategy," which will provide therapy to all HIV-infected individuals regardless of their CD4 count or viral load. Despite the full political will and commitment behind the new strategy, Treat All will require additional financial resources, just as donor funds begin to decline.

Further, Botswana is underperforming in maternal and child health. While the maternal mortality ratio dropped from 360 to 170 maternal deaths per 100,000 live births between 1990 and 2013, Botswana did not meet the Millennium Development Goal for maternal mortality. Botswana also failed to reach the goal for child health, as under-five mortality dropped only slightly, from 50 to 47 deaths per 10,000 live births (WHO 2015). These failures have prompted political leaders to question the performance as well as the sustainability of the current health system.

Considering that Botswana spends more resources per capita than many of its peers, these statistics raise alarming questions about the Botswanan health system's performance in the area of efficiency. Figure 1 plots the infant mortality rate against per capita health expenditure. As illustrated in the figure, Botswana's infant mortality rate (35 deaths per 1,000 live births) is similar to that of Malawi's despite Botswana spending about 10 times the resources per capita that Malawi spends.

Figure 1. Infant Mortality Rate versus Per Capita Health Expenditure, 2013



Source: Cali and Avila (2016)

In addition to suboptimal performance in maternal and child health, the rise of noncommunicable diseases presents a complicated - and expensive - challenge for the health system. By 2014, noncommunicable diseases accounted for 37 percent of deaths. These are primarily caused by cardiovascular disease, cancers, and diabetes. Left unchecked, these chronic conditions will grow to become a larger share of the disease burden and will consume more and more of the country's health resources.

Faced with the challenges of improving health outcomes related to HIV, maternal and child health, and noncommunicable diseases, the MOH must also respond to health systems challenges that further jeopardize performance. Of particular concern is the long-term financial sustainability of the health system. While Botswana still enjoys good prospects for growth over the coming decades, projected growth levels are nonetheless lower than the growth experienced throughout the 2000s. Further, Botswana must contend with the prospects of diminishing diamond revenues in the future - as one member of the HFTWG quipped, "diamonds are not forever." Meanwhile, donor funds for health are declining, and the private sector is experiencing significant cost escalation that has driven up premiums for medical aid scheme (MAS) beneficiaries and threatened the solvency of the Botswana Public Officers' Medical Aid Scheme (BPOMAS) and other MAS.

A financial gap analysis for HIV and primary care services highlights these issues. In 2015, there was a funding gap of 1.57 billion BWP (about 154 million USD)¹ for primary care services (excluding HIV) and a funding gap of 44.9 million BWP (4.4 million USD) for HIV (Cali and Avila 2016). Together, the funding gap for HIV and primary care services between 2015 and 2023 amounts to a cumulative 23.18 billion BWP, or 2.27 billion USD. (For a more detailed discussion of the funding gap, refer to HFG's Landscape Analysis (Cali and Avila 2016)).

All of these contextual factors point to the need for more resources for health, and to the need for better use of existing resources. Ultimately, the main challenge facing the Botswanan health system is similar to that of all countries seeking to provide better services in the context of limited resources. Essentially, Botswana must improve performance toward health outcomes while reining in costs and ensuring long-term financial sustainability. As discussed throughout this report, insurance reform has the potential to address those challenges.

1.5 Health Insurance: Basics Concepts and Definitions

The purpose of health insurance is to protect people from unexpected and often unaffordable, expenditures on health care. By paying for health care from a pool of prepaid funds, insurance spreads the costs among the population and mitigates the financial risk of any single person. The box below presents definitions of key insurance concepts used throughout the report.

Key Insurance Definitions

Insurance – A relationship whereby an entity (the insurer) assumes the financial risk of certain unexpected events and agrees to pay compensation for a group of clients or beneficiaries in exchange for payment (premiums)

Risk – The probability of a specific event occurring within a specific period of time

Risk Pooling – The collection and transfer of revenues to a purchasing entity charged with bearing the financial burden of unexpected health services for a large group of individuals or households

Principal – The insured client purchasing services from an insurer

Premium – Periodic payment for the purchase of insurance entitling the principal to a set of services and benefits

Insurance claim – Documents the occurrence of an insured event and requests payment from the insurer to the principal or a third party

Actuarial Analysis – The estimation of financial risk based on the risk of adverse events, utilization, and costs in order to calculate premiums and inform insurers' decision making

Risk Rating – The calculation of premiums based on the risk of each principal

Adverse Selection – The phenomenon in which healthy individuals do not enroll in health insurance while the sick, or those who anticipate having greater medical needs, do enroll. Adverse selection leads to a sicker and more expensive beneficiary population for the insurer, which can in turn result in higher premiums, further discouraging young and healthy individuals to enroll. Adverse selection is a key challenge for health insurance and is discussed more extensively in Section 2.3, Revenue Generation.

Source: Adapted from Precker et al. (2016)

¹ Currency exchange rate used is 10.2 BWP per U.S. Dollar.

Health insurance, at its core, is similar to other forms of insurance such as car insurance or home insurance, which provide financial protection in the event of a car accident or damage to a person's property. Taking car insurance as an example, insurance companies calculate the risk of accidents and the average cost of repairs. Based on that information, they calculate premiums (and other fees) to ensure that the insurance fund is solvent and makes a profit. Car insurance is a desirable product because for the most part, car owners do not save money in order to pay for car repairs in the event of an accident. By paying ahead for those repairs through insurance premiums, car insurance clients ensure that their cars can be repaired without their incurring undue financial hardship. The rationale behind health insurance is analogous: mobilizing prepaid funds to finance the costs of health services associated with future illness, and thus to mitigate the risk of financial hardship due to health care expenditure.

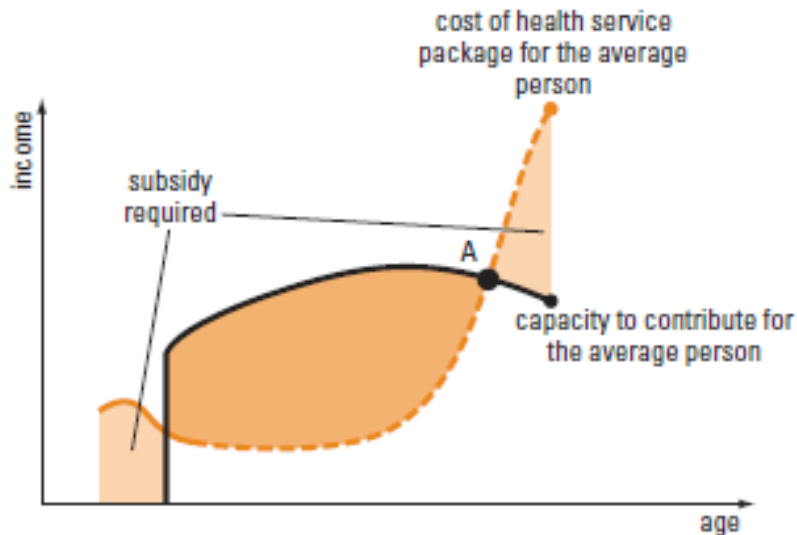
Furthermore, in both cases, it is impossible to know exactly when an adverse event - a car accident or a health emergency - might occur. Insurance companies can nonetheless calculate the long-term probability of these events, and they can manage those risks based on different clients' characteristics by adjusting premiums accordingly. This type of analysis is called *actuarial analysis*. A car insurance company may charge higher premiums to young, inexperienced drivers who have a higher probability of crashing, or for brand-new, expensive cars that are costlier to repair. Similarly, health insurance companies may charge higher premiums to the elderly, who have a higher likelihood of falling ill and incurring medical costs, or women of reproductive age, who may become pregnant. This practice is called *risk-rating*.

However, there are also important differences between car and health insurance. The striking difference is that access to an automobile is not a human right, whereas Botswana's constitution does recognize access to health care as a human right, and the GOB is committed to providing equitable access to quality health services for all Botswana, what is called "universal health coverage" (UHC). This distinction results in important differences in how health insurance must be designed in comparison to other types of insurance.

In other types of insurance, beneficiaries (or *principals*, in insurance terminology) pool their risk and subsidize each other across time periods. When a car insurance principal pays premiums in the present and enters the insurance risk pool, he is financing the repairs of other members' cars with the expectation that their premiums will pay for repairs his car might need at a future date. If principals pay different premiums based on their different levels of risk, that is not necessarily a problem so long as those rates are determined in compliance with laws and regulations. In health insurance, however, since Botswana is committed to guaranteeing access to health services, pooling funds and risk is intended not only as a subsidy across time, but also as a subsidy from the healthy to the sick, from the population of working age to the vulnerable (both old and young), and from the wealthy to the poor.

Figure 2 illustrates the relative contributions and risk of illness across a lifetime. The working-age population is the most healthy and economically productive; therefore, people in this group typically pay more into the health care system than they consume. In contrast, the very young and the very old typically consume more resources than they can contribute, so they need subsidies in order to access health care services.

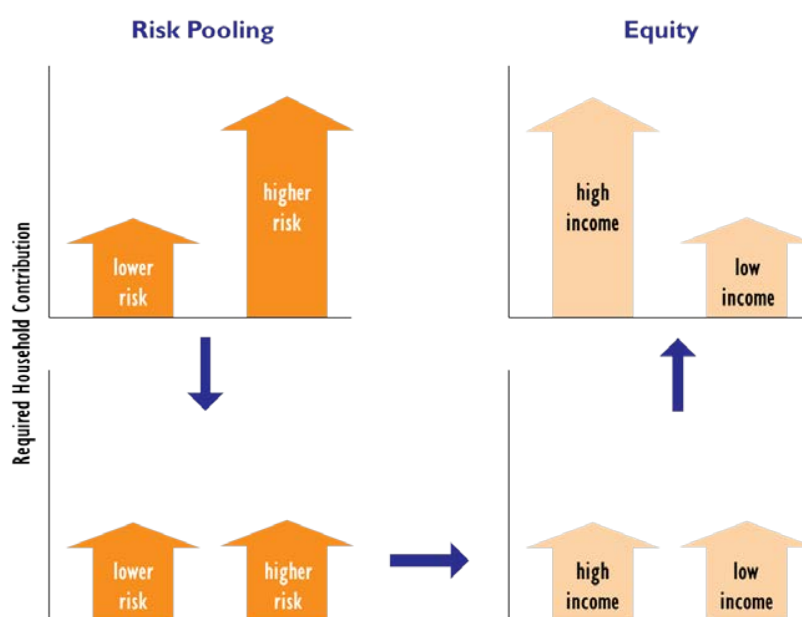
Figure 2. Cost of Health Services, Capacity to Pay, and Need for Subsidies Over the Lifetime of a Typical Individual



Source: Gottret and Schieber (2006), adapted from ILO/STEP (2002)

In addition to subsidies across age groups, health insurance systems can introduce subsidies across income groups, so that the wealthy finance health care services for the poor. The extent of these subsidies depends largely upon a country's values, particularly the degree of social solidarity and concerns for equity. As shown in Figure 3, there are multiple dimensions that can be modified to improve equity and social solidarity. In the top-left corner, those with higher risk of illness are incurring greater costs than those with lower risk. Moving toward the bottom-left (equalizing the costs between high- and low-risk households) improves equity. However, this situation may still prove inequitable if high-income, high-risk households are subsidized by low-income, low-risk households. Thus, moving from the bottom-right of the diagram to the top-right (where high-income households pay a larger share than lower-income households) can also improve equity and financial protection (Gottret and Schieber 2006).

Figure 3. Models of Cross-subsidization for Pooling Risk and Increasing Equity of Household Contributions for Health Services



Source: Gottret and Schieber (2006), adapted from ILO/STEP (2002)

1.6 Insurance - Evidence and Potential Health System Benefits

Health insurance is one way of financing and organizing a health system, but there are other ways to do this, so why should Botswana pursue health insurance reform? While the evidence supporting insurance reform will be analyzed in greater detail at future HFTWG meetings, this section summarizes the evidence supporting insurance and its potential to transform health systems and improve health outcomes.

The evidence base for insurance is well established. According to a recent review of the effectiveness of health systems strengthening interventions (Hatt et al. 2015), health insurance impacts health status, service utilization, service quality, and financial protection through four pathways: increasing financial access, influencing provider behavior, alleviating poverty, and improving the availability of inputs. By providing access to care regardless of a person's ability to pay up front, insurance mitigates financial barriers and encourages people to access care in a timely fashion. By modifying provider payment mechanisms, insurance can influence providers to behave differently and respond to service delivery and cost containment priorities. By increasing financial protection, insurance can prevent families from falling into poverty due to health expenditure, and financial stability can in turn contribute to achieving better health status. Finally, by securing financing for the health system up front, insurance improves the predictability of future financing for providers, which helps providers secure the necessary inputs to provide services.

Further, Hatt et al. review a number of systematic reviews highlighting evidence of the impact of health insurance on health status as well as on health systems outcomes and results in low- and middle-income countries. Health insurance schemes have reduced infant mortality in Ghana, neonatal mortality in Brazil, and cancer and cardiac mortality in India, to name a few examples. Further, health insurance is associated with higher levels of service utilization, and higher levels of financial protection. Reductions in out-of-pocket health expenditures have been observed in Colombia, Egypt, Georgia, Ghana, India, Mexico, Nicaragua, Senegal, and Vietnam (Hatt et al. 2015).

Moving beyond specific measures of impact or performance, Precker et al. (2013) enumerated four reasons that countries typically pursue health insurance reform:

- a. Inadequate revenue generation from existing financing mechanisms
- b. Inadequate financial protection against the costs of illness
- c. Inadequacy of resource allocation methods
- d. Institutional rigidity that impairs the government's ability to influence the three issues above

In the case of Botswana, the primary concern driving the consideration of insurance reform is the adequacy of resource allocation. Addressing inefficiencies is a high priority for the HFTWG, and the introduction of an insurance system has the potential to shift resource allocation methods from a predominantly supply-side approach to a demand-side approach that better responds to the needs of the population. Further, a national insurance reform enables broader institutional changes to entrenched organizational and management practices that contribute to existing inefficiencies. High-profile reforms such as insurance create a window of opportunity and a platform to reform these managerial practices.

Generating appropriate levels of revenue is another motivation for pursuing insurance in Botswana since the country is committed to providing financial risk protection and protect the gains and progress achieved in controlling the HIV epidemic by mobilizing adequate domestic resources for health. An insurance system that mandates enrollment and automatically collects contributions from formal sector workers through payroll deductions could increase the resources available to finance health care. Currently, only 55% of public sector workers are enrolled in BPOMAS, and only 34% of private formal sector workers are enrolled in MAS; those formal sector workers not yet enrolled in MAS could contribute to financing the insurance system, and these revenues can help offset the costs of covering the poor and informal sector. Further, an insurance reform could preserve Botswana's gains in financial protection - according to the 2009/2010 Health Accounts findings (MOH 2012), out-of-pocket expenditures as a share of total health expenditures were 4.2 percent. While this is low compared to most countries in sub-Saharan Africa, rising costs in the private sector threaten financial protection since MAS could seek to defray rising costs by raising copayments in addition to premiums.

In sum, insurance reform in Botswana has the potential to mobilize significant resources and to transform how resources are used to promote access, equity, and efficiency. Further, insurance reform provides a platform to increase transparency and accountability to the health system, to empower the population, and to improve consumer choice and foster competition. The remainder of this report is dedicated to exploring these changes in more depth.



PART II

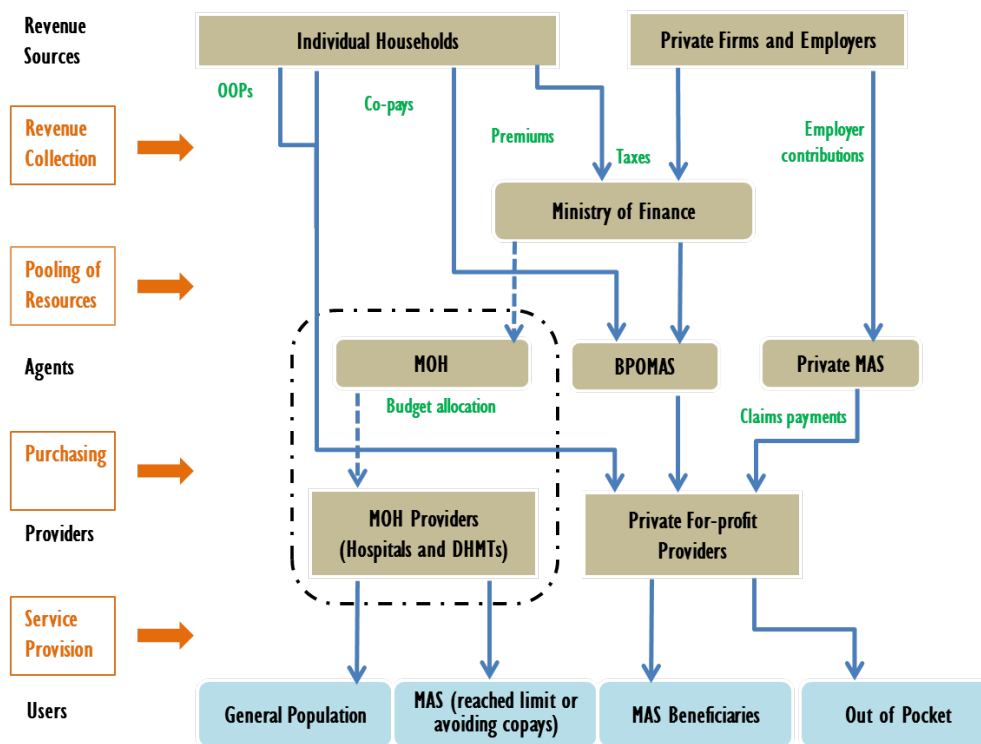
2. PROPOSED INSURANCE REFORM FOR BOTSWANA

2.1 Vision for a Botswana National Health Insurance Fund

A national health insurance reform proposal must provide a vision for how reform will transform the health system and result in access to better services for the population. Part II seeks to answer the question "if Botswana were to embark on a national health system reform, what should that reform look like?" In Botswana, health insurance reform has the potential to reshape the flow of funds throughout the health system in order to: a) generate more resources for health; b) direct those resources to priority interventions that improve equity and access; and c) promote efficiency throughout the health system to ensure long-term sustainability.

Figures 4 and 5 illustrate how financing flows will change with the introduction of insurance. For the purposes of these examples, the proposed public insurance scheme is called the "Botswana National Health Insurance" (BNHI).

Figure 4. Health Financing Flows in Botswana's Current Health System



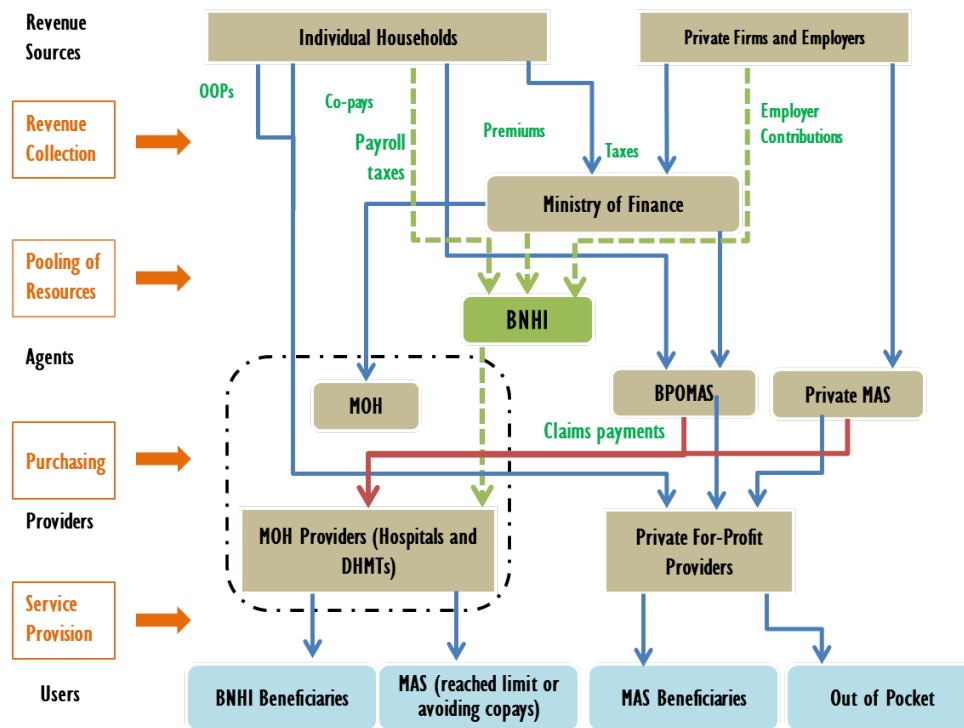
Source: Authors

Note: For simplicity's sake, private MAS are grouped together in the figure. They include: Botsogo Health Plan; Botswana Medical Aid (BOMAID); Botswana Public Officers' Medical Aid Scheme (BPOMAS); Call A Doctor (Pty) Ltd t/a Itekanele Health Scheme; Doctors (Pty) Ltd t/a Doctors Aid Medical Aid Scheme; Pula Medical Aid Fund; Wastikc Consortium (Pty) Ltd t/a Etudiant Medical Aid; Botlho Medical Aid (Pty) Ltd; and Symphony Health.

As illustrated in Figure 4, Botswana's health system is financed by households, government revenues, and private sector firms. Households contribute funds into the system by paying taxes to the GOB, by paying

MAS premiums, and by accessing private sector services directly with out-of-pocket payments. The Ministry of Finance (MOF) collects taxes in various forms from households and firms, and private sector firms contribute to employee MAS premiums. The MOF, in turn, allocates funds to the MOH and BPOMAS, a voluntary Medical Aid Scheme available to public sector employees. The MOH and MAS (including BPOMAS) represent risk pools for their respective beneficiaries. MOH funds are allocated directly to hospitals and district health management teams (DHMTs), which provide services to the population; the dotted line around the MOH and MOH providers indicates that they are the same entity. Meanwhile, MAS purchase services from private sector providers. At this point, households may also pay copayments to access those services. Thus, as illustrated with the blue arrows at the bottom of the diagram, public providers provide services to the general population but also to MAS beneficiaries who choose to access public services, whether to avoid copayments or because they have reached coverage limits. On the bottom right, the blue arrows indicate that private providers provide services for both MAS beneficiaries and to members of the general population who access services directly with out-of-pocket payments.

Figure 5. Health Financing Flows After Proposed Health Insurance Reform



Source: Authors

As illustrated in Figure 5, the insurance reform generates both a structural change and new flows of financing. The main structural change is the new pooling agent (BNHI), which collects revenues from households and firms through payroll contributions, and from general revenues allocated by the MOF. The arrows in green illustrate new flows of funds to the BNHI, as well as the new flow of funds from the BNHI to the MOH, since the BNHI must purchase services from the MOH provider network. In addition, there is a new flow of funds from MAS to MOH providers, illustrated by the arrows in red, representing claims payments from MAS to the MOH when MAS beneficiaries access services through MOH providers.

These changes generate new public sector financing for health, from BNHI payroll contributions and the MOH billing of private sector providers. They also separate the purchaser and provider - roles both currently performed by the MOH - with the BNHI as the purchaser and the MOH as the provider. The split between the purchaser and provider is a central element of insurance reform. This new purchasing dynamic essentially shifts resource allocation from a supply-based model to a demand-based model in which funds are allocated to regions and providers where people access services. This implies a shift away from inefficient historical line-item budgeting to other payment systems that empower citizens as consumers of health services. Further, the introduction of billing systems so that the MOH can bill MAS for services provided to MAS beneficiaries is a key reform necessary to recover costs in the public sector while nudging MAS to adopt more cost-containment measures rather than using the MOH as a safeguard against insolvency. When the MOH provides services to MAS beneficiaries without billing for them, the GOB is effectively subsidizing MAS and MAS members, who already consume more health resources per capita than non-members. Thus, this new billing mechanism is necessary not only for the health system's financial sustainability, but for equity.

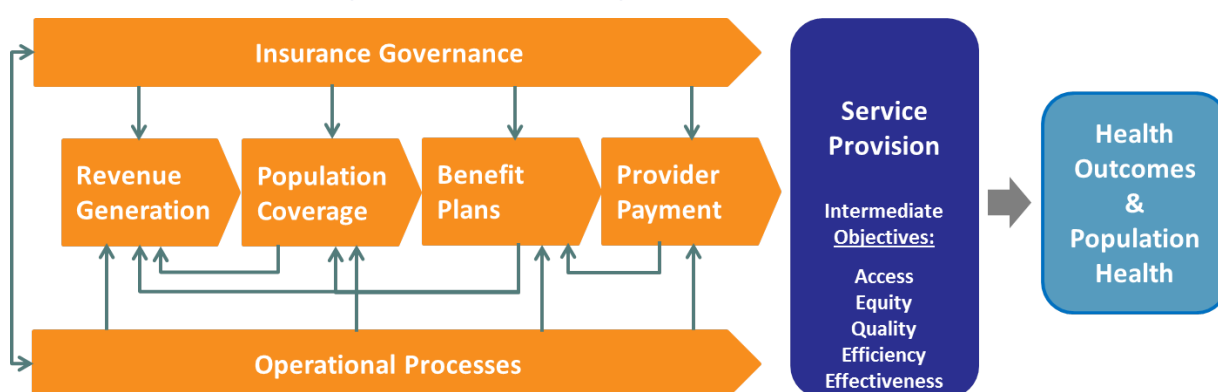
Another important aspect in Figures 4 and 5 is what has not changed - BPOMAS and other MAS continue to operate in the proposed health insurance system to expand choice and ensure a healthy mix of public and private options. The continued role of MAS in the health system achieved moderate consensus in the Health Insurance Policy Preferences Survey administered to the HFTWG. Sixty percent of HFTWG members agreed with the statement that "a new national health insurance system should preserve the current system of MAS, instead of creating one unified insurance fund," compared to 30 percent who disagreed with the statement. Though larger risk pools are theoretically more effective at pooling risk and mitigating adverse selection, merging the different MAS pools and the new insurance system would be politically unfeasible. MAS members are generally happy with their coverage and would strongly oppose any change to their situation.

Ultimately, the key to implementing ambitious health reforms such as a new insurance system is to build a coalition of active stakeholders. Thus, the MOH should partner with the MAS and private providers to design a reform package that benefits all parties, for example, developing affordable MAS plans for lower-income groups. While the new billing mechanism from MAS to MOH generates additional costs for MAS, there are ways in which health insurance reform could benefit MAS. For example, mandating health insurance enrollment for the formal sector (while giving employees the option to choose between the BNHI and the MAS) could result in large enrollment boosts for MAS. Further, the reform package could include regulatory reforms beneficial to MAS, such as allowing them to negotiate rates with private sector providers. Both of these actions could result in significant additional revenue for MAS, and could strengthen their bargaining power with providers, enabling them to contain costs. Private providers, meanwhile, would also benefit from a larger market for private health sector services if mandatory insurance enrollment resulted in higher MAS coverage levels.

2.2 Insurance Design Framework for Botswana

This section discusses the main design elements necessary to implement a new insurance system in Botswana. The design elements are the major part of HFG Botswana's framework (see Figure 6) for a new insurance system in Botswana. The framework draws heavily from other frameworks, including Wang et al.'s Health Insurance Handbook (2012).²

Figure 6. Insurance Design Elements Framework



Source: Authors, adapted from Wang et al. (2012)

The six design elements (depicted in orange in Figure 6) are key components of any health insurance system. Each design element asks a set of questions that are summarized in the following list:

- Revenue generation - Where will the money come from?
- Population coverage - Who will be covered?
- Benefit plan - What services will be covered?
- Provider payment - How will providers be paid?
- Operational processes - How will the system operate?
- Insurance governance - How will the insurance system be regulated and governed?

While there is inevitably some overlap between the topics covered in the design elements, the general framework serves to outline the main questions that need to be answered, and the decisions that need to be made when designing an insurance system. In the framework, two design elements, operational processes and insurance governance, are depicted as cross-cutting elements that influence all of the other design elements. Together, the design elements influence service provision and the intermediate objectives of access, equity, quality, efficiency, and effectiveness to ultimately improve health outcomes and population health.

² Besides minor name changes to some of the design elements and the order of the design elements, the main difference between this framework and that in Wang et al. (2012) is that this framework omits monitoring and evaluation (M&E) and provider engagement. M&E was omitted because this report presents only a preliminary sketch of an insurance system; because M&E depends heavily on the structure of the insurance system, a discussion of M&E would be either premature or too general to add value to the report. Provider engagement was modified to provider payment.

2.3 Revenue Generation

Summary of Key Points

Key issues

- Achieving UHC demands sufficient revenues to finance the provision of health services, and the revenue collection mechanisms must balance various objectives including equity, access, and efficiency.
- Adverse selection poses a significant challenge to the sustainability of health insurance schemes in a voluntary insurance system, particularly among small risk pools.

Policy recommendations for Botswana

- Design a diversified set of revenue sources for the public insurer.
- Mandate insurance enrollment for all Botswana.

2.3.1 Definitions and Key Issues

Financing is a key component of any insurance system. Health financing typically encompasses three main questions:

- a. Where will the money come from (revenue generation)?
- b. How are funds pooled together in risk pools (pooling)?
- c. How and for what will the funds be used (purchasing)?

This section will discuss revenue generation. The new pooling arrangements are described at the beginning of Part II. Purchasing and provider payment are discussed in Section 2.6, Provider Payment. While HFG will present further analyses pertaining to the financing of the insurance system at future HFTWG meetings, revenue generation is implicit in the development of an insurance system and merits a discussion in this report.

Policymakers must balance a variety of objectives when deciding how to finance an insurance system. Among these are: a) promoting universal access to services, b) providing adequate financial protection against the costs of illness, c) promoting equity in the financing and use of services; d) incentivizing quality and efficiency in the provision of services; e) promoting efficiency in the administration of the health system; and f) ensuring the long-term sustainability of the health system.

Balancing these objectives requires careful consideration of the tradeoffs of different financing mechanisms. Table I lists the major types of insurance and their traditional financing sources. In reality, national health insurance systems can be financed by a combination of different financing sources, including general and earmarked taxes as well as payroll taxes from employers and employees. In addition, insurers may also use copayments and coinsurance for cost-recovery or to discourage over-utilization of health services.

Table 1. Major Types of Health Insurance and Traditional Financing Sources

Types of Insurance	Financing Source
National health insurance	General taxes
Social health insurance	Payroll taxes from employers and employees
Private voluntary insurance-commercial	Premium payments from individuals or employers/employees
Community-based health insurance	Premium payments from individuals and/or community

Source: Wang et al. (2012)

2.3.2 Policy Recommendations

In Botswana, the main source of financing for health is general government revenue from taxation. MAS, meanwhile, are financed through employee and employer contributions. A new public insurer could be financed by a mix of taxation and employer and employee contributions.

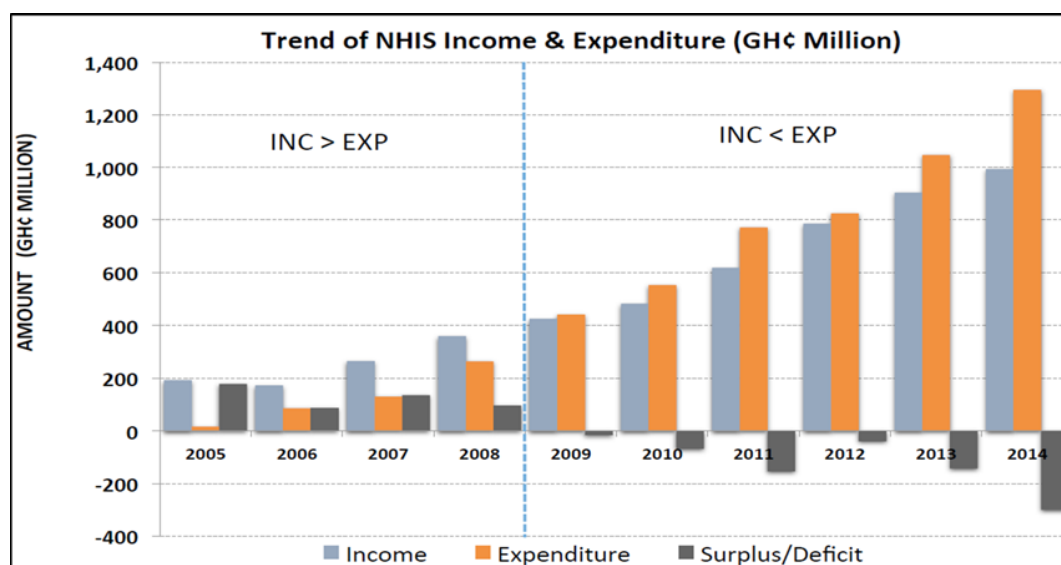
Enrollment in a new Botswana insurance system should be mandatory for all Botswana in order to ensure that the population can access health services and contribute to the financing of the health sector. Mandatory enrollment can mitigate the challenges of adverse selection - the phenomenon where healthy individuals do not enroll in health insurance while the sick, or those who anticipate having greater medical needs, do enroll. This leads to a sicker and more expensive beneficiary population for the insurer, which can force an increase in premiums, further discouraging young and healthy individuals to enroll.

One common approach to the challenge of adverse selection is to make insurance coverage mandatory. All 20 participants in the Health Insurance Policy Preferences Survey discussed earlier agreed with the statement that "Insurance enrollment should be mandatory for workers in the formal sector (with contributions collected through payroll deductions)." Mandating enrollment provides one safeguard against adverse selection, and payroll deductions are an efficient way of collecting revenue from formal sector workers.

Further, shifting from voluntary to mandatory enrollment could contribute to the solvency of not only the public insurer, but of the MAS. Botswana's MAS are challenged by a small population and thus limited opportunities for growth. While some new enrollees in the formal sector may opt for the public health insurer, some may opt to join a MAS, increasing the size (and solvency) of MAS risk pools.

Financing Mechanisms in Ghana's National Health Insurance Scheme

Ghana's National Health Insurance Scheme (NHIS) has made impressive achievements in increasing utilization of health services and mobilizing domestic resources for health, and the country offers several insights for Botswana's health system. One innovative aspect of Ghana's insurance system is its financing mechanism through an earmarked value-added tax (VAT). The increase in the VAT enabled a rapid expansion in access to health services. Further, the fact the tax is earmarked helps ensure that the revenue raised is allocated to the NHIS. Earmarking taxes such as the VAT is one potential innovative way for Botswana to diversify the sources of financing for a new insurance system, instead of relying on only employer/employee contributions, and on general budget allocations. The figure illustrates the growth in revenues and expenditures in Ghana between 2005 and 2014.



While increased revenues enabled increased service provisions, revenues have not kept up with expenditures. As also illustrated in the figure, revenue shortfalls since 2009 have led to a growing deficit, the result of a number of factors: administrative inefficiencies, stagnant levels of enrollment among the contributory population, and a generous benefits package that contributes to cost escalation (Otoo et al. 2014). As described in further detail in Section 2.5, The Benefit Plan, it is critical that Botswana design an explicit benefit package that is costed appropriately so that the costs of providing the benefits package are balanced by projected revenues.

Source: Jehu-Appiah (2015)

This report recommends that Botswana finance a new public insurance system through a mix of payroll contributions from the formal sector, from general taxation, and from innovative mechanisms such as an earmarked VAT or other levies. However, key questions remain as to the specific financing mechanisms to be employed, and regarding the financing of coverage for the informal sector, which is discussed in more detail in the population section of the report. HFG will present further analysis of the financing options for mixed contributory and subsidized schemes at future HFTWG meetings.

2.4 Population Coverage

Summary of Key Points

Key issues

- Establishing an insurance scheme requires a defined population to be covered.
- Some population groups are more difficult to engage, such as the rural poor, and the poor and non-poor informal sector.

Policy recommendations for Botswana

- Botswana's constitution mandates that all Batswana should have access to affordable quality health services; thus, all population groups, including the informal sector, should be eligible for the insurance scheme and should receive the same benefits.
- Insurance premiums for the informal sector should be subsidized by the GOB. A sliding scale for contributions from formal sector workers and GOB subsidies should be developed to ensure that poor formal sector workers are not overly burdened by the insurance contributions.

2.4.1 Definitions and Key Issues

Defining a beneficiary population is a critical component of designing an insurance scheme. Policymakers must identify different segments of the population to be covered and determine how to engage hard-to-reach groups such as rural populations, the poor, and informal sector workers and their families. Further, policymakers may be faced with choosing between expanding population coverage (who is covered) and expanding the services covered in the health benefits package. In Botswana, at least, there is no question as to whether the poor or informal sector or rural populations will be covered, but rather how they will be covered, and whether different segments of the population will be treated differently in the financing and provision of care. Will the poor and non-poor be required to contribute equal premiums or equal payroll tax rates, for example, and will they receive the same benefits even if they do not contribute equally?

2.4.1.1 Covering the Informal Sector

Coverage of informal sector workers and their families constitutes one of the main challenges to providing UHC through insurance systems. The informal sector presents a unique challenge in low- and middle-income countries because it includes both poor and non-poor workers and their families. This situation is exacerbated in countries with large informal sectors.

Unlike formal sector workers, whose payroll contributions can be deducted automatically by tax collection agencies such as the Botswana Unified Revenue Service (BURS), informal sector firms and workers are difficult to identify. Thus, enrolling and collecting revenue from them is a significant challenge for both voluntary and mandatory contributory schemes. Further, countries that provide noncontributory schemes for the poor and wish to exclude the non-poor informal sector from subsidies must implement a targeting system to identify the poor and non-poor (Bitran 2014).

2.4.1.2 Targeting Registries - Identifying Eligible Beneficiaries

"Targeting registries" are mechanisms that identify eligible beneficiaries. Often, these mechanisms distinguish between the poor and the non-poor in the informal sector, and they may include geographic targeting that selects beneficiaries based on location, or comprehensive means-testing (Cotlear et al. 2015). Implementing these systems can be costly. Further, targeting systems are not always accurate, either because of the methodology itself or because of the incentive to under-report income. As a result, targeting registries designate some citizens as non-poor (and therefore ineligible for subsidies) even though they may in fact be poor and cannot afford to contribute. On the other hand, the non-poor may be mistakenly designated as poor and eligible for subsidies.

Given the costs and difficulties of implementing sophisticated targeting registries, some countries that used to use them to define subsidy eligibility no longer do so. Colombia, Mexico, and Thailand, three countries that have made impressive progress toward UHC, have all transitioned away from targeting and instead cover the entire informal sector (Cotlear et al. 2015). Some health economists have argued that subsidizing informal sector workers may contribute to labor informality (World Bank 2012). However, the evidence around the labor effects of health insurance is mixed and should not deter policymakers from subsidizing the informal sector.

2.4.2 Policy Recommendations

In Botswana there is no question as to whether the poor, the informal sector, or rural populations should be covered, but rather how they will be covered. Botswana's constitution mandates that health is a human right and the GOB has an obligation to ensure that all Botswanans enjoy access to affordable, quality health services. This legal framework underpins the GOB's commitment to providing services free of charge under the current model of health financing and service provision. Any new insurance reform must take into account all members of the population. Further, there was strong consensus among the HFTWG (as evidenced by the Health Insurance Policy Preferences Survey) that the government should provide subsidies for poor families to enroll in a proposed insurance scheme.

In comparison to other countries, where health systems are fragmented into many different institutions serving different segments of the population, the Botswanan population is segmented into only three main groups when it comes to how they access health services

- Formal private sector workers enrolled in MAS
- Formal public sector workers enrolled in BPOMAS
- Population not enrolled in MAS (formal and informal sector workers, unemployed, etc.)

These three groups are illustrated in Figure 7. Those covered by MAS (including BPOMAS) comprise only 18 percent of the population. The majority of the population - from the public and private formal sectors, as well as the informal sector, which includes lower- and higher-income groups - uses MOH services. While this model offers MOH services for the entire population, it misses out on potential revenues from higher-income formal sector workers and firms electing not to enroll in a MAS.

Yet introducing compulsory health insurance for all, with mandatory payroll contributions from formal sector firms and workers, creates another challenge: should formal sector workers and their families receive the same benefits as non-contributing informal sector workers, even when some of those workers are not poor? Or should different schemes be created for contributory or non-contributory populations? In Botswana, where approximately 50 percent of the population works in the informal sector (MOH 2009), the question of how to cover the informal sector is of critical importance.

Figure 7. Population Coverage Under Existing Arrangements

Sectors of the Labor Force

		Informal Sector	Formal Sector (Public)	Formal Sector (Private)
Capacity to Pay	Higher Income	Private Care Out-Of-Pocket	BPOMAS	MAS
	Lower Income	Uninsured (MOH)	Uninsured (MOH)	Uninsured (MOH)

Source: Authors

Figure 8. Population Coverage With Proposed Insurance Reform

Sectors of the Labor Force

		Informal Sector	Formal Sector (Public)	Formal Sector (Private)
Capacity to Pay	Higher Income	Private care of pocket; BNHI	BPOMAS BNHI	MAS BNHI
	Lower Income	BNHI	BNHI	BNHI

Source: Authors

As illustrated in Figure 8, the BNHI would cover the poor and non-poor in the formal public and private sectors. This is a population that currently either cannot afford to enroll in a MAS, or chooses not to enroll because they perceive their health needs do not justify enrollment. Under the new insurance system, families in this group would need to enroll in either MAS or the BNHI. This helps ensure that higher-income workers contribute to financing the health system.

Formal and informal sector workers should participate in the same scheme, with equal benefits. The recommendation to cover the informal sector equally prioritizes equity in access to services and social solidarity in financing. It also avoids further fragmentation of the health system. This recommendation received moderate consensus based on initial discussions within the HFTWG: 55 percent agreed with the statement that "Botswana's insurance system should enroll all Botswana in the informal sector in a non-contributory system." Fifteen percent were uncertain, and 30 percent disagreed.

While this recommendation may draw some opposition because formal sector workers would contribute while the informal sector is subsidized, this can be mitigated by setting low contribution rates for those in the formal sector. As discussed in Part I, the impetus behind introducing insurance is less about collecting additional revenue from sectors of the population with ability to pay, and more about enabling institutional reforms to improve efficiency in the use and allocation of resources. Further, different subsidies and contribution levels may be set so that workers in the formal sector, who may also be poor, are not disproportionately burdened. This would also mitigate the effects of incentives for labor informality.



Coverage from the Bottom Up: Thailand's Universal Coverage Scheme

Thailand's health reform experience illustrates that it is possible to rapidly expand coverage to the poor and informal sector using a combination of different schemes if they all share the vision of seeking to harmonize the health financing system. It also demonstrates the importance of developing the necessary health sector infrastructure to expand service provision, since the Universal Coverage Scheme (UCS) reform followed a string of other reforms, including efforts to improve health system infrastructure and access to providers in rural areas.

The Thai health system consists of three main public schemes: UCS which covers the poor and informal sector, the Social Security Scheme (SSS), which covers private sector employees in the formal sector, and the Civil Servant Medical Benefit Scheme (CSMBS), which covers public sector employees in the formal sector. The UCS built on previous experiments with health insurance schemes, including voluntary health card schemes that were unsuccessful in encouraging the poor and informal sector to enroll. In response, the UCS was designed to facilitate enrollment (Hanvoravongchai 2013). In fact, enrollment is automatic for all those not already covered by the SSS or CSMBS schemes, though registration is also required, since the UCS reform also introduced a capitation system whereby beneficiaries register with specific providers, and providers are assigned funds based on their beneficiary population. The UCS currently covers about 71 percent of the Thai population (Cotlear et al. 2015).

Further, the scheme is almost entirely subsidized by the government, with most of the funds coming from general government revenues. The UCS was originally established with a "30-Baht Policy" in 2001, such that beneficiaries could access any services with a 30 Baht copayment (the equivalent of roughly 1 USD or 10 BWP); the copayment was abolished and then reinstated by alternating government administrations. In 2012, the 30-Baht copayment was reintroduced for patients receiving prescriptions and willing to pay on a voluntary basis; however, 21 beneficiary groups including the poor, the elderly, and children under five are exempt from the copayment (Hanvoravongchai 2013). During the period that the 30-Baht copayment was in place, the UCS used a targeting registry from a previous social program to identify the poor and other vulnerable groups and exempt them from copayment. Since the entire population not covered through another scheme is eligible for UCS, however, Thailand has effectively moved away from targeting registries and generating revenue from the informal sector. Despite the absence of direct targeting to the poor, however, there is evidence that the impact of the program has been pro-poor, as it has reduced inequalities in inpatient and outpatient utilization between the rich and poor.

Thailand's experience offers several lessons for Botswana. In Thailand, the reform succeeded in part because of the availability of service providers in rural areas to take on new demand generated by the introduction of UCS. Similarly, Botswana has a well-developed health system infrastructure that could support increased demand in rural areas. In addition, Thailand illustrates how mandatory enrollment can contribute to rapid increases in coverage in contrast to voluntary schemes that were unsuccessful in doing so. Further, the UCS reform created a purchaser/provider split when it created the National Health Security Office to manage the UCS, separate from the MOH, paving the way for provider payment reforms that have contributed to cost-containment.

Finally, the UCS also demonstrates that health insurance systems are highly customizable, and need not follow older models of financing arrangements - the UCS is not financed by payroll contributions, as social health insurance systems commonly are, for example. Instead, by creating a purchaser/provider split, defining an explicit benefits package, expanding coverage, and implementing innovative provider payment mechanisms, the UCS reform essentially transformed the way government funding for health is allocated and managed throughout the health system.

2.5 The Benefit Plan

Summary of Key Points

Key issues

- In a context of finite resources but ever-increasing demand for health services, countries must decide how to allocate resources effectively, efficiently, and equitably.
- In any health system, defining (or not defining) an explicit health benefit plan (HBP) is a policy instrument to direct the allocation of resources. In an insurance scheme, an explicit HBP is necessary to ensure clarity and transparency of what is covered by the HBP, to estimate accurate costs of providing those services, and to ensure the financial sustainability of the insurance scheme

Policy recommendations for Botswana

- Botswana must define an explicit HBP.
- The EHSP provides a starting point for developing the HBP, but more robust cost estimates and actuarial analysis are necessary to refine the EHSP into a sustainable HBP for the insurance scheme.

2.5.1 Definitions and Key Issues

Many countries - irrespective of whether their health systems are insurance systems - have adopted explicit benefits plans as a mechanism to redirect resource allocation toward cost-effective and efficient services. In insurance schemes, defining a HBP is a must. A HBP is defined as "a publicly managed list of guaranteed health services, accessed at approved health care providers by specific populations, with pre-established levels of financial support for beneficiaries" (Nakhimovsky et al. 2015).

As the World Health Organization (WHO) has stated, "No country, no matter how rich, is able to provide its entire population with every technology or intervention that may improve health or prolong life" (WHO 2010). The challenge of pursuing UHC in a context of finite resources demands that resources are allocated efficiently, and that they are used to provide effective services to the population. The formulation of a specific list of guaranteed services in a HBP establishes an explicit prioritization for health resources, and contributes to transparency in the allocation of public resources. When resources are allocated based on explicit prioritization, governments must justify the selection of services on a set of criteria such as health benefits, cost-effectiveness, and political feasibility.

Some countries choose not to make an explicit distinction between which services are covered and which are not. In these contexts, limited resources are allocated implicitly because there is a limit on the quantity of services that a provider can actually provide. In the absence of explicit prioritization, implicit rationing of resources takes place in the way resources are allocated across personnel, infrastructure, drugs and equipment. Care is implicitly rationed when a medicine is out of stock, for example, or if there are no health workers trained to deliver a service that is supposed to be available, or if a health facility lacks equipment needed to perform the service. The way these inputs are allocated across the health system impacts the health system's ability to provide services at different levels, and in different geographic areas.

A defined HBP is a policy instrument that allows the government to transparently prioritize services. The selection of services for inclusion in a HBP must take into account the objectives of the health system: equity in access to health services and health outcomes, financial protection, efficiency, and sustainability. Each included service must be costed so that the insurance scheme, the MOH, and MOF understand the full costs of providing the HBP. Accurate costing data and cost projections are necessary for planning and for ensuring the sustainability of the insurance scheme.

2.5.2 Policy Recommendations

Botswana has made important strides toward explicit priority setting with the development of an EHSP in 2010. However, the EHSP is not a HBP in the full sense because the services are not guaranteed; in some cases, the services included are those that the MOH aspires to provide rather than the services it actually provides. According to stakeholders, the adoption of the EHSP has not translated into a true prioritization of resources. Further, while cost estimates were produced in 2014 (Menon et al. 2014), these reflect normative costs (i.e., what the package should cost) rather than analytical costs (what it actually costs to provide the services in Botswana). Some stakeholders in Botswana have expressed concerns that the services included in the EHSP are too comprehensive, and that financing those service would not be feasible if they were actually being provided.

The MOH should define an explicit package of services to be included in an insurance health benefit plan. This recommendation achieved strong consensus in the HFTWG - 80 percent of participants in the insurance policy survey agreed with the statement that "Botswana's insurance system should explicitly define a benefits package." While the EHSP provides a strong basis for the HBP, the MOH must conduct a robust costing of the EHSP in order to assess its feasibility and sustainability. If the estimated costs are greater than the available resources, the MOH should convene country stakeholders to revise the EHSP in a transparent process prioritizing the criteria of equity, efficiency, and financial sustainability. Only if the EHSP is fully costed can it be used as the HBP for a new public insurance scheme.

The HBP should prioritize primary health care. All 20 HFTWG respondents agreed with the statement that "Botswana's insurance system should design benefits plans and payment systems that favor the provision of appropriate services at the primary health care (PHC) level to reduce avoidable hospitalizations and improve efficiency." Strengthening the primary care level is critical to improving the efficient allocation of resources. As discussed in HFG's Efficiency Brief, Botswanan hospitals currently have excess capacity and low occupancy rates (Nakhimovsky et al. 2016). Meanwhile, the most recent Health Accounts estimates peg curative hospital services at more than 50 percent of total health expenditures. Including promotive, preventive, and curative services at the primary level in the HBP is one step toward reducing Botswana's outsized hospital spending.

Explicit Priority Setting: Chile and Ghana

Chile

Chile's experience illustrates the utility of explicit prioritization, as well as the flexibility to design a HBP that covers all segments of a population with a minimum package of services while collecting different levels of financial contributions from beneficiaries. Chile has two HBPs. One is a minimum basic package of PHC services offered through decentralized municipal health facilities and financed by the federal government through capitation (MINSAL 2013). The second HBP, known as AUGE, is a list of explicitly guaranteed services that both FONASA (the national public insurance fund) and ISAPREs (private insurers) must provide (Bitran 2013). Rather than establish different benefits packages for different segments of the population, the AUGE HBP applies to all insurers and instead varies beneficiaries' contribution rates, as shown in the table.

The list started with 24 conditions in 2005, and reached 80 conditions in 2013. These conditions were selected based on a number of criteria including equity and cost-effectiveness of the interventions available to address the conditions. A key aspect of the AUGE reform is that all insurers are mandated to provide these services and guarantee access within specific timeframes. This enabled citizens to demand their guaranteed services and pressure the government to undertake additional reforms to ensure that services could be given within the mandated timeframes. When waitlists in the public sector grew, the government implemented new reforms to give those patients vouchers for the private providers (Bitran 2013).

Summary of Chilean health insurance schemes

Insurance Plan	Premium and Copayment
FONASA Public Insurance plans	
FONASA A - unemployed and indigent	No salary contribution, no copayment
FONASA B - employed, low income	7% salary contribution, no copayment
FONASA C - employed, lower-middle income	7% salary contribution, 10% copayment
FONASA D - employed, upper-middle income and above	7% salary contribution, 20% copayment
Private Insurers	
ISAPREs - high income	7% salary contribution, additional ISAPRE premium, variable copayments

Most recently, in response to high out-of-pocket spending on medication and political pressure from activist groups, Chile passed the Ricarte Soto Law to establish an additional fund for a set of high-cost conditions and medications (FONASA 2016).

Ghana

Like Chile, Ghana sought to implement a comprehensive benefits package. Rather than staged introduction of new services, however, Ghana implemented a generous benefits package early on, and the rising costs of providing the services has led to deficits (see Section 2.3 above). Further, Ghana's HBP is a "negative" list in that it does not explicitly specify what services are included, but rather what services are excluded (Cotlear et al. 2015). In addition, while insurance is mandated by law, there are no enforcement mechanisms, so the NHIS effectively functions as a voluntary scheme (Otoo et al. 2014). Because of this, many Ghanaians who could contribute premiums choose not to enroll; 68 percent of NHIS members are exempt from contributing and do not pay premiums (Otoo et al. 2014).

Despite its many achievements in improving coverage and financial protection, the NHIS faces serious financial sustainability challenge due to several factors. These include: a generous benefits package; a fee-for-service payment model that incentivizes providers (especially for-profit providers) to provide more services; and a de facto voluntary enrollment that misses out on potential premium contributions. Botswana's insurance system should seek to avoid these pitfalls by ensuring that its HBP is adequately costed and financed.

The MOH should review the EHSP in order to better assess future costs and utilization of services before it is established as a health benefit plan for the new insurance scheme.

Depending on the cost and actuarial analysis, it may be necessary to revise the EHSP to ensure sustainability of the new insurance schemes. Further, the final selection of included services must prioritize cost-effective interventions, with a view toward increasing equity across population groups. The finalization of the HBP should include a multi-stakeholder dialogue beyond the HWTWG to ensure that clinical best practices are also factored into the decision making process.

2.6 Provider Payment

Summary of Key Points

Key issues

- There are many mechanisms for a health insurer to pay providers, and each payment mechanism entails a set of incentives for providers and beneficiaries, as well as tradeoffs for the health system. Common payment mechanisms include fee-for-service (FFS), capitation, case-based payment, performance-based payment, and line-item budgets.
- For all payment mechanisms, the decision-making power of purchasing authorities to set or negotiate payment rates is an important lever to prevent cost escalation.
- The Botswana MOH functions as both purchaser and provider, and allocates resources through historical line-item budgeting - an inefficient payment mechanism.

Policy recommendations for Botswana

- The MOH should adopt payment mechanisms that link payment and results as a first step toward reforming payment mechanisms and establishing an insurance system.
- The national insurance system and MOH should negotiate a fee schedule for the public sector, and regulation of MAS should enable them to negotiate rates with private providers.
- Public sector facilities should bill MAS for services provided to MAS members by the MOH, so that the public sector is reimbursed when MAS beneficiaries consume MOH resources.

2.6.1 Definitions and Key Issues

Provider payment mechanisms are a key policy instrument to influence provider behavior and direct resource allocation toward priority services. In an insurance system, the purchaser and provider functions are separated in different entities. Thus, the insurer or purchasing agency must pay providers for the services provided to the insurance scheme's beneficiaries.

Purchasing refers to the allocation of resources to service providers. Passive approaches to purchasing (such as FFS and line-item budgets) provide little opportunity for performance monitoring or for influencing provider behavior, prices, or quality of care. (Mathauer 2016). Strategic purchasing, in contrast, refers to proactive purchasing arrangements or payment mechanisms that seek to link payment to providers to "information on aspects of their performance or the health needs of the population they serve" (Mathauer 2016).

There are different payment mechanisms that can be used to pay providers, and each entails a set of incentives for providers and beneficiaries, as well as tradeoffs for the health system. Below is a selection of common payment mechanisms³.

2.6.1.1 Selected Payment Mechanisms

Fee-for-service is one of the most simple and widely used payment mechanisms. Under FFS, patients and insurers pay the provider for each service rendered. This mechanism allocates resources to where services are being used, and it creates an incentive for providers to provide more services. While this may be desirable in contexts where providers are under-utilized, FFS is a blunt payment mechanism that can also lead to the provision of unnecessary services, and thus to cost escalation.

Capitation mechanisms establish a predetermined fixed amount per beneficiary, and providers are given an advance payment for delivering a defined set of services for each registered beneficiary over a specific time period. Unlike FFS, capitation shifts the risk of paying for health services from the insurer to the provider, creating an incentive to cut costs. While this creates an incentive to provide services more efficiently and to deliver prevention and promotion services, it might also lead providers to neglect quality.

Case-based payment mechanisms establish a fixed payment amount per "medical case" based on the average costs to provide services for that type of medical case, regardless of variables like length of stay. This mechanism is typically used with hospitals. One example is the Diagnostic-Related Group (DRG) system in the United States, which divides all hospitalizations into almost 500 categories, each with its own payment rate. This system incentivizes hospitals to cut costs by reducing the length of stay and using fewer inputs.

Performance-based payment mechanisms (also known as results-based financing and performance-based incentives) seek to incentivize providers to achieve results. There are many different models of performance-based payments. In Rwanda, for example, a quality-adjusted FFS scheme was introduced to incentivize increased service provision while maintaining quality. In Senegal, providers are incentivized to reach specific coverage targets, and in Argentina, provinces and providers are incentivized to increase enrollment in a maternal and child health scheme and improve outcomes (Cortez and Romero 2013). The rationale behind performance-based payments is to transition from paying for inputs to paying for outputs and outcomes.

Line-item budgets allocate a specific amount of funds for providers to cover specific budget line items such as personnel and medicines, over a defined time period (typically a year). This is a common mechanism of allocating funds in lower- and middle-income countries; however, it has considerable drawbacks. Line-item budgets pay only for inputs - not outputs or outcomes - and they are adjusted yearly based mainly on the line-item budget from the previous year, rather than planning prospectively to allocate funds based on anticipated future needs and utilization. Thus, historical budgeting sets no incentive to improve the quantity or quality of services provided.

2.6.1.2 Setting Payment Rates - Who Decides?

Deciding payment rates is a key component of provider payment. How are rates decided, and who has the power to set or influence rates? Does the insurer set rates, or do providers? These questions hold important implications for the financial sustainability of insurance schemes. Medical inflation and cost escalation are challenges for all health systems, but in settings where providers decide rates while the insurer is mandated by law to provide coverage, cost escalation tends to be high. Shifting the decision-making power from the provider to the insurer so

³ For a more comprehensive discussion on payment mechanisms, refer to Wong et al. (2012) and Langenbrunner et al. (2009)

that the negotiating power is not concentrated solely with providers can prevent price escalation. While this is less of an issue in a national insurance system where both the insurance fund and providers are public entities (as in the proposed BNHI) this is a critical question for systems where public insurers purchase services from private sector providers.

2.6.2 Policy Recommendations

In Botswana's current health system, the MOH plays both the purchaser and provider roles. Thus, there is no formal "payment" for services between the central MOH and providers, and resources are allocated by historical line-item budgeting. As a payment mechanism, line-item budgets provide limited opportunities for policymakers to create incentives and influence provider behavior. By separating the purchaser and provider roles, the introduction of a public insurer/purchaser would allow the MOH to implement provider payment reforms that better reflect the range of the GOB's policy objectives - from coverage, to efficiency, to quality. Shifting from line-item budgets to other payment mechanisms would give the MOH an additional policy tool to influence how resources are used to provide services. Further, adopting payment mechanisms other than line-item budgets is a precondition for establishing an insurance scheme.

The MOH should adopt strategic purchasing and payment mechanisms that link payment to results. Botswana should explore payment mechanisms such as capitation, case-based payments, and performance-based payments. This will require the MOH to conduct a comprehensive costing study to determine the costs of services included in the HBP, and to design a fee schedule incorporating each service. Further, while Botswana has made important strides in strengthening monitoring and evaluation and electronic information systems, the MOH will need to further improve information systems in order to better track utilization and accurately count the services provided. Both the fee schedule and accurate utilization data are necessary to implement billing and payment systems.

The public insurer should be endowed with the right and capabilities to negotiate rates with providers. If Botswana is to implement a national insurance reform, setting payment rates and fee schedules is an important step. A fee schedule for services in the public sector should be negotiated between the MOH and the insurer, and it should be based on actuarial analysis and the estimated costs of providing services in Botswana.

Regulation of MAS should enable MAS to negotiate rates with private providers. Medical inflation in the private sector in Botswana is 3 percentage points above non-medical inflation, and the escalation in costs poses a significant threat to the financial sustainability of MAS. This question is of the utmost importance for BPOMAS. Because it is the largest scheme, BPOMAS would gain significant bargaining power with providers if it was allowed to negotiate rates. Protecting the solvency and sustainability of BPOMAS is a key priority of the GOB, since the scheme is financed with public funds and covers civil servants. In the current dynamic between MAS and private sector providers, private providers have little incentive to keep costs low because MAS will pay whatever rates the private provider charges. Further, these costs are ultimately passed back to the public sector, since the MOH provides care to MAS members who have reached their MAS coverage limits, and since the GOB provides a significant portion of BPOMAS funding.

Public sector facilities should bill MAS for services provided to MAS members by the MOH. All 20 HFTWG respondents in the policy options survey agreed with the statement that "When beneficiaries from private insurance or MAS use health services in the public sector, the public sector should be able to invoice private insurers for those services so that the public system is reimbursed." Currently, MAS members can access health services through free, publicly funded clinics instead of private providers, whether to avoid copayments in the private sector or because they have reached their MAS coverage limit. MAS members already consume more health resources than non-members,

and when they access MOH services they are placing additional pressure on the public health system. The public sector already pays for BPOMAS members' premiums; when those members access public sector services, BPOMAS is essentially receiving an additional subsidy from the government, which is covering costs that would otherwise be borne by MAS.

The United States, Japan, and Argentina

The **U.S. health care system** provides a cautionary tale for many health systems. While the Affordable Care Act succeeded in expanding coverage and introduced some important measures for cost containment, the U.S. health system remains the most expensive in the world. Despite spending more, the United States achieves outcomes similar to (or worse than) countries that spend much less per capita. While many factors influence rising costs in the United States, the difference in costs between the United States and other OECD countries is largely explained by higher prices for goods and services. In the United States, private providers are able to negotiate higher fees from fragmented pools of private insurers. Further, pharmaceutical companies and medical device companies drive prices up with costly new technologies that often provide patients only marginal added value in comparison to existing technologies and interventions (Anderson et al. 2003). Providers, pharmaceutical companies, and medical device companies can continue to charge high prices in the absence of reforms that would prevent them from offering costly services, products, and technologies of questionable value, or without reforms that reduce fragmentation and improve insurers' ability to negotiate prices.

Japan, on the other hand, illustrates the potential for controlling costs by controlling prices through a national fee schedule. While insurers are largely private in the United States and public in Japan, service provision is mainly private in both countries. Despite having a rapidly aging population and one of the most advanced health systems in the world, with high levels of access to complicated medical procedures and technologies, Japan has done an impressive job of cost containment. Between 2000 and 2008, Japan's health care costs rose from 7.7 percent of GDP to only 8.5 percent, while U.S. costs rose from 13.7 percent of GDP to 16.4 percent. The main policy instrument Japan has used to achieve this is to set prices through a national fee schedule that is proposed by national regulatory agencies and negotiated with provider groups and other stakeholders. The national agency establishes a target for an overall rate increase, then sets target rates for different categories of illness, and finally for specific services. The rates take into account estimates of costs, utilization, and health needs (Ikegami and Anderson 2012). While there are admittedly many differences between Japan, a high-income country, and Botswana, an upper-middle-income country, the principle that a public insurer can keep costs low by setting prices in a national fee schedule is applicable in any context.

Argentina provides an example of how payment systems and benefits plans, through a performance-based financing scheme, can incentivize providers to prioritize key services. While Argentina's "Plan Nacer" reform is not an example of insurance, its use of incentives at different levels of the health system to modify provider behavior and public sector management practices provides useful lessons for Botswana. The main feature of the Plan Nacer program was to prioritize a small package of maternal and infant health services to be incentivized via monetary rewards for both providers and provinces (in Argentina's federal system, service provision is decentralized to the provinces). The national MOH incentivizes the provinces to increase enrollment in the program and to achieve targets in health outcomes. Meanwhile the provinces are responsible for identifying and enrolling providers to participate. The provinces incentivize providers to also identify and enroll beneficiaries (through a capitation payment), and to provide the specific maternal and infant health services (through a FFS payment). The program succeeded in shifting provider behavior toward achieving results. The MOH has since embarked on a new program (Programa Sumar), which builds on the success of Plan Nacer and expands the benefits package and eligible population. Policymakers have also highlighted how the initial experience with Plan Nacer allowed the MOH to work out operational issues for the new program prior to expanding to Programa Sumar. Argentina's success illustrates not only the potential of innovative provider payment mechanisms, but also the importance of implementing incremental reforms to ensure that the foundations of health reform are well established (Cortez and Romero 2013).

2.7 Insurance Operations

Summary of Key Points

Key issues

- Operational processes throughout the various design elements and functions of an insurance system underpin the systems implementation and performance.
- Operational processes must make information available to managers and policymakers to facilitate evidence-based decision making.

Policy recommendations for Botswana

- Formal sector workers should be automatically enrolled in the new insurance system unless they opt out.
- A third-party payment system should be used to prevent out-of-pocket payment at the point of service.
- Electronic information systems should be strengthened so they provide a foundation for an electronic costing and billing system.

2.7.1 Definitions and Key Issues

Operational processes such as beneficiary enrollment, claims processing, and billing underpin all insurance systems. These processes are critical to ensure that beneficiaries receive the services they are entitled to and that providers are paid in a timely fashion.

2.7.1.1 Beneficiary Identification and Enrollment

Enrollment of beneficiaries is a key component of insurance systems. In voluntary insurance systems in particular, insurers must implement marketing and communication strategies to persuade potential members to enroll. Further, if the scheme targets specific beneficiaries, it might need to establish mechanisms to distinguish eligibility.⁴ Moreover, once beneficiaries are enrolled, there must be a mechanism to identify them, typically by distributing insurance membership cards. The logistics and operations of these processes are a critical piece of insurance systems.

2.7.1.2 Collection of Financial Contributions

Insurance schemes must establish revenue collection mechanisms to receive payments from members (whether in the form of premiums or payroll contributions) as well as other potential funding sources including employers and the government. Further, where premium rates are dependent on income levels, insurance systems may need verification mechanisms to confirm the beneficiary's employment status or income.

⁴ For a more extensive discussion on eligibility, refer to Section 2.4, Population Coverage.

2.7.1.3 Financial Processes and Management

Establishing an insurance scheme requires instituting financial processes and management activities that providers in publicly financed health systems without insurance do not necessarily need to perform. Two critical financial processes are the budgeting system, and the expenditure tracking system (Wang et al. 2012). The budgeting system plans and budgets future expenses for the insurance system - not only for clinical services included in the benefits package, but also costs such as of managing claims and marketing the scheme. The expenditure tracking system comprises internal systems and controls that manage the flow of funds. This includes cash management and accounting systems, as well as financial management controls that document the flow of funds and accounts payable. These systems should track providers' and insurers' financials and provide up-to-date information to ensure that budgets are adjusted with accurate data, and to identify and address any cost management issues that arise (Wang et al. 2012).

2.7.1.4 Claims Administration

In health care, an "insurance claim" refers to a request (from either providers or beneficiaries) for payment from an insurance scheme based on the provision of services included in the insurance benefits plan. Claims administration refers to the process of "receiving, reviewing, adjudicating and paying claims" (Wang et al. 2012). In some insurance systems, services are provided without the patient having to make any payment at the point of service; the insurance system pays providers directly. In other systems, patients must pay out of pocket, and then submit a claim to the insurance fund for reimbursement. In some cases, the insurance system may not have the administrative capacity to perform the different claims management functions and may resort to contracting a separate firm or agency for claims management.

2.7.1.5 Information Systems and Monitoring

Well-functioning information systems are a critical component of insurance systems. From beneficiary enrollment to revenue collection and claims administration, accurate and timely data are necessary to ensure smooth functioning of the insurance system. Ideally, information systems are electronic in order to facilitate the communication of information and reduce processing times. In addition to enabling the administrative processes, the information system should be designed to facilitate the routine monitoring of the insurance system. As such, it should synthesize information from different sources and produce routine reports for managers at different levels of the insurance system.

2.7.1.6 Contract Management

Smaller insurance schemes (or those that are new) may not have developed the administrative capabilities to manage all of the different processes required for insurance. In these cases, the insurer may opt to contract an external firm to manage specific processes such as claims management, revenue collection, or information systems. The management of third-party administrators contracted for these purposes, in and of itself, requires setting up processes that document the responsibilities that are transferred to the contractor, and the regulations they must follow.

2.7.2 Policy Recommendations

Establishing new operational systems to form the foundation of a public insurance system in Botswana will undoubtedly present challenges, as some of these systems will be entirely new to MOH management, and to a new insurance agency. The Botswanan health system would do well to strengthen many of the functions, such as information systems and billing systems, which are necessary even without an insurance system. In fact, broad insurance reform can provide the impetus for these secondary operational process reforms. Establishing a billing system for the public system to bill MAS is already a priority, for example.

Botswana should automatically enroll beneficiaries employed in the formal sector.

Employees in the formal sector should be enrolled automatically in either a MAS or in BNHI. Botswana could establish an "opt-out" system, whereby formal sector workers are automatically enrolled in the BNHI unless they explicitly opt to enroll with a MAS instead. This could avoid the problems of an "opt-in" system, in which workers would have to initiate the enrollment process. In opt-in systems, potential beneficiaries could still fail to enroll in a MAS or BNHI even if enrollment is mandatory. By enrolling members automatically in a default option, opt-out systems ensure higher levels of enrollments.

Botswana should leverage existing technical expertise in the private sector to set up effective operational processes for a new insurance system. Given the complex operational processes that need to be set up, the GOB should look to private sector expertise in the insurance and MAS sector. The GOB should consider contracting a third-party administrator to administer the BNHI, as Associated Fund Administrators (AFA) does with BPOMAS, for example.

The GOB should invest in electronic information systems and cost centers at the district and health facility level. According to key informant interviews, the GOB has embarked on the ambitious effort of building electric and information system infrastructure in rural areas. Health facilities should be equipped with an electronic system that facilitates the communication of utilization, claims, and cost data.

2.8 Insurance Governance

Summary of Key Points

Key issues

- The national insurance system must be held accountable to stakeholders including government, employers and civil society.
- There is no one-size-fits-all approach to designing accountability mechanisms; they must take into account the organizational structure of the insurance fund and the health system.

Policy recommendations for Botswana

- Design accountability mechanisms into the organizational structure of the insurance system.
- Establish one regulatory authority to supervise both the public insurance fund and MAS.
- Leverage existing mechanisms and institutions, such as the Office of the Auditor General and NBFIRA, to exercise financial oversight and regulatory functions.

2.8.1 Definitions and Key Issues

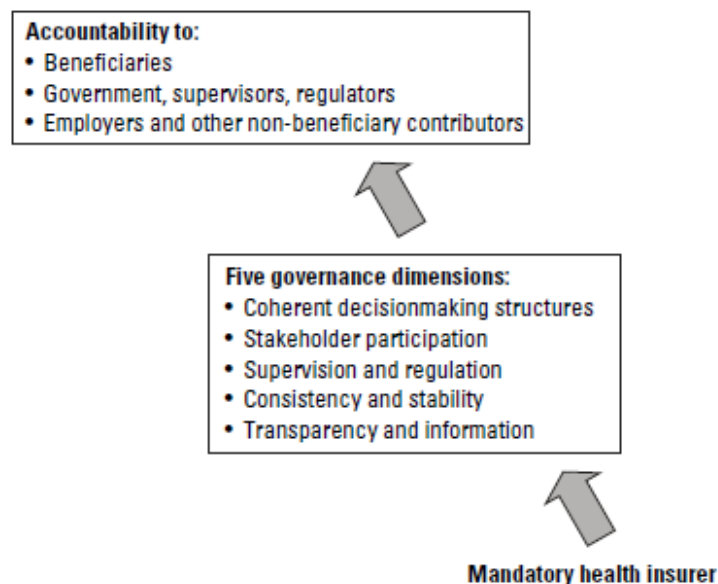
"Governance" is broadly defined as the set of rules and institutions by which authority is exercised (Health Systems 20/20 2012). Applied to health insurance, the concept of governance comprises the relationship between the insurer and stakeholders to which it is accountable - mainly government, beneficiaries, and other contributors including employers (Savedoff and Gottret 2008). Because the insurer interacts with many different actors for different functions, it essentially serves many masters at the same time, and this can create conflicting incentives and reward structures (Precker 2013).

Further, the governance and organizational structure design element is highly cross-cutting with the other design elements of financing, population, benefit plans, payment mechanisms, and operational processes. Included in this section is the consideration of the decision-making authority related to those design elements, for example, who sets the contribution rates of employers and firms? How is the health benefits plan updated and who is responsible for what is included? This section will first cover the governance through accountability framework (Savedoff and Gottret 2008), and then discuss the implications for the governance and organizational structure for the insurance system as a whole, including the other design elements.

Designing governance mechanisms for a mandatory health insurance system is less about "which forms of governance encourage the best performance by mandatory health insurers" but rather about which mechanisms are the best "fit" for the insurance system's organizational structure (Savedoff and Gottret 2008). The relationships and governance functions between different stakeholders and institutions are necessarily dependent on how those institutions are organized. Given the variety of organizational structures employed by different countries, the governance mechanisms designed to regulate and hold insurers accountable are equally diverse.

The governance framework utilized in this report (Figure 9) focuses on five governance dimensions through which a mandatory health insurer is held accountable: a) coherent decision-making structure; b) stakeholder participation; c) supervision and regulation; d) consistency and stability; and e) transparency and information.

Figure 9. Accountability through Governance Framework



Source: Savedoff and Gottret (2008)

Coherent decision-making structures (including institutions, laws, and regulations) give actors responsible for particular decisions and functions the discretion, authority, tools, and resources they need to perform their functions effectively. This dimension also includes the consequences established to align actors' decisions and interests with the overall performance of the insurance system.

Stakeholder participation refers to the participation of various actors and stakeholder throughout the decision-making process. They include government, citizens and civil society, providers, employers, and other contributors to the insurance system.

Supervision and regulation are directly related to accountability. This dimension consists of the consequences established to align actors' decisions and interests with the overall performance of the insurance system. These consequences include both sanctions and incentives.

Consistency and stability are meant to avoid uncertainty related to rule-making and enforcement over time, especially through political transitions. This dimension is critical to ensuring that stakeholders can make long-term decisions confidently without fearing that the rules and regulation will not change arbitrarily.

Transparency and information ensure accessibility to information for decision-makers, including the insurer, government, and beneficiaries.

In addition to these five dimensions, Savedoff and Gottret stress two important contextual factors: competition and the relationship between insurers and providers. The degree of competition in and of itself is a mechanism for accountability when beneficiaries can choose between different insurers - thus creating competition between insurers to innovate to lower costs, improve performance, and provide better, more affordable services. The relationship between insurers and providers (and whether that relationship is cooperative or adversarial) also influences the type of accountability mechanisms, incentives, and sanctions that can be implemented.

2.8.2 Policy Recommendations

Designing a new insurance system for Botswana presents the opportunity to design effective governance mechanisms from the outset, building accountability directly into the broader organizational structure of the insurance system. Thus, there is presently ample flexibility to establish measures directed at the five governance dimensions. This is not to say that Botswana would be starting from scratch, as there are already structures in place for the regulation and supervision of MAS.

In addition to regulation and supervision, the GOB should establish governance mechanisms aimed at the other four dimensions of health insurance governance.

As the insurance design process continues, the GOB should involve additional stakeholders beyond the HFTWG. Health reform is a highly political process. Engaging stakeholders throughout the process is not only good governance, it also gives them an opportunity to influence the design of the insurance system and maximizes the likelihood that important stakeholders such as providers and civil society support the reform proposal. Once an insurance system is established, stakeholder participation is also important to ensure that the insurer is held accountable to stakeholder needs. One way to achieve stakeholder participation is to include formal representation from different stakeholders in the governing body of the insurance agency, or in the agency or council assigned with regulatory functions.

The GOB should facilitate transparency and access to information in the new insurance system. Like stakeholder participation, this is important not only in the design phase, but also in implementation. The roll-out of the insurance system should be accompanied by communication campaigns aimed at educating the public - including citizens and employers - about the reform and the benefits and responsibilities of each under the new system. Information on the contribution rates and

benefits plans should be easily accessible. Further, performance monitoring and evaluation of the new public insurer should also be made available to the public. Periodic satisfaction surveys are one option for measuring the satisfaction of beneficiaries over time. These surveys could be administered to beneficiaries of MAS as well as of the public insurance system.

The governance and accountability mechanisms and relationships should leverage existing institutions and regulatory mechanisms. Currently, Botswana's MAS are regulated by the Non-Bank Financial Institutions Regulatory Authority (NBFIRA), which also regulates non-health related insurance products and micro-loan enterprises. However, the potential purchaser/provider split introduced by insurance reforms introduces the question of who will be responsible for regulating the new public insurance fund, and whether that regulator should also oversee insurance and MAS in the private sector. Will a new regulatory agency be formed, or will those responsibilities fall to an existing entity such as NBFIRA? While governance and regulation were not the primary topics of discussion at the June HFTWG meeting, participants were asked this question in the policy options survey. Fifty-five percent agreed with the statement that "If Botswana adopts a new national insurance system, the institution mandated to regulate that system should be NBFIRA, not a new regulatory agency," while 30 percent disagreed and 15 percent were uncertain. Thus, the question of who will provide regulatory oversight of the new insurance fund merits further discussion. However, regardless of which agency is ultimately tasked with the role, NBFIRA's experience in regulating MAS should be applied to the regulation of the public insurer.

The same regulatory authority should regulate MAS and the public insurer. While the public insurer must be held accountable to stakeholders beyond the regulatory authority (such as the MOH, MOF, Office of the President) it would be beneficial for one regulatory authority to oversee both MAS and the public insurer. As in the example of Chile in the box below, establishing a joint regulator can help ensure that the rules and regulations are applied fairly, and that regulatory policies are enacted with the interests of the overall health system in mind, rather than treating MAS and the public insurer as two different systems.

The public insurer should be an autonomous public institution reporting directly to the Office of the President, which will appoint the fund's director. In addition to reporting directly to the Office of the President, formal accountability mechanisms should be established for other stakeholders, including Parliament, the MOH, the MOF, the Office of the Auditor General, the insurance regulator (NBFIRA or otherwise), DHMTs, and beneficiaries. The box below describes the governance of the Chilean Public Health Insurance, FONASA.

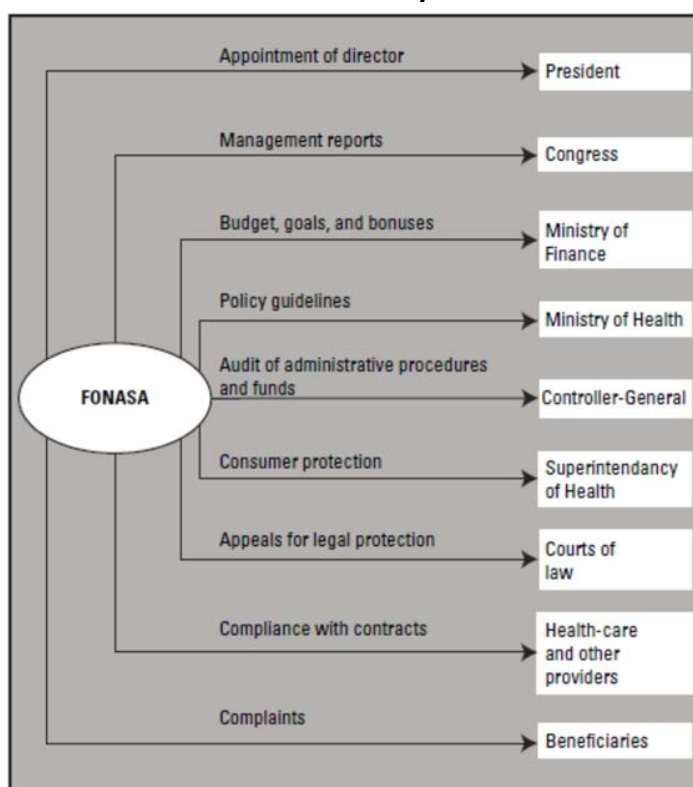
Governance of Chile's Health Insurance Fund, FONASA

Good governance has been a key driver of the success of Chile's public health insurance scheme, FONASA. The fund is managed by a director appointed by the president. While FONASA is an autonomous entity, it, the MOH, and the MOF all report directly to the Office of the President, so it is unlikely the FONASA director would be able to make policies inconsistent with those of the ministries (Bitran et al. 2008). Further, the Office of the President can settle disputes when they arise.

In 2004, the Superintendencia de Salud (Superintendence of Health) was established to regulate both FONASA and the ISAPREs (private insurers). This agency built on an existing agency that had previously regulated only private insurers. The introduction of a supervisory and regulatory agency for FONASA independent of the MOH created a new entity to which FONASA would be held accountable, and ensured that the same standards could be applied to the public and private insurers.

In addition, accountability mechanisms are built into FONASA's relationship with other entities. FONASA must submit annual progress reports to Congress, for example, and beneficiaries can lodge complaints with FONASA, the Superintendence of Health, and ultimately with the courts. The figure illustrates FONASA's accountability mechanisms to different stakeholders (Bitran et al. 2008).

FONASA Accountability Mechanisms



Source: Bitran et al. 2008

The Chilean system's accountability mechanisms provide a good example of how a public insurance fund can be held accountable to different stakeholders for different functions and objectives.

As discussed in the introduction to this section, the relationships between the various actors that participate in the implementation of insurance are a critical component of the governance and organizational structure of a health insurance. Because governance is inherently a cross-cutting concept, it touches upon all six insurance design elements discussed in this report. Table 2 summarizes the roles of the main actors in the proposed insurance system.

Table 2. Proposed governance roles and responsibilities by insurance design element

Design Element	Actors and Roles
Financing	<ul style="list-style-type: none"> • MOH - projects expenditures and calculates financing gap • Insurance fund - projects expenditures, claims, and calculates financing gap • MOF - establishes revenue collection policies and determines contribution rates for employees and employers; determines budgets and allocates resources • BURS - collects revenue
Population	<ul style="list-style-type: none"> • Parliament - passes legislation creating national public health insurance agency to cover population • MOH - monitors enrollment in health insurance and progress toward UHC
Benefit Package	<ul style="list-style-type: none"> • MOH - defines and updates the insurance HBP based on clinical guidelines and actuarial analysis
Provider Payment	<ul style="list-style-type: none"> • MOH - conducts costing analyses to assign fees for each service provided in the HBP • Insurance fund - together with MOH, establishes payment mechanisms that signal MOH policy priorities
Insurance Operations	<ul style="list-style-type: none"> • Insurance fund - establishes operational processes for enrollment, financial and accounting systems, claims administration, electronic information systems, etc. • MOH - bills insurance fund and MAS for services provided
Governance	<ul style="list-style-type: none"> • President - appoints insurance fund director • Parliament - reviews annual management reports • MOF - assigns budget, establishes goals and incentives for fund management • MOH - sets policy guidelines • Auditor General - financial auditing • Insurance regulator (NBFIRA or other) - audits administrative procedures, protects consumers, implements beneficiary satisfaction surveys • Courts - resolves conflicts between insurer and beneficiaries, and between insurer and providers

Source: Authors

2.9 Conclusions and Next Steps in the Policy Process

Botswana's health system has made important strides over the past 25 years – from strengthening MAS to turning the tide against the AIDS epidemic. During the launch of the Treat All Strategy, for example, President Khama highlighted how Botswana has played an important leadership role in the global response to HIV/AIDS by proactively adopting and adapting WHO treatment guidelines. But the Botswanan health system needs serious reforms if it is to preserve prior gains, address the persistent underperformance in maternal and child health, and face the challenges of the future. Specifically, the Botswanan health system must secure adequate and sustainable financing, improve efficiency, and ultimately improve access to health services to improve population health. By providing a platform to drive these changes, embarking on insurance reform holds great potential to transform the Botswanan health system.

Health insurance reform is no easy task – it is a highly political process that involves a wide array of stakeholders. Engaging these stakeholders throughout the process is key to understanding their needs and designing a system that works for everyone in order to enlist support for the reform. As illustrated throughout this report, designing an insurance system requires careful consideration of key design elements. From revenue generation to insurance governance, each design element merits further discussion within the HFTWG and with other stakeholders before the group decides on a reform proposal. As part of its fiscal year 2017 work plan (Sept. 2016–Aug. 2017) HFG will continue to support the MOH by facilitating meetings of the HFTWG and by presenting additional analyses exploring the feasibility of a national health insurance system in Botswana.

Further, once an insurance proposal is more fully developed, the GOB will need to implement a robust communications strategy to disseminate the proposal and ensure that the population understands the proposed reforms. This messaging will be critical to ensuring that the proposed policy reforms secure political support for legislation and implementation.

Moving from the current phase of policy dialogue to the next phases of policy adoption and implementation will no doubt entail a new set of political challenges. But Botswana's history of innovation in the health sector and commitment to upholding health as a human right give cause for hope that reform is indeed possible. By putting into policy Botswana's aspiration to achieving the concept of *Botho* – trust, respect and compassion for one another – health insurance reform in Botswana has the potential to improve health services and to ensure a bright and healthy future for all Botswana.

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ANNEX. HEALTH INSURANCE POLICY PREFERENCES SURVEY

HFG Botswana HFTWG Meeting - June 15, 2016 Health Insurance Policy Preferences Survey

Objective

Developing an insurance-based health system for all Botswana is one of the priority initiatives identified by the Health Financing Technical Working Group. The purpose of this exercise is to further explore the option of establishing a National Health Insurance in Botswana by pinpointing some of the specific policy questions that arise when designing insurance-based system. Ultimately, the objective is to better understand the HFTWG policy preferences and begin answering the question: “If Botswana were to adopt a national health insurance system, what should that system look like?”

Instructions

Below is a series of vignettes describing a health insurance policy issue. Each vignette describes a challenge or decision related to establishing an insurance system, and is accompanied by a statement on how the issue could be addressed. Based on the vignette, the discussions from today’s HFTWG meeting, and on your knowledge and experience with the Botswanan health system, please indicate your level of agreement with the bolded statement at the end of each vignette by circling one of the five options below: 1) Strongly Agree; 2) Agree; 3) Uncertain; 4) Disagree; and 5) Disagree. **Remember, there is no right or wrong answer.**

Vignettes

1. *A common challenge for insurance pools is adverse selection – the phenomenon where healthy individuals do not enroll in health insurance while the sick, or those who anticipate having greater medical needs, do enroll. This leads to a sicker and more expensive beneficiary population for the insurer, which can in turn result in higher premiums, further discouraging young and healthy individuals to enroll. One approach to limiting adverse selection in health insurance is to mandate enrollment in the insurance scheme.*

Insurance enrollment should be mandatory for workers in the formal sector (with contributions collected through payroll deductions).

1. Strongly Agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly Disagree

2. *Poor (and non-poor) informal sector workers present a unique challenge to national health insurance systems. Roughly 50 percent of Botswanan workers are in the informal sector.⁵ It is not possible to deduct payroll contributions from informal sector workers, and in insurance systems where enrollment is voluntary, informal sector workers and their families are often reluctant to enroll. This can contribute to adverse selection. The process of measuring household socioeconomic status in order to determine a household's eligibility for subsidies or welfare services, however, may entail significant administrative and financial burden. In some countries with high poverty rates and informality, governments have largely abandoned means testing in favor of low premiums for all enrollees (Ghana) or providing exemptions for large segments of the population (Mexico). According to one study, the countries that have achieved high levels of enrollment in the informal sector have largely abandoned attempts to collect revenue from this population in the form of premiums or other contributions.*

Botswana's insurance system should enroll all Botswana in the informal sector in a non-contributory system.

1. Strongly Agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly Disagree

3. *In Botswana's health system, citizens currently pay nominal user fees (5 BWP) to access basic health services at public facilities. Shifting to an insurance system would entail collecting contributions from enrolling individuals; however, 30% of Botswana live below the poverty line, such that paying an insurance contribution could present financial difficulties. In many countries with national insurance schemes, the government provides subsidies for low-income families to enroll in the insurance scheme.*

In order to encourage enrollment among low-income families, the Government of Botswana should subsidize the costs of enrolling in a national insurance system.

1. Strongly Agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly Disagree

4. *Insurance Systems require the separation of the health system's purchaser and provider functions. In Ghana, for example, the National Health Insurance Scheme (NHIS) purchases services from private providers and from the publicly funded Ghana Health Service, while the Ministry of Health's role is in policy, stewardship and governance. In Botswana, The Ministry of Health is responsible for policymaking, purchasing and provision of services. Since provision is now decentralized to DHMTs, there is some degree of split between the purchaser (MOH) and the provider (DHMTs). Nonetheless, DHMT budgets are set by the MOH and MOF using historical budgeting, as opposed to a true purchasing arrangement, where the MOH would pay DHMTs for the services provided.*

If Botswana adopts a new national insurance system, a new purchasing/insurance entity should be established to purchase services from DHMTs (or other providers).

1. Strongly Agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly Disagree

⁵ According to the international labor organization, the informal sector consists of small-scale entities engaged in the production of goods and services with little division between labor and capital. Labor relations are often based on casual employment, personal and social relationships or kinship, instead of formal contractual arrangements. They often resemble household enterprises. It is difficult for tax authority institutions to identify and collect tax revenues from unregistered firms and entities in the informal sector.

5. *Insurance systems require a regulating body to provide oversight and regulation. These regulatory institutions sometimes cover both public and private insurance schemes. In Botswana, the Non-Bank Financial Institutions Regulatory Authority (NBFIRA) is responsible for overseeing Medical Aid Schemes.*

If Botswana adopts a new national insurance system, the institution mandated to regulate that system should be NBFIRA, not a new regulatory agency.

1. Strongly Agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly Disagree

6. *An explicit insurance benefit package is a central component of most insurance-based systems. Through explicit priority setting, the package delineates the list of services covered and not covered by the insurance fund. Typically, benefit packages take into account a population's epidemiologic profile, the effectiveness and costs of the services provided, and the insurer's ability to pay for the services included in the benefit package. Explicit priority setting allows government to transparently decide what services to cover. On the other hand, some countries choose not to make an explicit distinction between which services are covered and which are not. In these contexts, however, limited resources are allocated implicitly because there is a limit on the quantity of services that a provider can actually provide. Care can be implicitly rationed when a medicine is out of stock, for example, or if there are no health workers trained to deliver specific services that are supposed to be available to the population.*

Botswana's insurance system should explicitly define a benefits package.

1. Strongly Agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly Disagree

7. *Inflation in the health sector is typically higher than in the overall economy. Escalating prices and tariffs in the health sector lead to higher expenditures on health, which place pressure on both private and public insurers. One approach adopted by public insurance systems to contain costs related to price escalation is to set caps on tariffs and provider-reimbursement rates.*

Botswana's insurance system should have the authority to set tariff rates for services that are paid by public sector and provided by private sector.

1. Strongly Agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly Disagree

2. *In Botswana's current health system, MAS members can also access health services through free, publicly-funded clinics instead of through the private sector. MAS members may use public facilities in order to avoid copayments in the private sector, or because they have reached the coverage limit in their MAS benefit package. MAS members already consume more health resources than non-members, and when they access MOH services they are placing additional pressure on the public health system.*

When beneficiaries from private insurance or MAS use health services in the public sector, the public sector should be able to invoice private insurers for those services so that the public system is reimbursed.

1. Strongly Agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly Disagree

8. *In some countries, beneficiaries of public insurance systems can access services through the private sector instead of in public facilities. Often, there is a perception (rightly or wrongly) of higher quality and lower wait times in the private sector. However, services are typically more expensive in the private sector than in the public sector.*

Botswana's publicly financed insurance system should pay for beneficiaries to receive services in the private sector, even if those services are available with public sector providers and the services are more expensive in the private sector.

1. Strongly Agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly Disagree

9. *Some health issues can be resolved by appropriate care and prevention at the primary health care level. When patients visit a hospital for a condition that could have been resolved at the primary care level, or when the lack of appropriate care at the primary level leads to avoidable hospitalizations, resources are used inefficiently. In Botswana, about 70% of public sector health expenditures are consumed at the hospital level.*

Botswana's insurance system should design benefits plans and payment systems that favor the provision of appropriate services at the PHC level to reduce avoidable hospitalizations and improve efficiency.

1. Strongly Agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly Disagree

10. *Health reform is a complicated process involving multiple stakeholders with different interests and preferences. Seventeen percent of Botswana are currently covered by Medical Aid Schemes.*

A new national health insurance system should preserve the current system of MAS, instead of creating one unified insurance fund.

1. Strongly Agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly Disagree

Optional Comments

In the box below, please provide any additional comments you wish to share in relation to any of the above vignettes and insurance policy issues.



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