



**Ministry of Health and Social Welfare-Tanzania**  
**German Development Cooperation**

**OPTIONS FOR HEALTH INSURANCE MARKET STRUCTURING**  
**For: The Tanzania Health Financing Strategy**

**Final Report**

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16 July, 2013

## Abbreviations

Admin	Administration
APHTA	Association of Private Hospitals Tanzania
Art.	Article
BBP	Basic Benefits package
BMA	British Medical Association
BOT	Bank of Tanzania
BP	Benefits package
C	Cross subsidies
Cap	Chapter (of the Laws of Tanzania series)
CBHF	Community based health fund
CBHI	Community based Health Insurance
CCG	Local Commission Group
Cf	Conform
CH	Confederacio Helvatica (Switzerland}
CHF	Community Health Fund
CHSB	Council of Health Service Board
CMO	Chief Medical Officer
Comp	Complementary
CQI	Continuous quality improvement
CSMBS	Civil Servants Medical Benefits Schemes
D	Deutschland/Germany
DG	Director General
DMHI	District Mutual Health Insurance
DOH	Department of Health
DPP	Department of Policy and Planning
DRF	Drug Revolving Fund
DRG	Diagnosis related Group
EAU	East African Union
EHSP	Essential Health Services Package
F	France
FBO	Faith Based Organization
FFS	Fee for service
FGD	Focus Group Discussion
FSDT	Financial Sector Deepening Trust
GB	Great Britain
GBS	General Budget support
GIZ	German International Cooperation
GOT	Government of Tanzania
GP	General Practitioner
GTZ	German Technical Cooperation
HAS	HautAuthority de Sante
HDI	Health Development Index
HF	Health Financing
HFTWG	Health Financing Technical Working Group
HI	Health Insurance

HIC	High Income Country
HIM	Health Insurance Market
HIMS	Health Insurance Market Structure
HMIS	Health Management Information System
HMO	Health maintenance organization
HSF	Health Services Fund
HSSP III	Health Sector Strategic Plan III
HTA	Health Technology Assessment
IP	Inpatient
ISC	Interministerial Steering Committee
IT	Information Technology
JRF	Joint Rehabilitation Fund
LGA	Local Government Authority
LGU	Local Government Unit
LIC	Low Income Country
LT	Long Term
LR	Literature Review
LTC	Long Term Care
M	Million
M&E	Monitoring and Evaluation
MBMO	Medical benefits management organization
MBP	Minimum benefits package
MCDEG	Ministry of Community Development and Gender
MHO	Mutual health Organization
MIC	Middle Income Country
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania
MMAM	Mpango wa Maendeleo wa Afya ya Msingi
MOF	Ministry of Finance
MOHSW	Ministry of Health and Social Welfare
MOLE	Ministry of Labour and Employment
MOU	Memorandum of understanding
MSD	Medical Stores Department
MT	Mid Term
MTEF	Medium Term Expenditure Framework
NA	Not available or not applicable
NAO	National Auditing Office
NB	Nota bene (note well)
NGO	Non-government organization
NHA	National health accounts
NHIF	National Health Insurance Fund
NHIS	National Health Insurance System
NHS	National Health System
NHSB	National Health Security Board
NHSO	National Health Security Office
NL	Netherlands
No	Number
NSRGP	National Strategy for Growth and Development
NSSF	National Social Security Fund

OECD	Organization for Economic Cooperation and Development
OOP	Out of pocket payment
P/pp	Page/pages
P4H	Providing for Health
P4P	Pay for Performance
PER	Public Expenditure Review
PhD	Dr. Of Philosophy
PHE	Private Health expenditure
PHI	Private Health Insurance
PhilHealth	Philippines Health Insurance Corporation
PMO-RALG	Prime Minister's Office-Regional Administration and Local Government
POP	Population
POPSM	President's Office, Public Service Management
POS	Point of Service
PPP	Purchasing Power Parity
P	Premium
Prof.	Professor
RBF	Results Based Financing
RE	Risk Equalization
RS	Risk Selection
S./Ss.	Section/sections
SDC	Swiss Development Cooperation
SHI	Social Health Insurance
SHIB	Social Health Insurance Benefit
SHP	Social Health Protection
SPN	Supervision
SSA	Sub-Saharan Africa
SSRA	Social Security Regulatory Authority
SSRAA	Social Security Regulatory Authority Act
SSS	Social Security Scheme
ST	Short Term
STC	Short Term Care
Supp	Supplementary
SWOT	Strengths, Weaknesses, Opportunities and Threats
T	Taxes
THE	Total Health Expenditure
TI	Transparency International
TIKA	Tiba kwa Kadi Treatment by card), the urban Community Health Fund
TIRA	Tanzania Insurance Regulatory Authority
TOR	Terms of Reference
TZS	Tanzanian Shillings
UC	Universal Coverage
UHC	Universal Health Coverage
UHIC	Universal Health Insurance Coverage
UK	United Kingdom
VAT	Value added tax
VHI	Voluntary Health Insurance
WHR	World Health Report

## **Acknowledgements**

The team of consultants that prepared this report is grateful for receiving the support of the staff of MOHSW and of the management and staff of the GIZ offices in Eschborn and in Dar es Salaam, especially in assisting to get the necessary Tanzania related documentation and in scheduling meetings with stakeholders, listed in Annex 3. It also would like to thank all those who have provided comments on previous versions of this report and the previously shared Inception Report.

# Executive summary

## 1. Introduction

Achieving universal coverage (UHC) in countries with a large informal sector of poor people is only possible with subsidies from general government revenues irrespective of how the market of individual contribution-based health insurance is structured. Cross-subsidies from other sources such as mandatory or voluntary private health insurances can help but given the small scale of voluntary insurance in developing countries this is not sufficient. Obviously government subsidies can come from general taxes as well as from taxes specially earmarked for health.

The regulatory environment in which health insurance is allowed and stimulated to work is another key factor, requiring the setting clear rules and enforcing them. The simpler the design, i.e. the more unified a health insurance system is and the more tools are provided for health services supply side regulation, the more such system will provide value for money in the health services. A well regulated and supervised single payer system, combined with adequate regulation of the supply side as regards planning and distribution of services and fee control has advantages over multi payer systems in achieving UHC at relatively low cost. As the examples of the UK and the Nordic countries show, it is possible to achieve UHC with almost fully tax based national health systems at relatively low costs as compared with contribution based insurance systems.

All countries studied for this report have mixed financing systems with cross-subsidies from taxes to health insurance. The legal position, public or private, of an insurer does not matter; it is the regulatory framework and its well-supervised implementation that makes the difference.

Multi-payer systems are found in many countries due to a variety of reasons, mostly historical. Private health insurance, when not offering the mandatory insured basic health services package or offering substitutive health insurance is mostly focused on voluntary insurance, broadening or deepening the benefits available to their enrollees by offering supplementary or complementary insurance.

Where private insurance is offering voluntary duplicative insurance, mandatory insurance will not miss potential resources. However, where people are allowed to opt out of mandatory insurance of the minimum benefits package, this mandatory insurance will miss the revenues of the mostly better off and will be left with the higher health-risk insured (barred health cross-subsidization).

These are in a nutshell the lessons that can be learned from other countries. So, when Tanzania is considering the formal structuring of its insurance market, it will obviously take into account the status quo of health financing and health insurance in the country. To gradually move towards UHC of the planned universal MBP, different models are considered that all could help achieve this. The differences are in the complexity of the market and hence the necessary regulatory capacity and speed with which this can happen.

The **emphasis** in this report is on achieving universal health protection (**UHC**) for accessing an established MBP with a suitable structuring of the health insurance market. It is hard to imagine achieving UHC without having mandatory enrolment in a contribution and/or subsidy based system. ***However UHC of a defined MBP can also be achieved through a national health system, financed from tax revenues.*** This is still the basis of the current Tanzania health financing system and is also the model used in e.g. the United Kingdom (UK). So, a choice needs to be made by GOT. Although the TOR for this report does not ask for elaboration of this option but instead request to focus on health insurance it is still very useful to consider because of the inherent difficulties of organizing UHC in a health insurance

based system in a country with a large informal sector. The much simpler NHS type system would also come with lower admin costs.

## **2. Options for Tanzania**

Assuming that the planned minimum benefits package (MBP) will be defined and further taking as starting point the current Tanzanian health financing system and its actors as well as taking into account the GOT's health policy, social policy and economic objectives and the lessons learned from other countries described in this report, the following options are recommended for consideration, whereby it should be noted that opting for the current national health services system, funded from general revenues such as exists in e.g. the UK would be the simpler one. It should be noted that the option 1 is the gradual introduction of change model while the others are more like big bang options.

- 1. Existing model**, gradually improved and ultimately leading to convergence of insurances, including CHF enrollers, into a mandatory health insurance for all residents offering a gradually expanding MBP while private health insurance is offering voluntary duplicative, complementary and supplementary insurance, the latter two sharply delineated from MBP:

- a. Step 1**

- i. Strengthening oversight
- ii. Until decision on competition-based HI and possibly setting the context for it:
  1. The National Health Insurance Fund (NHIF) is restricted to insuring civil services staff and dependents for its basic mandatory package
  2. The National Social Security Fund's Social Health Insurance benefits (NSSF-SHIB) is restricted to formal private sector employed.
- iii. Stop on expansion of NHIF & NSSF benefits packages (BPs)
- iv. Continued and gradually increasing GOVT subsidies for Community Health Funds (CHF) towards offering the MBP, and preparing these for merging into the NHIF/NSSF successor.

- b. Step 2:**

- i. Step 1 plus:
  1. Mandatory enrolment for all non-insured with NHIF and/or NSSF-SHIB into CHF, merging with CBHI & micro-insurance, which cover the set MBP and is implemented by NHIF
  2. NHIF is restricted to only offer its basic package and focuses on MBP expansion. The top-up services are left to private insurance.
  3. BP of NHIF/NSSF is kept frozen and can only continue to rise when MBP equals the NHIF/NSSF BP and then rise together
  4. NSSF-SHIB and Private insurance continue, stay out of MBP as covered by CHF, but can offer voluntary duplicative health insurance to formal private sector and self-employed.

- c. Step 3**

- i. Step 2 plus:
  1. NHIF and NSSF merged into one and offering mandatory insurance for formal sector (civil & private)
  - d. Formal sector includes self-employed with income above a defined threshold.
  - e. BP of NHIF/NSSF is frozen and can only continue to rise when MBP is equal and can rise together.
  - f. NHIF/NSSF stay out of private insurance market

1. Enhanced regulatory capacity
  2. Private health insurance can offer duplicative, supplementary and complementary insurance, covering extra amenities and medical interventions not covered by NHIF/NSSF packages and MBP
- 2. NHIF-NSSF merger, becoming the sole social insurer,** incorporating CHF and CBHs, therewith simplifying mandatory insurance reducing the admin costs of CHF and CBHs and solving the current problems with differences in the covered services and with the lack of portability, thus and enhancing effectiveness and efficiency in insurance and health services by creating a single purchaser. In essence Model 2 is the big bang approach towards model 1 plus the disappearing role of the LGA's in health financing. This latter step can obviously also be made as part of Model 1.
- a. Mandatory for all residents, including the informal sector.
  - b. Implementing the MBP. Local Government Authorities (LGA's) will not anymore be involved in HI but stay engaged in community oriented public health, health policy making (via MOHSW) and advocacy on behalf of their citizens.
  - c. No role in covering non-MBP benefits
  - d. Second tier insurer takes over mandatory insurance of current top-up NHIF/NSSF packages
  - e. Private Insurers can cover Non-MBP-Non-NHIF/NSSF BP
  - f. stronger oversight and enhanced regulatory capacity and requirements for PHI
- 3. NHIF-NSSF as competing statutory insurers,** aiming at more efficiency and client orientation:
- a. mandatory for MBP and formal sector workers, offering merged NHIF/NSSF BP
  - b. Free choice for insured between NHIF and NSSF.
  - c. MOHSW/MOFDP will operate a risk-equalization scheme between NSSF and NHIF.
  - d. NHIF-NSSF BP is frozen and can only continue to rise when MBP is equal and can rise together
  - e. NSSF-SHIB introduces its Micro Health scheme for low income h/holds.
  - f. Private Insurers can cover Non-MBP-Non-NHIF/NSSF
  - g. stronger oversight and enhanced regulatory capacity
- 4. Creation of single health fund, together** with multiple geographically divided MBP insurers, not being satellites of the single fund:
- a. Collects all mandatory contributions directly from employers
  - b. Receives all government funding for individual health services which currently flows into health sector, including conditional cash grants to LGA's and subsidies for CHF.
  - c. Receives cross subsidies from private insurers
  - d. NHIF and NSSF-SHIB will become the National Health Fund
  - e. Licensing autonomous regional health insurances with public status, which offer MBP and BP of former NHIF-NSSF
  - f. Distributes funds over regional HIs according to risk-adjusted capitation-based formula
  - g. NHIF-NSSF BP is frozen and can only continue to rise when MBP is equal and can rise together
  - h. Private Insurers can cover Non-MBP-Non-NHIF/NSSF
  - i. Stronger oversight and enhanced regulatory capacity
- 5. Creation of single health fund,** facilitating the implementation of health insurance of the defined MBP by either public or private competing insurers:
- a. collects all mandatory contributions directly from employers
  - b. receives all government funding for individual health services which currently flows into health sector, including conditional cash grants to LGA's and subsidies for CHF.



- c. NHIF and NSSF-SHIB will become the single health fund
- d. All residents are mandatorily insured
- e. BP
  - i. Those in the formal sector and those above a set income threshold receive the former NSSF/NHIF BP
  - ii. Those under the set threshold (somewhere above the poverty level) receive the MBP
- f. Licenses private health insurers which
  - i. offer MBP together with BP of former NHIF-NSSF
  - ii. compete for insured
  - iii. comply with all conditions to prevent risk selection
- g. Distributes funds to private insurers according to risk-adjusted capitation-based formula
- h. NHIF-NSSF BP is frozen and can only continue to rise when MBP is equal and can rise together
- i. Private Insurers cannot cover both MBP/NSSF/NHIF BPs and Non-MBP-Non-NHIF/NSSF supplementary and complementary insurance.
- j. Stronger oversight and enhanced regulatory capacity

The specific features of the elements, constituting the above models can be chosen using the in Chapter 10 elaborated decision points.

### ***Pros and cons***

The pros and cons of the 5 models are summarized in table 1 hereafter

**Model 5** is the most complicated, given the current situation. It will require the most profound changes and requires the most as regards additional regulation and regulatory capacity, the most detailed information and a sophisticated information system to run a risk equalization system and therefore will take the longest to implement. Neither social health insurance scheme in Tanzania has currently the tools to operate in a system with regulated competition and participate in a risk equalization scheme. This latter is due to the absence of a insured-based health services consumption related information system. The conditions for competing health insurers, as described in Chapter 10 will all need to be fulfilled. Even if these are fulfilled then its advantages are not clear as compared with improving the current system and building on it. Similar to other countries which spend a lot of effort, time and admin costs on their competing health insurance systems, people still may fall between the cracks due to risk selection and/or risk rating by insurers, thus possibly preventing equal access for all.

**Model 4** Is a bit less complicated than model 5 but still requires quite some changes, i.e. the transformation of some of the current NHIF/NSSF satellite offices into autonomous health insurance entities with all the features of e.g. the current NHIF national level office. It will also require the adjustment of legislation and implementation regulations, including those related to oversight. It offers the possibility of benchmarking the regional insurers. This can be used for efficiency improvement and client orientation of the insurers. Since these regional insurers will need to get a legal status the option exist to define performance criteria and recruitment, evaluation and discharge procedure for the senior management, the stage can be set for making benchmarking effective and preventing complacency. The transformation of NHIF and NSSF-SHIB into a national health fund in charge of the risk adjusted financial resources to the regional funds will also offer the possibility to overcome the problems in the current

distribution of monies from the central to the district governments<sup>1</sup>. The scale of the regions would need to be carefully chosen to allow the inclusion of existing or to be established referral hospitals (approximately 1 M people or more) or the portability and the use of top level facilities elsewhere guaranteed via e.g. a money follows the patient system to avoid that costs of patients in one region would be shifted to another one.

**Model 3** is in essence formalizing the status quo in which NHIF and NSSF are already competing though not explicitly regulated and therewith having the possibility of risk selection. It may enhance efficiency and client orientation but that would come at the cost of more regulatory arrangements and would require capacity building and time to establish it albeit less then in model 5 while still running the same risks for the residents as pointed out for that model. The simpler and hence less costly option is:

**Model 2** which unifies the administration systems of NSSF and NHIF, creates a powerful single purchaser and, if well regulated, offers the most efficient and fast way to get value for money and covering the whole population. It is in essence the big bang variant of Model 1. To realize such big bang requires quite some preparation as regards capacities of NHIF and requires regulatory changes.

**Model 1** is the gradual-change option which offers nevertheless the end point of the process which would help all actors to prepare themselves for this. It offers also the possibility of a regionally differentiated MBP, which could be necessary due to differences in geographically available health services.

The table below provides a SWOT analysis of these models:

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<sup>1</sup> Boex, Jamie & Selemani Omari: Strengthening the Geographical Allocation of Resources within the Health Sector in Tanzania: Towards Greater Equity and Performance; Report to the Tanzania Health Financing Technical Working Group, MOHSW Tanzania. Draft, March 2013

**Table 1 Pros & Cons/SWOT of options, proposed for consideration**

	<b>1 Existing</b>	<b>2 NSSF/NHIF merger</b>	<b>3 NSSF-NHIF competition</b>	<b>4 Single HF Non Comp. HI</b>	<b>5 Single HF Comp. HI</b>
<b>Achieving UHC</b>	+	+	+	+	+
<b>BP breadth &amp; depth</b>	+	++	+	++	+
<b>Effective &amp; efficient insurers</b>	+	+	–	++	+
<b>Effective &amp; efficient health services</b>	+	+	–	++	–
<b>Simplicity in HIM and implementation</b>	++	++	–	+	– –
<b>Realization period</b>	ST	ST	ST	MT	LT
<b>Capacity requirements</b>					
<b>Additional regulatory burden &amp; costs</b>	L to M	M	M to H	M to H	H
<b>Cost-effectiveness HIM</b>	+	+	–	+	?
<b>Acceptance</b>					
• <b>Insurers</b>					
○ <b>public</b>	++	++	++	–	– –
○ <b>private</b>	+	+	+	+	++
• <b>Providers</b>	+	+	+	+	+
• <b>Public</b>					
○ <b>Poor</b>	+	+	+	++	–
○ <b>Non-Poor</b>	+	+	+	–	++
• <b>GOVT</b>					
○ <b>Nat</b>	+	+	+	+	–
○ <b>LGA</b>	+	+	+	–	–

UHC Universal health coverage, i.e. access for all and no risk of impoverishment

BP Benefits package

HIM Health Insurance market

Nat national

LGA Local Government Authority

ST Short term

MT Mid term

LT Long term

L Low

M Moderate

H High

+ Possible or likely

+ More or less; or neutral

– Negative or less likely

### **3. Regulation**

The current health insurance system is already in need of strengthening, clarifying mandates of the Tanzania Insurance Regulatory Authority (TIRA) and the Social Security Regulatory Authority (SSRA) regarding the specifics of health insurance and getting them more tools for assuring the objectives of effective and efficient health insurance and therewith guaranteed access to health services for enrolled residents. Detailed reviews, recommendations and concrete proposals for amending current legislation and sub-level regulations have been provided, based on a report commissioned by the Tanzania Ministry of Health and Social Welfare (MHOSW)<sup>2</sup>.

Dependent of the preferred model for the Health Insurance Market Structure (HIMS) further legislation and regulation will be needed and capacities of TIRA and SSRA will need to be re-evaluated and strengthened. Besides the grand model, the decisions on the particulars of the model, out of the many provided options will also need to be reflected in the legislation and respective regulations. This concerns e.g. the responsibility for contribution collection, the mandating of an authority for administering the pool or pools of revenues, the purchasing mandate of the insurer(s), the governance structure of insurances and the possibilities for legal recourse of insured and health services providers vis a vis the decisions of the insurer(s).

Not only health insurance legislation deserves attention. Other areas may also be in need of adjustment, dependent of policy decisions, regarding the mandates of Ministries, LGAs and health services providers, e.g. re-distribution of the roles of MOHSW, the Ministry of Labour and Employment (MOLE) and the Prime Minister's Office of Regional Administration and Local Government (PMO-RALG); the role of MOH and LGA's as owners of health facilities and employers and payers of health staff. On the reverse side the health services supply side will need to be considered in complement to strengthening the purchasing position of insurers, requiring more autonomy for the management of health facilities or mergers thereof to flexibly respond to demands for more efficiency by insurers and allowing health facilities to use their consolidated resources efficiently. Supply side aspects are not receiving attention in the TORs for this report but would need to get attention as is argued later in the report. A separate report is recommended to get commissioned as to feed into the decision making on the HFS while it touches also on other consultancies/reports.

Lastly, the regulation of external assessment of the quality of health services providers needs to be considered to reflect the GOT's policy: keeping the fragmented accreditation as it is right now with NHIF and NSSF implementing different systems, moving towards a single system implemented by the single national insurer or to an independent accreditation body, incorporating the lessons from MOHSW policy on "Step-wise approach to accreditation".

#### **The report**

After a short introduction, Chapter 2 reflects the objective of the report, Chapter 3 the used methodology and approach, Chapter 4 provides for an interpretation of the terms of reference to avoid misunderstanding while chapter 5 describes the scope of the report. Chapter 6 gives a typology of health insurances and definitions and it describes the many features health insurances may show which reflect also the choices actors in the national systems have. These choices can be made by legislators or other

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<sup>2</sup> Bultman, Jan et al: Tanzania Health Insurance Regulatory Framework. review on request of the Ministry of Health and Social Welfare and the Social Security Regulatory Authority. GIZ/P4H. Dar es Salaam, March 2012

actors in the system dependent of the legally provided mandates. Chapter 7 describes competition between health insurers in different countries, the different faces it can have and the problems such systems and their actors may be confronted with, especially the residents of such countries, in light of UHC and equal access with equity in payment for health insurance. This chapter is anticipating on the description of country examples later on in the report. Chapter 8 summarizes the status quo of health insurance in Tanzania and describes issues relevant for the decision making about options for its future structuring. Chapter 9 actually gives the country examples. The many steps that need to be taken are provided as decision points in chapter 10 which reflect also the detailed choices on modalities of health insurance that can be made. Chapter 11 gives the options for the HMS that are recommended for consideration in Tanzania. Finally, chapter 12 gives attention to the regulatory framework and the possible changes to be made to create effective and health insurances allowing for cost-effective health care system, i.e. stimulating value for money. Of the annexes, annex 6 gives excerpts from international literature providing short overviews of the countries discussed in chapter 9. These excerpts give more background info on the presented countries.

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## 1. Introduction

In follow up on the adopted *Health Policy*<sup>3</sup>, which envisions “to improve the health and well-being of all Tanzanians with a focus on those most at risk [...]”, the Government of Tanzania (GOT) is committed to moving towards *Universal Health Coverage* and to ensure that all citizens have access to quality services and be protected from financial risk. As part of *the Health Sector Strategic Plan III*<sup>4</sup>, a decision was taken to develop a Health Financing Strategy to ensure that this vision would become reality. This report focuses on "Insurance Market Structure: options for the Social and Private Health Insurance architecture", in accordance to the Terms of Reference (TOR) which are attached (Annex 1).

It has been prepared by two consultants<sup>5</sup>, contracted by GIZ on behalf of the Providing for Health Initiative (P4H) and guided by the Ministry of Health and Social Welfare (MOHSW).

Hereafter, attention will be paid to (1) the objective and scope of the work on HIM structuring, to (2) the interpretation of TOR and used definitions, to (3) the used methodology and to (4) the reference framework for this assignment, i.e. the GOT policy goals, relevant for the health sector and health insurance. It describes thereafter (5) the current situation of health insurance in the wider context of financing of Tanzania's individual oriented health services. This is followed by (6) a description of different health insurance systems and ways of structuring the health insurance market in low, middle and high income countries with single and multiple insurers and with competing and non-competing insurers, leading to (7) providing general options for structuring the Tanzania HIM in reference to international experience and subsequently (8) describing options for Tanzania based on this international experience which could help achieving the GOT's policy goals and would seem feasible. Lastly (9) preconditions will be described, including possible regulatory and institutional consequences related to the presented options for the structuring of the HIM.

## 2. Objective

The objective of the HIM study is to develop three to five comprehensive, adequate and feasible reform strategies/options for the HIM, which are specific enough to bring out differences and general enough for a strategic document and providing a document which can feed into the planned Health Financing Strategy. The options should be adaptable and modifiable in implementation and all backed up by an analysis of strengths, weaknesses, opportunities and threats (SWOT) in reference to the policy goals of the Government of Tanzania (GOT). It should allow the Inter-ministerial Steering Committee (ISC), which coordinates and is ultimately responsible for the HFS, to assess the different options / scenarios and to make a choice for which Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis provides further support. In more detail, the study has to provide:

- The status quo of the HIM as regards population coverage related wealth/income levels;

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<sup>3</sup> Tanzania Ministry of Health. National Health Policy. October 2003

<sup>4</sup> Ministry of Health and Social Welfare. Health Sector Strategic Plan III. 2008

<sup>5</sup> Mr. Anselmi Mushi, Insurance Expert and Lecturer at the Institute of Finance Management, Dar es Salaam, Tanzania; & Jan Bultman, MD, Health Systems Expert, Netherlands.

- An overview of the current roles and responsibilities of different segments of the HIM and to reflect the ambitions and views on the "market";
- a reference to the GOT policy goals in health, health insurance and the labour market to assess possible performance of reform options;

Proposals for Tanzania have to profit from international experience with the structuring of insurance markets while foreign country context need to be taken into account, especially as regards the meeting of certain preconditions and conditions. The experiences to be described should cover:

- HIM in low, middle and high income countries with social health insurance (SHI), paying attention to:
  - population coverage
  - benefit coverage
  - cost coverage;
- Single and multi-payer social health insurance (SHI) addressing fragmentation of SHI markets where several providers (of health insurance) co-exist :
  - ways to manage risk selection,
  - preventing adverse selection and other risk-pool related issues
  - use of risk equalization schemes to mitigate such issues
- International experiences with private health insurance (PHI) in countries with SHI, acting as complementary, supplementary or substitutive PHI and experience with public-private risk equalization and subsidization;

The international experiences will have to be applied in the national Tanzania context and pay attention to:

- The possibility of re-insurance of local schemes, e.g. of Community Health Funds (CHF) and its feasibility and/or desirability.
- The use of tools for cost control in and via health insurance as regards health service and administration costs in comparison with cost control in TAZ HIM segments.
- The use of generally existing systems in different HIM structures for e.g. quality assurance or accreditation, claims verification, information technology (IT) and monitoring and evaluation (M&E).
- Technical and M&E requirements for risk equalization between schemes.
- Needs for changing regulatory requirements & institutions for different HIM structures;

### **3. Methodology**

The following methods have been used for the implementation of the HIMS study:

- Interpreting the terminology used in the TOR for the study, followed by a description of the used characteristics of insurances and a typology and definitions of different types of insurances and their qualifications.
- Document review
  - National policy documents

- Regulations and regulatory mechanisms, using among others the MOSW/SSRA/P4H regulatory review<sup>6</sup>.
- External national and international reviews of TZ health financing (HF) and health insurance (HI)
- General international studies on health insurance market structuring
- Country examples presented in systematic overviews
  - Single payer (of MBP) systems
    - National health services (NHS) type system together with supplementary insurance, e.g. UK, SSA examples
    - Insurer, mainly payroll tax based, possibly together with voluntary supplementary insurance, e.g. Korea, Mongolia, France
  - Multiple payer systems
    - MBP non-competition, Netherlands before 2005, Germany before its change to a competition based system while maintaining its opt out possibility, i.e. quitting public insurance and enroll in private health insurance without the possibility of going back into the public sphere.
    - MBP insurance in competing systems, e.g. Switzerland, Germany and The Netherlands
    - Mandatory or voluntary, including CBHI/micro-insurance
- Meetings / interviews with national stakeholders and with international experts of selected countries on an as needed basis and possibly a focus group meeting.
- Inception meeting to present the outline and main content of the inception report and solicit/receive comments, especially on the scoping questions as indicated in Section 3 as well as discuss the approach.

## Reference Framework

Several sources have contributed to the reference framework for the in this report proposed elaborated HIM structure options:

- The criteria mentioned in the objective of this study (TOR):
  - **Comprehensiveness**, interpreted as:
    - encompassing all existing Tanzania health insurance variants and existing BPs,
    - considering all relevant internationally existing HIM structures with their different features seemingly contributing to UHC of a national MBP
    - taking into account the main functions of an insurance system in the Tanzania context.
  - **Adequateness**, in this report interpreted as:
    - Advancing the achievement of UHC with the broadest and deepest BBP economically possible with an eye on what can be financed from different sources without negatively impacting economic growth and poverty reduction.
    - Promoting effective and efficient implementation of health insurance arrangements and their regulatory context and processes
    - Promoting effective and efficient delivery of health services as included in the BBP
  - **Feasibility**. This relates to:

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<sup>6</sup>Bultman, Jan et al.: Tanzania Health Insurance Regulatory Review, on request of MOHSW & SSRA, March 2012

- the available capacity and/or the possibility to strengthen the current capacity to implement the proposed options.
  - cost/effectiveness and the possible additional costs of implementing the proposed HIM structure, i.e. the administration costs of health insurers in the market and of the regulatory bodies. and their activities.
  - the important aspect of the political environment and the acceptability for main stakeholders and ultimately the Tanzania legislator. Of course the authors of this study may grasp some aspects of the political economy via their interviews with stakeholders but cannot judge the ultimate political feasibility.
- **Simplicity.** The simpler the market structure the easier it will be to implement and to regulate.
- Criteria for social health insurance (SHI) performance<sup>7</sup> (bolds are from the authors):
  - *"Percentage of population covered by SHI"*
  - *Ratio of prepaid contributions to total costs of SHI BP*
  - *Percentage of households with catastrophic spending*
  - *Is membership compulsory in all/some contributing population groups? **"The extent of compulsory membership is thus an essential performance indicator"**.*
    - *What percentage of each contributing group is covered by SHI?*
    - *Are dependents of contributing groups compulsory insured?*
  - *Multiple risk pools? If yes, are there risk equalization measures in place?*
  - *Are there efficiency incentives for risk pools?*
  - *Is the benefit package based on explicit efficiency and equity criteria?*
  - *Are monitoring mechanisms -patient appeals mechanism, full information on claimants rights, peer review committees and claims review in place?*
  - *Do provider incentives encourage the appropriate level of care?*
  - *Percentage of expenditure on administrative costs."*

Further:

- Received guidance of the Health Financing Technical Working Group (HFTWG),
- GOT policies as expressed in a number of documents and coming from different corners of the GOT will also contribute to the reference framework and are relevant for the health sector and its financing in light of the country's social-economic context, such as the
  - National Health Policy. October 2003;
  - Tanzania Health Sector Strategic Plan III. 2008;
  - Ministry of Health and Social Welfare. The Tanzania Quality Improvement Framework in Health Care 2011-2016. October 2011;
  - Ministry of Finance and Economic Affairs, National Strategy for Growth and Reduction of Poverty II (NGRP II), July 2010;
  - Ministry of Labour, The National Social Security Policy, Dar es Salaam, January 2003;
  - Tanzania National Five Year Plan 2011/12 – 2015/16.
    - i. Improving health
    - ii. Health sector financing and the role of health insurance
    - iii. Economic development and labour market areas to establish a frame of reference against which to assess possible performance of reform options
- International references (to characteristics of cost-effective health financing systems to achieve universal coverage; e.g. WHR 2010.)

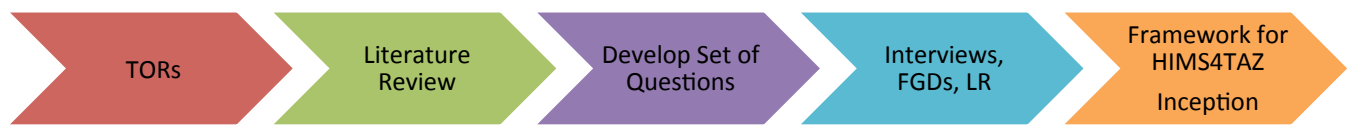
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<sup>7</sup> Carrin, Guy & Chris James: Key performance indicators for the implementation of social health insurance. Appl Health Econ Health Policy 2005 (1) 15-22

## Approach

The consultants have used a two (2) phase approach in developing the scenarios and options to structure the HIM. The first phase established a framework used to develop the HIMS options for Tanzania. Activities involved in this phase were the interpretation of the TORs, conducting preliminary literature review to establish the key aspects of the study, developing a set of questions and tools used in data gathering, conducting interviews, focus group discussions and further literature review and establishing a benchmark framework that will be used to develop the strategies for structuring the HIM in Tanzania.

**Figure 1: Phase I**



After completion of the first phase with the delivery of the inception report the second phase started with a set of definitions and a typology of health insurance, based on international examples and literature. The established reference framework is consolidated to meet the benchmarks of the assignment, viz comprehensiveness, adequacy and feasibility of the options. Activities in this phase involved further review of international literature reflecting the different options other countries have used to structure their health insurance markets with attention to the perceived effectiveness and efficiency of chosen structures in achieving UHC and equal access to health services. In Tanzania site visits, interviews and Focus Group Discussions (FGDs) were held to receive feedback on the acceptance, feasibility and adequacy of various developed HIM structuring options in light of international experiences. A draft final report with options etc. in conformity with the TOR was presented to MOHSW and other key stakeholders during the second consultant mission. Based on received comments, the report was finalized and submitted to MOHSW and GIZ for follow up.

**Figure 2: Phase II**



#### **4. Interpretation of Terms of Reference**

This report proposes the following interpretations of the terminology used in the TOR for this particular study:

- **"Insurance"** is not only based on payroll tax or premiums/contributions but can also be totally or partially funded from general revenues<sup>8</sup>. What matters is that people are insured against the necessary costs of health services by a third party payer<sup>9</sup>. However, in common language and common understanding health insurance is seen as a health financing modality based on individual enrollment and financed from individual contributions despite possible cross-subsidies from general revenues and other sources. Nevertheless, in this report and in the future health insurance market the substantial contributions by the Tanzania governments on national and district level to the CHF and for investments, capital repairs and the remuneration of staff in public health facilities cannot be ignored. These subsidies complicate the governance of health financing of public health facilities, fragment fund flow to health facilities and reduces the clout of health insurers as purchasers of services while governments as owners of health facilities and employers of staff may have interests that conflict with the implementation of insurance.
- **"Social"** is a word that features in relation to health insurance.
  - Social health insurance (SHI) is mostly seen as a mandatory health insurance system, mainly based on income-dependent payroll taxes, covering categories of the population such as formal sector workers possibly with their dependents but it can also aim to cover other categories such as students, pensioners and unemployed or even the whole population such as in Mongolia. However, the word "social" can create misunderstanding.
  - **"Social"** is not a synonym for **"public"** in insurance. **Private** entities, such as sickness funds can also offer a **mandatory** public scheme as was the case in e.g. The Netherlands until 2005.

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<sup>8</sup> OECD: Proposal for a taxonomy of health insurance. Paris, June 2004

<sup>9</sup> World Health Organization: The World Health Report. Health Systems Financing, the path to universal coverage. Geneva 2010

- After its reform and unification of health insurance schemes, Dutch national mandatory health insurance is implemented by private insurance companies.
- "Social" like in "social health insurance" (SHI) is also not opposite to a-social or anti-social. SHI is mostly seen as public (contrary to private) compulsory insurance. However, private insurers can also implement a compulsory scheme. Private insurers can be for-profit and non-profit and "still social". All insurances have an element of solidarity among their enrolled people albeit in different gradations.
  - So, the term "social" would be better avoided when identifying different types of insurance, discussed in the next section.
- **"Market"** is seen in the economic context as a place of exchange between different parties which can be organized in different ways, mandating different parties to supply or demand goods and services. It does not necessarily mean competition. The regulatory environment makes the difference. In the health insurance context: **mandating** legal entities to offer people insurance for the use of health services in a non-competitive or competitive way. **Mandating** is the crucial term. The regulatory environment and process determine whether competition exist and for which categories of persons and for what type of health services and amenities that may accompany the services.
  - **Universal Health Coverage** is defined as access to qualitative key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving **equity in access**. The principle of **financial-risk protection** ensures that the cost of care does not put people at risk of financial catastrophe or prevents them from seeking care to preserve or restore their health.

## 5. Scope

The study focuses on the macro-level of the insurance market, rather than the micro-level of institutions. It is aimed at clarifying the structure and necessary rules and conditions to be set for achieving goals of GOT to effectively and efficiently expand coverage of the population. While specific shortcomings of existing institutions should be noted and flagged for change, it is not meant to be an institutional assessment of insurance and regulatory institutions in Tanzania.

As mentioned before, the study will provide relevant international evidence from various countries which have different systems. These could come from single- and multi-payer systems such as the Netherlands, Germany, Switzerland and France but also from low- and middle-income countries such as Rwanda, Kenya, the Philippines, Thailand and Ghana. Clarifying the different roles PHI can take on will be done by drawing in experiences from e.g. France and the United Kingdom.

The study is supposed to also focus on all key functions of insurances, including collection, pooling, purchasing, and benefit package formulation. It should also reflect on health insurance in relation to accreditation.

A few more scoping issues draw attention: the character of insurance and what will health insurance pay for: MBP, operational and investment cost, public and private providers?

### **Minimum Benefits Package**

The MOHSW has defined an essential health care package (EHSP)<sup>10</sup>. This document is the starting point for developing and constantly updating a minimum benefits package (MBP) accessible for all Tanzania residents in the framework of the HFS development. So, it is logical that the options for the health insurance market structure (HIMS) also have a focus on insuring access to this MBP while taking into account that public health facilities already provide access to a number of services included in the EHCP.

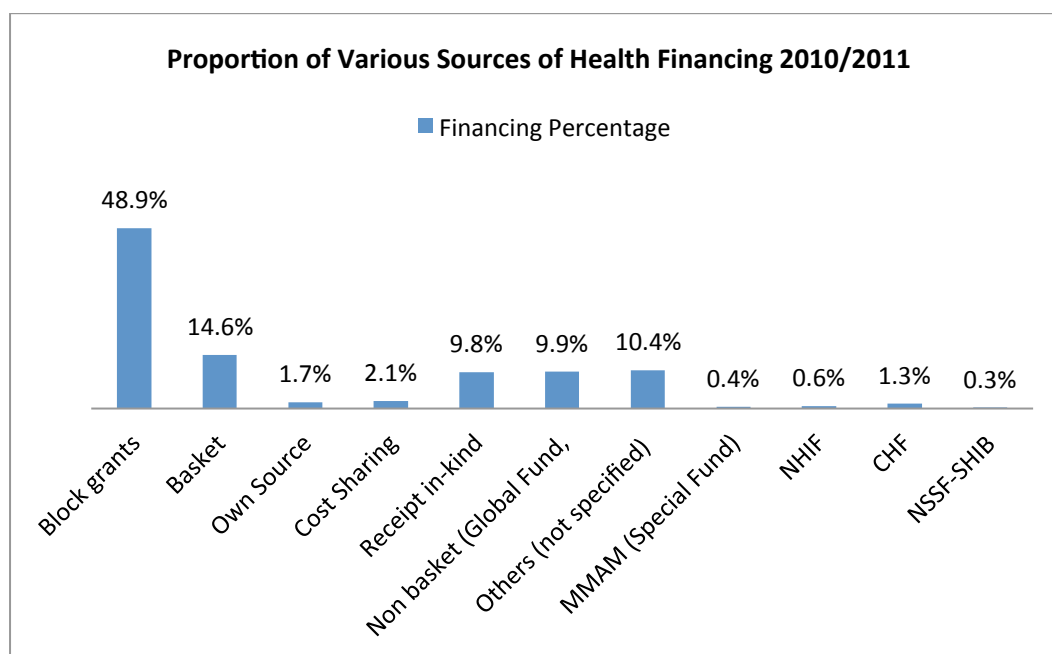
### **Budget and contribution based finance of health services**

The direct financing of health facilities, infrastructure and salaries, by national and local government authorities should also come into focus.

Contribution based health insurance in Tanzania is currently financing only a relatively small portion of health services costs. Besides out of pocket payment (OOP) by patients at the point of services (POS) the insurers mostly pay the marginal costs of health services in public facilities. Investments, capital repairs and staff salaries of public facilities are being paid from general or local revenues. This fragments financing of services, where national and local governments may have contradicting interests, i.e. trying to shift the burden and the costs as much as possible via referrals to other level facilities.

Fund pools and financial streams to health facilities are further fragmented by the existence of a multitude of payers thus diminishing financial clout to health insurers which impacts their purchasing position (see Graph 1).

**Graph 1. Health Financing Sources 2010/2011 in percentages of total health sector funding.**



Source: Statistics from MOHSW, 2012, Health Sector Public Expenditure Review 2010/11

<sup>10</sup> Ministry of Health and Social Welfare. National Package of Essential Health Interventions in Tanzania, January 2000



Although most people will think of health insurance as contribution based similar to e.g. indemnity or life insurance, health insurance can also be partly or totally financed from general taxes, according to the definition of OECD in its taxonomy of health insurance. What matters for patients is that their access to services is insured whether from the general revenues or from contribution based insurance. Several originally only contribution based health insurances, such as Germany's and the Netherlands' are receiving subsidies from the government budget with the aim to either support the enrolment of e.g. the poor in the informal sector or to prevent labor costs becoming too high and negatively impacting the viability and competitiveness of enterprises. When interpreting "insurance" in this broad meaning than the general revenue funding of health facilities is part of the health insurance market and hence subject of this study. It implies that general revenues funding and the roles of national and local governments have also come into focus. (See also the definition section later on in this report.)

***What will health insurance pay for*** (besides its own administration costs)?

○ ***Expenses will certainly be for health services.***

- Although the emphasis is on achieving UHC of a defined BP, the existence of insurers offering more or planning to offer more than a minimum package is not ignored in this report.
- ***MBP*** is used in this report as ***minimum benefits package*** and not as mandatory benefits package. A benefits package (BP) cannot be by itself mandatory, only enrolment in a health insurance can be mandatory for indicated categories of the population.
- ***Mandatory or voluntary insurance of MBP.*** The ***emphasis*** in this report is on achieving universal health protection (***UHC***) for accessing an established MBP. The question is: which entity or entities will offer this minimum package. In case the MBP will be offered by contribution based insurance, possibly directly receiving subsidies or having possibly individually subsidized enrollees, then the question arises whether this insurance will be mandatory or voluntary. It is hard to imagine achieving UHC without having mandatory enrolment in a contribution and/or subsidy based system. However UHC of a defined MBP can also be achieved through a national health system, financed from tax revenues. This is still the basis of the Tanzania health financing system and is also the model used in e.g. the United Kingdom (UK). So, a choice needs to be made by GOT.
- ***Regionally differentiated MBP.*** A future MBP may have to differ across regions or districts due to differences in health services availability. It is assumed that the study on MBP, commissioned on behalf of ISC/MOHSW, will address this issue. In case the MBP differs across the country then the HIMS will have to be flexible to accommodate this for as long as the differences exist.
- ***MBP and additional services coverage.***
  - Currently people in Tanzania who pay higher contributions to either a private health insurance or to NHIF may enjoy a broader BP and/or more services or fast track care than those who cannot afford such higher contributions. The policy question is: ***should this remain for health services that are essential for preserving or restoring health*** and be included in one of the options for structuring the insurance market, other than for amenities via voluntary supplementary insurance?
  - In case future mandatory health insurance of the MBP in its gradually extended version has copayments than voluntary complementary health insurance could cover this unless GOT would aim to prevent the consumption-utilization effects of copayments be neutralized by such complementary insurance, e.g. in case of copayments for self-referrals meant to curb unnecessary use of medical specialist care. France for example has introduced the role of a referral doctor, a "chosen doctor", which can be a

generalist or a specialist via which all visits to a hospital or other specialist should go. Bypassing the referral doctor leads to a copayment for the patient. This copayment cannot, by law, be insured and covered by complementary insurance.

- The National Health Insurance Fund (NHIF) is characterized by mandatory enrolment for civil service members and their dependents. The breadth and depth of the current NHIF benefits package is, most likely, more extended than would be possible for the universal MBP.
- Besides this, non-basic (top-up) packages exist also with the National Social Security Fund (NSSF) and its Social Health Insurance Benefits (SHIB), although enrollment in SHIB is voluntary, as well as with NHIF via its system of brown and green cards which gives the higher salaried NHIF green card holders access to fast track treatment and private doctors.
- Other non-basic (top-up) packages are offered by private insurers which offer also duplicative health insurance
- **Breadth and depth of BP.** Breadth of the BP relates to the covered health relevant medical intervention and depth to the extent that the costs of particular interventions are covered (totally or partly).

The existence of several different BPs in Tanzania, most likely encompassing more services than can be afforded for the MBP, are also considered in the HIMS.

- **Paying for investment and all operating costs?** Will Insurance pay for operating costs and investment costs of providers or only for operating costs?

Tanzanian contribution based health insurance pays mainly operating costs, especially NHIF and NSSF\_SHIB and as regards the public health facilities. Infrastructure and staff in these public facilities are paid from the General Revenues. Also private insurance pays only operating costs of the public facilities. These operational costs are marginal compared with total costs, as mentioned before. Staff and pharmaceuticals are centrally procured and distributed to the public health facilities. Health insurers have no influence on their distribution.

This means that on the one hand people may not have an interest in buying insurance themselves and on the other hand purchasers have no clout vis a vis the investment decisions of providers or their owners/managers and cannot use purchasing to its full potential.

**Private facilities** have to raise their own capital and to reflect these in their fees. In case public and private health insurers will have to pay these fees and cover at least some of the investment costs in case their policy holders are entitled to use these private facilities.

- This touches upon the future position of private health facilities, for-profit and not-for-profit, in the future HIMS: will this position be equal to that of the public facilities and will both have the opportunity to offer the insured MBP. If so, then a **level playing field** should be created and health insurers have to also reimburse investment costs.

**Providers of health services** are not in the focus of any of the 9 studies that will feed into the HFS. However, at least when discussing the options for HMIS, their position and features cannot be ignored. This does not only concern the assurance of the quality of the health services, referred to in the TOR as regards accreditation, but also the level of autonomy of public health services providers and therewith their ownership status. Effective purchasing by a health insurer supposes a sufficient level of autonomy at the provider side.

## 6. Health Insurance Typology and Definitions

This report uses the following typology of insurance modalities and the characteristics that they can have<sup>11</sup>. The relative effectiveness and efficiency of the indicated characteristics, options and tools are indicated. References are made to international example when discussing features

1. **Health insurance** is "a way to distribute the financial risk associated with the variation of individuals' health care expenditures by pooling costs over time (pre-payment) and over people (pooling)". It differs from
  - a. Out of pocket payments (OOP) which has no pre-payment and does not pool.
  - b. Individual medical savings accounts (MSA) which offer pre-payment but no pooling<sup>12</sup>.
2. Health insurance shows many other features, besides pre-payment and pooling, which are detailed in Annex 5, related to:
  - a. **Goal orientation:**
    - i. primarily **business oriented** primarily **health oriented social/financial security oriented: preventing impoverishment** due to the consumption of necessary health services.
  - b. **Legal status, which can be:**
    - i. **public**
    - ii. **private:**
      1. **for-profit**
      2. **not-for profit**, e.g.
        - a. NGO
        - b. Mutual or cooperative

**NB:** an insurance entity can implement any type of insurance irrespective of its legal status. The differences are brought about by the **regulatory environment** in which the health insurer has to work or is licensed to work and can implement health insurance. This means that a private health insurer can also implement a mandatory health insurance, commonly called social insurance. This is the case in e.g. Switzerland with not-for-profit private insurers and in The Netherlands which has for profit private insurers. In other words, the legal status of an insurer does not determine its orientation, the cover it offers or the level of financial protection. What matters is the regulatory environment that determines the mandate of the licensed insurer.

**c. Sources of financing:**

The source of finance does not define the orientation of health insurance or the level of coverage or social protection offered. Private health insurance can also be funded from income based contributions and public insurance from flat rate premiums in countries such as the Netherlands and Switzerland.

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<sup>11</sup> The quoted definitions are mainly from OECD's Proposal for a taxonomy of health insurance. Op Cit.

<sup>12</sup> This option is not discussed in this report because it has no solidarity element and hence is no solution to solving the health services access problems for the poor. MSAs can be found in e.g. Singapore and the USA, where enrollment offers a tax deductible <http://www.irs.gov/pub/irs-pdf/p969.pdf>

Most countries have mixed sources of financing. Even countries of which one would easily assume that these would be fully funded from general taxes have dedicated other sources, such as the NHS in the UK which is partly funded from a special health insurance tax. The reverse is the case in the USA where private health insurance seems to be dominant but where about half of total health expenditures (THE) come from general taxes, such as for Medicare, Medicaid and the Veterans Health System.

**d. *Determining level of resources***

This depends, besides of the composition of the MBP and its estimated costs, of the sources of financing and of the characteristics of the BP: a) provision oriented (such as the English NHS), b) reimbursement system or c) an in kind system with the main difference between these being the existence of enforceable entitlements and fixed budget or open-ended funding system.

**A *provision oriented system is supply oriented.***

A ***reimbursement system*** reimburses the insured the incurred costs of care, provided the received care was covered and the insured has an indication for the used care. A reimbursement system is not only administratively more costly than an in-kind contract supported system it has also less possibility to influence the fee levels and it offers less protection to patients as regards charging high fees as the example of the Philippines health insurance system shows (See annex 6).

An ***in-kind system*** obliges the insurer to pay directly to the providers it has contracted to guarantee access.. This system offers the best guarantee to insured of getting access to services and to know in advance what he has to pay for. It is found in most so-called statutory or social health insurance systems. From the point of the insured this is the best system for enforcing his rights.

An ***in-cash system*** pays the insured a predefined sum of money in case an insured event happens. It is left to the insured to spend the money either on its intended purpose or to his own liking. Such systems are seen in indemnity insurance as well as in long term care arrangements and for medical aids and supplies for the handicapped.

**Fixed or open-ended**

A system of legally enforceable entitlements is mostly combined with an open-ended financing system with adjusters for balancing revenues and expenditures. These adjusters can be: the introduction or increasing of copayments, the reduction of benefits, the reduction of provider fee levels or the adjustment of the contribution rate. Temporary balancing can be done from reserves, bank-loans or government back up.

**e. *Types of contribution rate setting***

All contributions are based on an estimate of the risks the insurance runs in covering its insured. This can range from individual risk rated contributions, via family risk rating, community risk rating, enterprise-related risk rating to risk rating for all enrollees in a system.

- i. ***income based*** with percentage fixed for all contributors progressively or regressively set for identified income brackets, sometimes combined with
  1. maximum income level above which no contributions are paid.

2. minimum income level up to which no contributions are paid.

This type rate can be easily done for formal sector employees and in countries with an effective tax system for self-employed and people in the informal sector, possibly combined with a proxy means testing system.

- ii. **flat premiums** which can be risk rated in all possible variants as mentioned above
- iii. a **combination** of income based and flat rates

Individual flat rates can be increased with fixed amounts to cross subsidize e.g. from private health insurance for the well off to public mandatory health insurance for the not well off categories of the population.

NB. **Taxes and income based premiums imply the highest level of solidarity.** Cross subsidies from private insurance can also enforce some level of solidarity. But, unless these are income-dependent, they will not imply the same level of solidarity. OOPs and individual risk-rated contributions have the lowest levels of solidarity.

Adjustability of contribution rates is warranted in a system with enforceable entitlements while at the other end of the spectrum it can prevent too high fixed contribution rates, possibly leading to unnecessary high reserve funds at the insurer such as in Tanzania's NHIF.

**f. Collection of revenues or contributions**

- i. by health insurance entity directly from insured
- ii. by intermediary
  1. general tax collection system
  2. employer
  3. other

**Direct collection via the tax-collector would be the more efficient system**, practiced in NHIF's system, as compared to a system in which the insurer has to establish and implement its own contribution collection system whereby this in enterprise related enrolment goes easier than in case of individual enrolment .

**g. Pooling of revenues:**

- i. by insurance entity
- ii. by a health fund, also called central fund or health and equity fund.

**h. Reserves:**

To be built and kept. Reserves will be required from contribution based health insurers to guarantee members access to covered services. The level of reserves is dependent of the extend of the risks the insurer is running and of the existence of a government funded back up or stop loss system.

**i. Purchasing.**

Besides **what kind of services** (BP) insurance has to pay for, the actual tools it has at its disposal to purchase will co-determine the cost-effectiveness of health services delivery, i.e. the *freedom to select providers, to select specific services of selected providers and in specified volumes, using competition between providers and selection as instrument for*

*enhancing efficiency in health services delivery; to determine the remuneration system and to negotiate the fee levels; and to review the financial claims of the providers or insured? The more an insurer has of these instruments and the freedom to use them the more effective he can be in cost-containment and quality assurance on the supply side. Of course selection can only happen in case of oversupply and multiple providers in an area small enough to allow access for all. In Tanzania this is only the case in urban areas and even there "oversupply" is relative given the general shortages in facilities and services.*

**j. Benefits package**

BP design and maintenance can be done by the legislator, with details possibly mandated to the Minister of Health, or left to the insurer. The first option is seen in mandatory insurance, the second one also in mandatory insurance, to some extent, and obviously in private voluntary insurance. Dependent of the level of detail in a legally determined BP, such detailing can also be left to statutory insurance bodies and providers in order to accommodate progress in medical science and technology and to include emerging new health technologies or the application of existing ones for new indications as part of the BP. Of course, obsolete health technologies can also be dropped. There are tradeoffs between the detailed regulation by using positive lists and the more flexible one with delegation to either a minister of health or an insurer. A detailed regulation and positive lists do not come with surprises and makes it easier to control costs (but not the volume of services) but it does not offer flexibility re a quick adjustment of the BP to e.g. incorporate a new life-saving drug or another emerging health technology. Dependent of the level of regulation, i.e. in the law, in by-laws, executive regulations or MOH decisions, such changes will require time-consuming procedures, changing the laws will take the most. Having flexibility by e.g. using a system of negative lists by which everything is included until explicitly forbidden and delegation to the lowest regulatory level comes with the risks of less cost-control and running behind the facts of automatic introduction of new health technologies. In a system of **mandatory insurance with competing insurers** it is important to have a centrally set and detailed BP with absolute clarity on what's covered in order to avoid risk selection by insurers via manipulation of the BP and hence limiting access to necessary care. Interpretation problems re the BP should be set by an independent body which can either do this spontaneously or on request/complaints of involved parties or with a combined mandate as is the in the Netherlands with its Health Care insurance Board (College voor Zorgverzekeringen)<sup>13</sup>.

**k. Contracting**

Contracting between health insurers and providers is an important tool in purchasing. This is common in statutory health insurance and also used in private health insurance. Contracts can be made on the national level, e.g. as models outlining the general aspects, and on the individual level incorporating all the necessary details. If, when contracting, a health insurer is allowed to select providers, based on the needs of its insured and on the perceived quality and performance of providers than such selection option supports the insurer in making health services more efficient and of better quality: selective contracting as incentive for **competing health services**

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<sup>13</sup> <http://www.cvz.nl/en/cvz>

**providers.** If such selection is possible, can the insurer **select between public and private providers** for the same type and quality of services and does a level playing field exist to allow for fair competition between all providers irrespective of ownership status? This latter aspect touches upon the way investments in health services infrastructure and equipment are financed. This question is not only important for an effective role of insurance to enhance effectiveness and efficiency among providers but also for the possible role of private health institutions in delivering the MBP as mentioned before.

***l. Fee levels***

One of the challenges health insurance is confronted with is the question of reasonableness of the fees requested by providers for specific health interventions or admission days. Although line-item budgeting of public providers helps in getting insight in costs of providers, this method does not provide information about the cost-effectiveness of the medical interventions and does not give insights into the necessary labor and in ways to increase productivity. Actually paid fees seldom reflect the real costs of interventions. Overhead costs are arbitrarily divided over the different health interventions. Productivity and efficiency may change over time after the introduction of new interventions due to learning phase problems and delegation to lower paid staff. So, adjustability is key.

Besides costing studies to determine a benefits package, many countries use **health technology assessment** to base decisions on for the introduction of new health technologies into the benefits package, such as the UK's National Institute of Clinical Excellence and Care (NICE). Such assessments not only address the costs per intervention or e.g. a new drug in the necessary dose but can also provide information on the expected volume of use, i.e. about the expected yearly costs of an intervention. This information can be used by insurers in fee negotiations with providers and for the calculation of contribution rates and/or cross-subsidies.

***m. Centralized fee setting***

Although the determination of fees can be left to the individual insurer and its negotiations with providers, only a monopolist insurer will have full insight in the production and performance of providers. In countries with multiple national insurers an insurer will not have such comprehensive oversight and insight in provider performance. Reviewing whether requested fees or their increases are reasonable requires expensive capacity at the insurers. It is therefore efficient to set fees on the national level by either negotiations between representatives of insurers and providers, such as in Germany, or ultimately by a national public authority such as in The Netherlands until 2005. A capable secretariat or an independent outside institution can support the underpinning of the fee levels. Centralized fee setting was also proposed in Tanzania during the preparation of the Health Insurance Regulatory Review<sup>14</sup>.

***n. Provider performance review***

An important task of an insurer is the review of submitted claims by providers or their insured, checking whether the provided care is included in the BP; whether the claimant or its patient is entitled to reimbursement; whether there is a justified medical

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<sup>14</sup> Bultman, Op. Cit.

indication for the health intervention for which reimbursement is claimed; whether the provider has delivered the care in accordance with agreed or nationally accepted standards of care, algorithms and medical protocols and whether the requested fee level is in accordance with the pre-determined level?

**o. Level of compulsion**

This does not address the insurance entity but refers to people belonging to categories of the population that are obliged by law to enroll in insurance. This can be either in a public or a private scheme. It can be into a single insurance in a particular country or region or in one of many insurances, possibly competing with each other. It can be bound to the type of enterprise or conditions of employment or compulsory for the population at large. **The level of compulsion is a decisive factor in achieving UHC**, unless enrolment is for free, such as for the poor in the Universal Coverage Scheme (UHS) in Thailand. The definition of who is "mandatory insured" can go and probably has to go into great detail as part of the regulatory process and dependent of the type of insurance, e.g. as regards exempted categories in an formal employment sector related insurance system for diplomatic staff, persons on short term contracts, stand-by contracts or working minimal hours per months. The term "employer" will also have to be described in an employer/employee based system, e.g. is a person which has a domestic aid worker once per week an employer.

**p. Contributor-beneficiary split**

Distinction and possible separation between paying into a contribution based HI and enjoying the benefits is happening around the world. One can be beneficiary while exempted from paying contributions such as in case of co-insured dependents or non-paying categories such as children, pensioners, unemployed etc).

**q. Accreditation of health services**

is one of the external assessment systems of quality of health care services. It is defined as *"A public recognition of the achievement of accreditation standards by a healthcare organization, demonstrated through an independent external peer assessment of that organization's level of performance in relation to the standards."*<sup>15</sup>

Accreditation is not a key insurance function or a universal feature of insurers or insurances. In most countries, especially with multiple insurers, accreditation is done by an outside body. However, **insurers should make sure that they contract providers able to provide quality services according to generally endorsed standards**. Being accredited should be an important feature in the selection of providers and contracting their services. However, it is not meant act as an entitlement to getting a contract with an insurer for an accredited provider. This means **that accreditation and contracting are two different activities**. Accreditation can be used as a condition for a contract but it needs not necessarily have to lead to a contract.

In a situation of multiple insurers, such as in Tanzania, it will be confusing for providers and patients if different standards exist, besides cumulating admin costs.

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<sup>15</sup> Shaw, Charles D. Toolkit for accreditation programs, some issues in the design and redesign of external health care assessment and improvement systems. The International Society for Quality In Health Care Melbourne 2004



As part of its purchasing function an insurer would have to care for the review of the performance of contracted providers vis a vis the BP and the appropriateness of the provided services against agreed standards. Claims review is an important vehicle for such review. These purchasing functions should be more in the focus than accreditation, which can be left to an outside body. Besides this, the Tanzania MOHSW has established a Quality of Care Department. It is working, based on the MOHSW quality strategy<sup>16</sup>, on a program of stepwise going to accreditation, supported by international accreditation agencies. This could lead to the establishment of a national accreditation body, posing the question whether separate accreditation systems of different insurers should remain in Tanzania. In case accreditation is done by a national accreditation body then contracting by insurers can be based on the external quality assessment of such body and the standards used for accreditation.

### ***Types of insurance***

The above description of insurance characteristics and the details as described in annex 5 illustrate that calling insurance public or private is not decisive for achieving UHC and for having an efficient health financing system. It is the regulatory framework that makes the difference in gearing the mandate of health insurers, the level of compulsion, the chosen collection and pooling of resources and the provided tools for purchasing all towards the potential of UHC. Obviously implementation capacity matters too. The sources of financing as such do not matter that much but the poor cannot be covered without income transfers, solidarity from the rich via either a progressive tax system and/or an income based individual contribution system, possibly combined with an income dependent system of copayments when using services.

Nevertheless different countries have organized their health insurance systems in different ways and with health insurances that differ in the above mentioned characteristics. The main distinction is between mandatory and voluntary systems.

The **mandatory systems** can have different features, described above.

The voluntary systems can be:

- **Substitutive** for the mandatory insurances in case people have either the possibility to opt out of the mandatory system or are not belonging to a category of the population that is mandatory covered.
- **Duplicative** when people, although already mandatory insured, chose to also voluntary join a private insurer offering voluntary insurance with a BP of possibly the same breadth and depth as the mandatory system or even more.
- On top of the mandatory system:
  - **Supplementary insurance** pays for the residual costs of mandatory insured but not fully reimbursed benefits. It extends the depth of coverage.
  - **Complementary insurance** covers those benefits and services that are not covered by mandatory systems. These can be e.g. private rooms and amenities in as such mandatory covered hospital care or medical interventions and national

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<sup>16</sup> MOHSW: The Tanzania Quality Improvement Framework in Health Care 2011-2016. October 2011

or international providers that are not covered by the mandatory system. It extends the breadth of the coverage

This report will use the above definitions of mandatory and voluntary insurances in conformity with the OECD's Taxonomy of Health Insurance although also other and different definitions are used<sup>17</sup>. (See Annex 4 for a more detailed quote of OECD's taxonomy. Besides the referred OECD taxonomy paper on health insurance, a World Bank published handbook also offers valuable additional definitions and concepts<sup>18</sup>.

**Community based health insurance** does not principally differ from other insurances except for its scale. It is mostly voluntary and uses flat rates.

***Choosing the best health insurance arrangements and market structure: who is allowed to operate which type of insurance with which characteristics?***

The above described possible features of health insurances and the indicated advantages of some features as compared with others will be used further on in this report to offer options for the insurance market and may help in choosing the best options in accordance with Tanzania's health policy goals, values and existing market and stakeholders, including the GOT as payer, owner and deliverer of health services.

## **7. Competition between Health Insurers<sup>19</sup>**

Several countries have embarked on using competition between mandatory insurers and hope that this works as an instrument for improving client orientation and efficiency in health insurance administration and the delivery of health services as included in the MBP. However, the supposed effects on efficiency have never been proven and have shown to be difficult to evaluate due to many concomitant other interventions in country health systems<sup>20</sup>. Given the market failure in health care as regards

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<sup>17</sup> e.g. by Mossialos & Thomson their book on Voluntary Health Insurance in Europe (EU Observatory 2004; <http://www.euro.who.int/en/who-we-are/partners/observatory/studies/voluntary-health-insurance-in-the-european-union>);

1. **Substitutive:** cover that would "otherwise be available from the state
2. **Complementary:** "cover for services excluded or not fully covered by the state (including cover of copayments imposed by the statutory health care system)"
3. **Supplementary:** "provides cover for access and increased consumer choice"

<sup>18</sup> Wang, Hong et al: Health Insurance Handbook, how to make it work. World Bank Working Paper 219. Washington, 2012

<sup>19</sup> This section draws heavily from the articles of Ven de Ven and Thomson and from the study of Schneider, quoted hereafter as well as from the personal experience while working in the Dutch health insurance system from 1981 till 1998, and a later study of one of the authors of this report on "Risk adjusted funding in the Netherlands, Bultman, World bank, December 2004.

<sup>20</sup> Thomson, Sarah et al. Statutory health insurance competition in Europe: A four-country comparison. Health Policy, 1020130 20-225

guaranteeing access to basic care, countries that care for access and affordability of care have regulated the competition of health insurers.

### **Challenges**

Those countries that have embarked on competition between insurers in the implementation of mandatory health insurance have been faced with many challenges, most of all with the problem of risk selection by insurers, also called "cream skimming". To stay within their budget, risk selection is easier to do than trying to reduce health services expenditures by improving efficiency of health services providers via purchasing and in-depth provider performance review. It is for the insurer a more effective and efficient policy to stay within budget and prevent premium increases and loose out in the competition. However, ***risk selection reduces access to health insurance and hence to health care for those most in need.***

**Risk selection** comes in many forms, e.g.:

- i. Selective marketing by focusing on the relatively healthy, e.g. the young, the well off and going for collective contracts with enterprises in non-health-risky sectors, and avoiding to focus on the high risk categories: elderly and chronically ill.
- ii. Selective contracting, e.g. not with medical specialists preferred by the chronically ill.
- iii. Using enrolment barriers to supplementary insurance to fend off the chronically ill, in case statutory competing insurers are allowed to also offer voluntary insurance for which they can do risk rating and excluding the high health risks.
- iv. Giving discounts on other insurances, offered in a package together with health insurance, especially via collective contracts with companies

### **Pre-conditions**

To respond to the posed challenges several conditions need to be met, which e.g. neither Belgium, Germany, Israel, the Netherlands and Switzerland have done yet in full despite many years of implementation of a system of competitive health insurance. See annex 6 for more details on competition based health insurance.

- a. Meeting these conditions is very demanding for a health insurance and health services system and are costly to meet (see annex 6)

### **Competition tools**

Assuming that all conditions are met, the following instruments can be used by the insurer as instrument for competition and to distinguish itself from its competitors, if the regulation grants these tools or doesn't prevent their use::

- i. Selective independent purchasing by an insurer of a sufficient number of providers to allow access to necessary care for its insured and using with all possible purchasing features as described above. This does not mean that insurer and providers need to become adversaries. The insurer can reward good performance of providers which offer good quality care, from a professional and a patient perspective. In e.g. Belgium such independent contracting does not exist, all contracts are centrally negotiated. The trade-off in selective purchasing can be the lack of trust in the insurers among insured who fear that they may lose their favorite provider or particular doctor

- ii. An alternative to purchasing is the integration of health services providers into the health insurer as is done by Kaiser Permanente<sup>21</sup> in the USA with mixed success<sup>22</sup> and is also allowed in the Netherlands.
- iii. Giving free choice of provider to the insured. This obviously contradicts the selective purchasing power of the insurer.
- iv. Giving an insured the choice between an in kind system and a reimbursement system, the latter more costly to operate.
- v. Offering additional benefits on top of a defined minimum package, which is not a supplementary insurance with additional premiums.
- vi. Offering different levels of general deductible to insured within legally set margins.
- vii. Being the advocate of the insured, e.g. in finding suitable providers in case of long waiting times for elective treatment.
- viii. Being friendly to its insured in explaining his rights and obligation, and being easily accessible.
- ix. Charging a low contribution rate to insured.
- x. Offering an attractive supplementary insurance. However, if not regulated, insurers can do risk rating and/or exclude people from access to this insurance, thus reducing the possibility for those people to switch insurers and consequently limiting competition.
- xi. Offering discounts on other products the insurer may have on offer.

Obviously, purchasing tools will only work if insurers have the freedom to contract or not to contract and if providers have some level of autonomy to respond to the challenges of purchasers and to improve the quality and cost-effectiveness of their services. Selective purchasing presupposes also some level of oversupply in order to have something to choose from. However, such oversupply comes at a cost, i.e. for additional infrastructure and training of staff, luxuries that are hard to afford in developing countries.

In case providers get their investments paid or subsidized by e.g. the government than they have less incentives to economize their care.

Countries differ as regards the extent they regulate competition and offering more or less instruments for insurers and more or less options for insured to choose from<sup>23</sup>. However, countries can adjust their systems based on evaluation results. Resistance from providers, secrecy from insurers and political opposition impact regulation and its effectiveness. Differences on supply side regulation also have an effect on the regulation of insurers.

***Risk adjusted capitation based funding of insurers*** comes also with many requirements (see annex 6) to operate in accordance to its intention: adjusting for differences in the risks between insurers as regards the differences in the health status of the enrollees in their portfolios as to prevent risk selection and hence people with high health risks being left without health insurance or only on inequitable terms..

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<sup>21</sup> see [http://www.kaiserhealthnews.org/?utm\\_source=khn&utm\\_medium=internal&utm\\_campaign=nav-bar](http://www.kaiserhealthnews.org/?utm_source=khn&utm_medium=internal&utm_campaign=nav-bar)

<sup>22</sup> Abelson, Reed. The Face of Future Health Care New York Times, March 20, 2013; [http://www.nytimes.com/2013/03/21/business/kaiser-permanente-is-seen-as-face-of-future-health-care.html?pagewanted=all&\\_r=0](http://www.nytimes.com/2013/03/21/business/kaiser-permanente-is-seen-as-face-of-future-health-care.html?pagewanted=all&_r=0)

<sup>23</sup> Ven, Wynand van de. Ven, Wynand van de, et al: Preconditions for efficiency and affordability in competitive health care markets: are they fulfilled in Belgium, Germany, Israel, the Netherlands and Switzerland? Health Policy 109 (2013) 226-245.

Despite the long trying to improve systems, especially information systems, and to meet the conditions, no system of ex ante risk equalization between insurers is able to fully predict the health risks, the best is explaining only a meager 22% of expenditures<sup>24</sup>. It took the Dutch 15 years to build a reasonable risk equalization scheme and to still arrive at such meager outcome of 22% prediction. This is caused by the complexity of such system, the vast amounts of required data, spread over 73 cost-categories, and the need to periodically update the set of parameters due to perceived unjustified budget distribution over the insurers because of not incorporated costs for unevenly spread high cost insured. That's why, besides ex ante also ex post equalization for high costs cases was introduced, further adding to the complexity of the system and hence its admin costs. The total cycle took in 2005 four years, from predicting the costs, setting the budgets for the different insurers, paying advances, auditing the numbers of insured and the designated costs, to adjusting the budgets based on actual numbers and acceptable costs and settling on the final amount. The imperfections in the equalization systems in the five review countries offer still substantial incentives for risk-selection by insurers<sup>25</sup>.

Besides elaborating on an equalization system a decision needs to be taken on which institution will operate the system, complying with conditions:

1. Not implementing itself health insurance
2. Independent and impartial
3. Trustworthy for contributors and insurers
4. Necessary human resources capacity, infrastructure and business support systems.

**In conclusion**, using competition between insurers requires quite some regulations and regulatory and supervisory capacity and hence budget while the advantages as compared with a non-competition based system are thus far unproven (See text box 1)

### Text box 1

*"In theory, health insurance competition can enhance efficiency in health care administration and delivery only if people have free choice of insurer (consumer mobility), if insurers do not have incentives to select risks, and if insurers are able to influence health service quality and costs. In practice, reforms in the four countries have not always prioritised efficiency and implementation has varied. Differences in policy goals explain some but not all of the differences in implementation. Despite significant investment in risk adjustment, incentives for risk selection remain and consumer mobility is not evenly distributed across the population. Better risk adjustment might make it easier for older and less healthy people to change insurer. Policy makers could also do more to prevent insurers from linking the sale of statutory and voluntary health insurance, particularly where take-up of voluntary coverage is widespread. Collective negotiation between insurers and providers in Belgium, Germany and Switzerland curbs insurers' ability to influence health care quality and costs. Nevertheless, while insurers in the Netherlands have good access to efficiency-enhancing tools, data and capacity constraints and resistance from stakeholders limit the extent to which tools are used. The experience of these countries offers an important lesson to other countries: it is not straightforward to put in place the conditions under which health insurance competition can enhance efficiency. **Policy makers should not, therefore, underestimate the challenges involved.**" (bolds are from the authors of this report)*

*Thomson, Sarah. op cit*

<sup>24</sup> Schneider, Pia et al: Health Insurance and Competition. World Bank, Report NO.44316-ECA, May 5 2009

<sup>25</sup> Ven, Wynand van de. op cit

## Alternatives for competition

*"If countries have to decide between overhauling the whole insurance system or changing some elements of the existing system to make it more efficient, the latter may provide a larger pay-off"<sup>26</sup>*. Instead of competition, countries can also consider improving the existing insurance system or establishing a non-competitive multi-payer system which are adequately regulated and supervised on the payer and supplier sides. A non-competitive multi-payer system would also offer the possibility of benchmarking insurers and taking action on the outliers.

Mobilizing the community is also helpful

- a. participation in boards of insurers and review panels
- b. enforcing transparency and accountability of insurer operations
- c. publicising wanted and unwanted performance
- d. Household surveys
- e. Free press
- f. Improving health literacy among population

## Equalization in non-competing models

A health risk adjusted equalization scheme can also be useful in case of non-competing multiple insurers:

- Geographically distributed with uniform income based contributions such as in Austria,
- Divided along enterprise-sector lines as e.g. Germany had in the past where insurers directly charged the contributions to their enrollees. To compensate for the differences in health care costs between the insurers.

Such equalization mechanism would need information from the insured populations in either e.g. the Districts/geographical entities or from the enterprise category related insured. Rough parameters are age and gender categories to be related to health services consumption. More sophisticated ones would e.g. take into account the income and education levels of the insured populations and, in case of specific professional activities related morbidity their specific health care costs, e.g. in case of coal mining.

## Cost/effective insurance model

Based on the above it seems that, apart from a national health type of system, the least fragmented insurance mechanism, i.e. a single payer, paid from either taxes, income-dependent contributions or both sources collected via the tax collection system, pooled at the treasury, with mandatory enrolment for all, covering the government set MBP as in-kind system, no financing of operating costs by the government, with comprehensive purchasing tools for the insurer, is the most cost-effective option to realize UHC of an MBP in Tanzania. Of course such mechanism requires effective oversight to keep the single payer focused, assuring the delivery of the MBP by autonomous qualified providers and cost-effective in its administration.

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<sup>26</sup> Schneider, op cit.

## 8. Status Quo of Health Insurance Market in Tanzania

The coverage of the contribution based health insurance schemes in the market is about 16% of the whole population. This is not close to the objective of the GOT to provide health insurance coverage to 45% of the population by 2015. The health insurance market is composed of five (5) key players, the National Health Insurance Fund (NHIF), National Social Security Fund – Social Health Insurance Benefit (NSSF-SHIB), Community Health Fund (CHF)/ Tiba Kwa Kadi (TIKA), Private Health Insurance (PHI) and Community Based Health Insurance (CBHI)/Micro insurance.

**Table 8.1: Description of Health Insurance Participants in Tanzania**

Dimension	NHIF	CHF	NSSF-SHIB	PHI	CBHI
<b>Coverage #</b>	2.5 m beneficiaries (468,611 phs)	3.8m beneficiaries (593,643)	51,300 beneficiaries (31,000 phs)	450,000 beneficiaries (150,000 phs)	440,000 beneficiaries
<b>Coverage %</b>	5.6%	8.4%	0.12%	1.02%	1%
<b>Market segment</b>	Civil servant (+Private)	Informal Low Income H/holds	Formal + Semi formal	Private	Informal Low Income H/holds
<b>Enrollment</b>	Mandatory	Voluntary	Voluntary	Voluntary	Voluntary
<b>Collection meth</b>	Payroll deduction	Remit @ HF	Payroll deduction	Remit to PHIs	Remit to CBHI
<b>Premium range</b>	6% of salary p.m (50/50 for employer/employee)	5,000-15,000 (+Matching grant)p.a	Part of 20% contribution p.m	300,000 – 950,000 p.a	30,000 – 40,000p.a
<b>Benefit package</b>	Medium range1	Primary & some hospital care	Broad range	Full range	Primary & Hospital care
<b>Type of Benefit</b>	In kind	In kind	In kind	In kind + Reimbursement	In kind
<b>Provider payment</b>	Fee for service	Capitation	Capitation	Fee for service	Capitation
<b>Regulator</b>	SSRA	SSRA	SSRA	TIRA	Unregulated

Source: Interviews with Stakeholders, 2013 and FSDT & Cenfri 2012, Insurance Diagnostic Study<sup>27</sup>

- 1. NHIF:** The National Health Insurance Fund is the largest in the health insurance market with 468,611 policyholders, catering for about 2.5M beneficiaries, about 5.4% of the population. Enrollment to the fund is mandatory for civil servants and for private servants and other categories of employees as the Minister responsible for Health may declare from time to time. The Scheme so far is open to

<sup>27</sup> FSDT & Cenfri 2012, Insurance Diagnostic Study for Tanzania, FSDT/Cenfri, Dar es Salaam.

all. Membership is based on employment status and not family. A 6% payroll tax is monthly charged . NHIF pays the providers a fee-for-service (FFS) for providing a medium range benefit package that includes registration fees, basic lab tests, outpatient services including e.g. medicines and further diagnostics, surgery, physiotherapy, optical services, dental services, medical/orthopaedic appliances and spectacles, as well as in-patient specialist care (paid by a fixed rate per day, differentiated per level of health facility). The fund is regulated by the Social Security Regulatory Authority (SSRA) according to the Social Security Regulatory Authority Act of 2008. With a network of 5,426 facilities accredited by NHIF itself, the fund spent Tzs. 78.1billion (~ \$47.9m) in 2011/12 of which 62% (Tzs. 48.4bn ~ \$ 29.7m) was used to pay for benefits, 28% (Tzs. 21.9bn ~ \$13.4m) was administrative expenses and 11% (Tzs. 8.6bn ~ \$5.3m) was miscellaneous expenditure. On the other hand, the fund in the same year collected Tzs. 199.1billion (~ \$122.2m) whereby 80.8% came from contributions, 19.0% from investment income and 0.1% from other sources.

2. **CHF/TIKA:** Community Health Funds and its city equivalent Tiba Kwa Kadi provide basic health insurance cover to low income households, managed at district level which has been rolled out to 112 districts. With 593,643 households, the schemes provide basic health coverage to 3.8m beneficiaries which is about 8.6% of the population in 2012. The scheme covers the informal sector who enroll voluntarily to the scheme by contributing between Tzs. 5,000 (~ \$3) to Tzs. 15,000 (~\$9) per year for a household of six and the government provides a matching grant of equal amount as subsidies upon request by CHF schemes in respective districts. The scheme offers primary and some hospital care which is paid on a capitation basis. Since 2009 the scheme is administered by NHIF and falls under the mandate of SSRA. In 2010 the CHFs generated a revenue of about Tzs. 3bn (~ \$1.8m) of which it used about Tzs. 2.1bn (~ \$1.3m) for provision of health care benefits and 30% for administration expenses as per CHF guidelines.<sup>28</sup>
3. **NSSF-SHIB:** The National Social Security Fund – Social Health Insurance Benefit is one of the benefits offered by the fund to its members, introduced in 2006 as a short term benefit in which 31,000 members have registered. Benefits are received by 51,300 beneficiaries, which are about 0.12% of all enrollees in the NSSF. The scheme is for the formal private sector employees, including companies, non-governmental organizations, embassies employing Tanzanians, international organizations and organized groups in the informal sector. It also covers government ministries and departments employing non-pensionable employees, parastatal organizations, self-employed or any other employed person not covered by any other scheme and any other category as declared by the Minister of Labour. Contribution is collected from the payroll, where 20% of monthly salary contributes to the scheme and part of it goes to the SHIB to provide a medium range of benefits such as outpatient services including consultations, basic and specialized diagnostics, a limited number of medical interventions and pharmaceuticals incorporated in the National Essential Drug list; in-patient services include accommodation, consultation with a Medical Officer or specialist and basic diagnostics which are paid on capitation basis. The regulatory authority for the fund is the SSRA.
4. **PHIs:** Private Health Insurance is estimated to have about 150,000 policyholders with about 450,000 beneficiaries accounting for approximately 1.02% of the population, mainly being enterprise-wise enrolled employees and high-end income private sector individuals. These voluntary health insurance arrangements provide a full range of benefits including inpatient services such as: consultation and general treatment, physiotherapy, intensive care and emergency services, surgery

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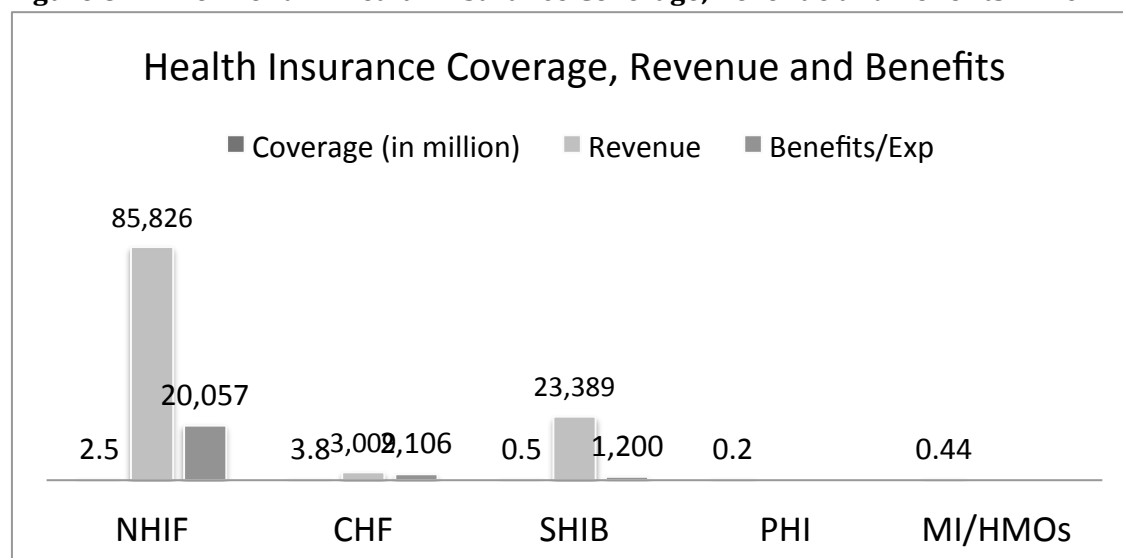
<sup>28</sup> World Bank 2011, Making Health Financing Work for Poor People in Tanzania: A health financing policy note.



services. Outpatient benefits further include: general and specialist consultations, x-rays, laboratory tests, small trauma treatment and maternity services covering medical treatment costs for ailments directly related to pregnancy. Premiums range between Tzs. 300,000 (~\$ 150) to Tzs. 950,000 (~ \$ 600). Providers are paid on a fee-for-service basis. The PHIs are regulated by TIRA conform the Insurance Act No 10 of 2009. About 21% of PHI expenditures are paid for administration of these schemes.

5. **CBHIs:** Community Based Health Insurance Schemes, operating as micro insurance schemes and including NGOs and Donor funded pilot project. They cover about 440,000 individuals which is about 1% of the population in the informal sector. The membership is voluntary, contributing between Tzs. 30,000 (~ \$ 18) to Tzs. 40,000 (~ \$24.5) for primary and hospital care paid on capitation basis. The CBHIs are not regulated.

**Figure 8.2: The Trend in Health Insurance Coverage, Revenue and Benefits in 2011**



Source: Authors Computations, 2013 (Statistics by World Bank 2011, Making Health Financing Work for Poor People in Tanzania: A health financing policy note)

## 8.2 Problems with the current status quo

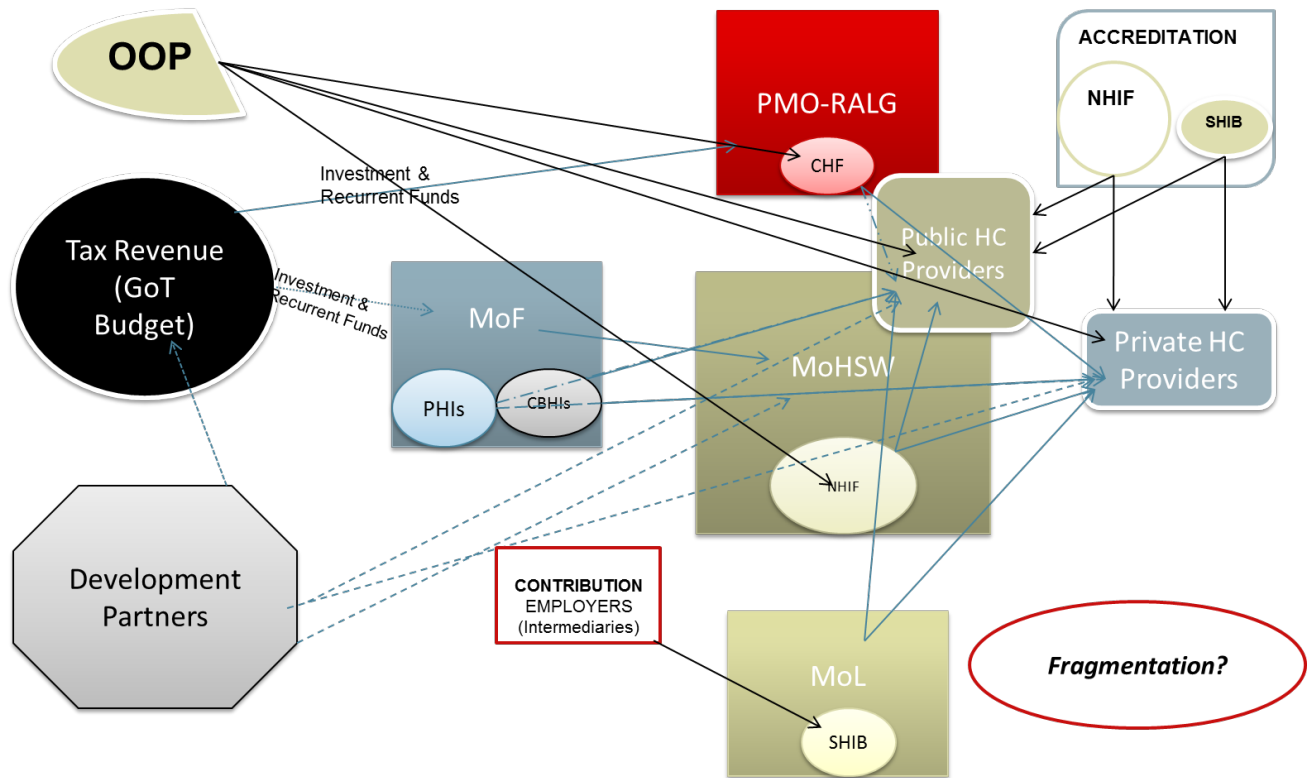
With only two years to 2015, the current health insurance coverage of 16% is only half way to the objective of the GOT to cover 30% of the population. This status is a result of various challenges as pointed out by insurers and other stakeholders. The main challenge observed is fragmentation of the HIM. This fragmentation begins from the top, where different ministries are responsible for different health insurance schemes including the MoHSW, MOF, MOL and PMO-RALG.

The schemes are fragmented, competing sometimes for the same clients without the possible benefits of competition materializing. Other schemes are themselves fragmented such as the CHF's which are restricted to the district level, have no portability and lack the ability to pool the risks more widely and thus cannot gain the pooling advantages expected in any insurance scheme.

Fragmentation within the HIM manifests itself in coordination difficulties of strategizing, resources and functions amongst the actors, duplication of activities and processes, not profiting from economies of

scale, wastage of resources in the absence of an integrated approach and a strategy to achieve formulated policy goals.

**Figure 8.3 Current Health Financing Structure**



Source: Authors (2013)

The current problems can be distinguished in:

- a. Supply side challenges
- b. Stewardship challenges
- c. Demand side challenges

**Supply side challenges:** The supply side is considered to involve the insurers and the providers of health care. The direction of health insurance performance is mainly determined by these two components:

*Insurers:* Health insurers face challenges, which, if addressed, will improve drastically the condition of the HIM as regards coverage of the population and the provision of benefits. These challenges include inadequate reimbursement of the providers, legally fixed contribution rates not geared to actual needs, limited use of collected resources leading to unnecessary reserves with insurers while the beneficiaries are not satisfied with the level of access to health care services. Insurers provide limited feedback (and communication) with the insured and lack of transparency, showing a delayed reimbursement to the

providers,<sup>29</sup> lack of an integrated approach and partnership in issues that require synergy such as accreditation, quality assurance and the distribution of health services infrastructure.

The usage of FFS as the main provider payment approach despite its associated weaknesses, the limited usage of ICT including mobile communication systems to reach the masses and enhance efficiency, multiple accreditation systems that do not ensure delivery of accredited services at the pretended level, high administration expenses, low coverage levels (only 15.7% of the population), weak distribution channels for insurance, mandatory double payments by people into different insurances (NSSF and NHIF), monopolies of insurers catering to distinguished categories of insured while the monopoly associated problems are not addressed.

*Providers:* Providers of health care services have their own share of challenges resulting into limited and unequal access to quality care by the beneficiaries, shortages of essential drugs which providers are supposed to have at their disposal, lack of equipment, stereotype against beneficiaries of health insurance where insured stay in queue and are treated in a separate window (different from OOP patients), poor understanding of other provider payment approaches such as capitation and case based payment systems. Health services are inefficiently provided, lack transparency in the manner the revenues are used, show abuse of health insurance by unprofessional health workers and show high inflation rates<sup>30</sup> of medical costs. Rural dwellers have limited access to care due to absence of facilities or to travel distance to the health facilities while lacking means of transportation.

**Stewardship:** The responsibility of overseeing the health sector primarily lies with the government which executes it through ministries, departments and agencies. As noted earlier, this area is fragmented: four ministries are responsible for the HIM: MOL for NSSF-SHIB, MoHSW for NHIF, PMORALG for CHF and MOF for PHIs. Two government agencies are responsible for regulatory oversight – the SSRA and TIRA. MOHSW and District governments have dual and conflicting roles as owners of health facilities, employers of health staff and at the same time MOHSW overseeing NHIF, i.e. there is no purchaser-provider split leaving NHIF with limited purchasing power.

*Ministries:* The ministries pose various challenges related to HIM and the providers paid by insurance, such as inability to supply timely and adequately needed medical supplies, lack of sufficient health facilities, inadequate human resources for health, a conflict of interest exists in inspection and quality assurance whereby the owner of the facilities (MoHSW) simultaneously does inspection and quality assurance with lack of autonomy of the inspection and quality assurance unit. The department responsible for IQA is under the ministry and inspect hospitals which are also under the ministry.

The government has apparent difficulties in structuring HIM to ensure its sustainability, equity, feasibility and efficiency, in the absence of an integrated strategy and subsequent actions towards all components of the HIM to ensure attainment of the GoT HI goals *Regulators:* SSRA and TIRA have the responsibility to oversee compliance with the regulations by the players in the HIM. However, they face several challenges to implement this responsibility: The limited mandates of especially SSRA and the grey zones as regards the regulation of HMOs and medical benefits management organizations and secondly the inability to implement their regulatory role (particularly SSRA which has recently started) due to their limited mandate and lack of sufficient human resources, business support systems and infrastructure<sup>31</sup>.

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<sup>29</sup> Findings from interview with key stakeholders

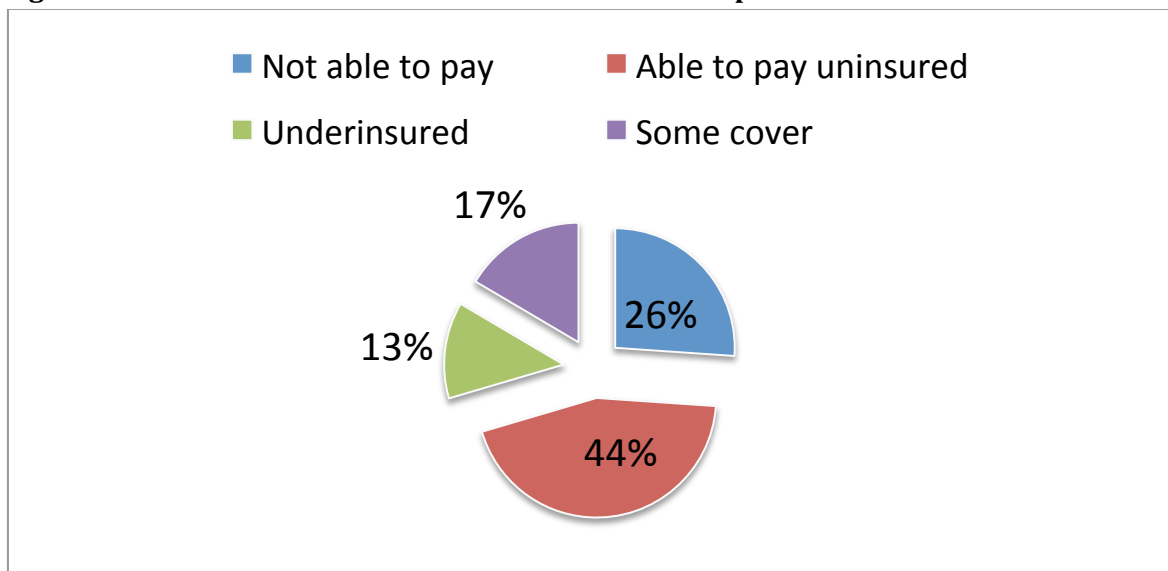
<sup>30</sup> In 2012 it was between 43% to 100%

<sup>31</sup> Bultman, Jan et al: Tanzania Health Insurance Regulatory Framework. Review on request of the Ministry of Health and Social Welfare and the Social Security Regulatory Authority. GIZ/P4H. Dar es Salaam, March 2012

*GOT:* The Government of Tanzania also faces various challenges resulting in discrepancies between budget formation and budget execution as regards the health sector aggravated by the late receipt of monies by the sector. The matching grants which are anticipated to be received by CHF at district are rather low, reported at only 34% of the actual due amounts because of qualification obstacles and understanding of the procedure by the district health management councils. Again, other sources of financing health care have not been explored. Identification of the poor for waivers and exemptions of health insurance contributions and copayments is still a challenge due to the lack of appropriate instruments. There are no tax incentives for health insurers (especially PHIs) and for individuals who enroll to encourage enrollment, widen the risk pool and providing a basis for extending the benefit package.

**Demand:** The growth of health insurance and the HIM is hindered by the lack of awareness and understanding of policyholders, beneficiaries and the public at large, dropping out from the schemes, by low income levels and thus inability to pay for needed health insurance cover, lack of willingness to join health insurance for various reasons particularly by the middle income group and abuse of health insurance by members.

**Figure 8.4 Potential Insurance Demand of the Adult Population**



Source: Authors Computation 2013, Data Financial Sector Deepening Trust2012, Tanzania Access to Insurance Diagnostic<sup>32</sup>

## 9. Health Insurance Markets Abroad

### Introduction

The way other countries have organized their health financing systems and structured their markets can provide insights in the possible options and features of such markets and their positive and negative effects on achieving the objectives of UHC, covering a decent MBP at reasonable costs. However, the specific context of a country, its size, its geography, its population size, its culture, the health literacy of its population and a host of general characteristics such as governance, consumer protection and general market regulation need to be taken into account when considering specific country systems. As regards the relative cost-effectiveness of specific country health financing systems, it is also necessary to look at the other building blocks of a health system, e.g. the effectiveness of health services supply side regulation via planning and price/fee setting mandates.

Hereafter examples are being provided of how countries have organized their health financing systems. Some proxy indicators are described which reflect the success of these systems.

What is not described is why countries have ended having the systems they have and what it took to get there. Many countries have taken a long time to develop their systems and are still adjusting to emerging needs for care, for cost-containment and consumer preferences while the supply side is pushing to get its services and technologies paid from the public purse.

### Low income countries (LICs)

Low income countries have put in place reforms towards Universal Health Care (UHC) and Universal Health Insurance Coverage (UHIC) for the whole population. Some of these are Burkina Faso, Senegal, Gambia, Gabon, Rwanda, Ghana (referred to as the example of best practice) and Kenya. In this report, three countries have been reviewed, viz Ghana, Rwanda and Kenya. While there are important lessons to be learnt, the differences in politics, economy, socio-cultural dynamics, geographical and population differences and technological pace should be taken into consideration.

**Ghana** operates a three tier health insurance system: District Mutual Health Insurance (DMHI) schemes subsidized by the government from tax (2.5% VAT) and from NHIF, to which every employee contributes 2.5% of his income as social security contribution<sup>33</sup>. Membership of DMHI is portable, allowing beneficiaries to access services in different districts. PHI and Private Mutual Health Insurance provides a second and third voluntary insurance option, not receiving subsidies.

The National Health Insurance Authority licenses, monitors and regulates operations of health insurers. The NHI System accounts for 30% of public health expenditure. Public health expenditure are 16% of the THE and there are no co-payments.<sup>34</sup> Insurance covers about 54% of population. Objectives of the UHIC in Ghana are to improve health outcomes, financial protection, equity, responsiveness to consumers and sustainability. The NHIS has been built on the system of Community Health Insurance. It is an example of demand side financing with legislated UHIC that caters for vulnerable group.

According to Schieber et al, (2012), Ghana is one of a very few emerging market countries to take serious steps toward demand-side financing for health, pass legislation for universal health insurance coverage, begin implementation by covering vulnerable groups, while significantly expanding enrolment, and

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<sup>33</sup> See, World Bank, (2011), Making Health Financing Work for Poor People in Tanzania: A Health Financing Policy Note, Human Development Department, Africa Region.

<sup>34</sup> See, Schieber, G. et al (2012), Health Finance in Ghana at Crossroads, World Bank.

earmarking substantial resources to support the system. The revenue base for Ghana's overall health financing system is largely progressive, and NHIS relies on a diversified set of largely progressive funding sources, resulting in significant and stable sources of revenues. Ghana's approach is pragmatically built on its existing system of community-based health insurance plans transitioned into DHMISs and is evolving toward a uniform national system. According to NHIS, active membership in 2010 is 8.16 million, some 34 percent of the population. Since 2005 outpatient visits have increased 23-fold, inpatient service use 29-fold, and expenditures by 40-fold (Schieber et al, 2012).

With current expenditure and expansion plans, the NHIS is not financially viable and is projected to be insolvent possibly as early as 2013<sup>35</sup> (Schieber et al, 2012). Premiums, taxes, and reinsurance payments for NHIS and to DMHISs are not actuarially determined, and premiums for informal sector workers are low relative to their costs. The original health insurance law does not require a necessary reserve fund. The basic benefit package (BBP) is heavily biased toward curative care; coordination with MOH vertical programs is poor; and, coverage of 95 per cent of the Burden of Disease (BOD) with no cost sharing may not be affordable. Lack of an effective gatekeeper system, an ineffective referral system, and misaligned provider payment incentives preclude NHIS from being an effective 'active' purchaser. Large numbers (e.g., perhaps on the order of 30 per cent) of the 65 per cent premium exempt members could afford to contribute. The stringent definition of indigent excludes some poor and near poor. Lack of a modern management information systems results in poor claims management and quality assurance, high administrative costs, and incomplete information on enrollees and providers.

Reforms have been in motion since July 2010. Establishing a consolidated premium account for all districts, a consolidated claims management centre, requiring payment plan preparation to all DMHIs managers, de-accredit private facilities run by full time public staff and introduce capitation based payment for outpatient care and case based payment for inpatient care, adjusted quarterly are some of the reforms that are intended to improve performance of the health insurance. However, Schieber et al (2012) provides the following reform suggestions:

1. At least maintaining the share allocated to the health sector of any new revenue, either from economic growth or improved revenue collection.
2. Ensuring that the full amount of commitments from all sources is transferred to the NHIF in a timely manner.
3. Optimizing the mobilization of resources *within* the NHIS through enforced means-tested premiums and possibly strategic copayments to both add to the revenue base and direct utilization toward more cost effective services.
4. Re-visiting the NHIS eligibility and benefit package to be sure they are rational given the economic realities in Ghana. The comprehensive benefit package may be sustainable if it is combined with appropriate cost-sharing and serious provider payment/cost-containment reforms.
5. Embarking on an effective strategy of strategic purchasing within the NHIS to use provider payment systems and other purchasing tools to contain cost growth, improve the cost-effectiveness of service utilization, and drive greater efficiencies in the health system.
6. Addressing the severe operational inefficiencies within the NHIS particularly claims processing bottlenecks and the slow process of automation and HMIS modernization.

7. Addressing the inefficiencies in the health service delivery system, particularly high administrative costs and low health worker productivity.

8. It also is necessary to examine the large transfer of funds from the NHIS budget to the MOH. It is not clear why such large subsidies are being made back to the MOH, and whether the funds would be more effectively used to augment the demand-side financing and cover a larger share of the health system's operating costs through the provider payment mechanisms of the NHIS.

Ghana has made substantial progress in transitioning the NHIS into a functioning health insurance program for a significant part of its population. However, its future is now dependent on strategic health policy choices and an effective transition to universal coverage. Those choices will determine whether the NHIS becomes an effective health insurance entity for the entire Ghanaian population and a true global 'best practice', or another stage in Ghana's quest for universal coverage.

**Table 2: Health Insurance Market Structure in Selected Low Income Countries**

	GHANA	RWANDA	KENYA	TANZANIA
<b>Population/Size</b>	25m / 240,000km <sup>2</sup>	12m / 26,000km <sup>2</sup>	44m / 581,000km <sup>2</sup>	48m / 945,000km <sup>2</sup>
<b>Life exp/birth</b>	65.32	58.85	63.29	60.76
<b>HDI ranking:</b>	135 <sup>th</sup>	166 <sup>th</sup>	145 <sup>th</sup>	152 <sup>nd</sup>
<b>TI ranking</b>	64	50	139	102
<b>THE % GDP</b>	5.2 (2010)	10.5 (2010)	4.8 (2010)	6 (2010)
<b>Coverage MBP</b>	Universal	Universal	Not defined	Not defined
<b>Breadth</b>	STC ++;	STC ++; LTC +	30%	
<b>Depth/OOP</b>	37%	6%		
<b>Funding source</b>	T. (+eT), P., & C	T., P., & C.	T. (+eT), P., & C.	T., P., & C.
<b>Payer</b>	Multiple payer	Multiple payer	Multiple fragmented	Multiple fragmented
	SHI, PMHI and PHI	MHOs, FNG & FSD provides risk equalization and cross subsidization	Budget	Budget
	Households	RSSB, MMI for formal sector	NHIF	NHIF
	Budget	Cross subsidies	PHI, CBHIs	PHI, CHF/CBHI
	Subsidies/Cross subsidies			
	<b>GHANA</b>	<b>RWANDA</b>	<b>KENYA</b>	<b>TANZANIA</b>



<b>Premium set by</b>	Insurers & government	Insurers & government	Insurers	Insurers & government
<b>Collected by</b>	Insurers & government	Insurers (tontines)	Insurers	Insurers
<b>Reinsurance</b>	NHIF	FNG & FSD	n/a	n/a
<b>Coverage</b>	12.5 m ~ 54%	~91%	~ 18%	15.60%
<b>Position of the insured</b>	Mandatory membership to NHIS-formal employees	Voluntary for informal ~ 91%	Mandatory for formal sector (NHIF)	Mandatory for formal sector (NHIF)
	Card used for any hospital, no copayment	Mandatory for formal sector (5%), co pay introduced	Voluntary for informal sector	Voluntary for informal sector
<b>Cost control</b>	Consolidated claims mgt centre	Weekly report	N/A	
	Unitary contracting & capitation	Financial modeling tool		
<b>QA / Accreditation</b>	NHIA	MoH, Boards	MoH, Boards	MoHSW, Insurers
<b>Regulation</b>	NHIA	RSSB/MMI Boards, MoH	NHIF Board, MoH	SSRA, TIRA
<b>Evaluation</b>	Continued enrollment suggest support by the people.	Mobilization in the community has created ownership by the population	?	?
	WHO refer to Ghana as 'Best practice model'			

T = Taxes, et = earmarked taxes, P = Premium , C= Cross subsidies

Compilation: Authors, 2013

**Rwanda** has reached the highest levels of coverage, providing health insurance to 96% of its population of 12m people, where 5% are in the formal sector, insured by RSSB and MMI. 91% of the population is in the informal sector and are insured by District Mutual Health Organizations (Mutuelles). This move started in 1998, where MHOs were related to existing structures of communities in 2003. Local authorities, NGOs, FBOs and religious leaders took a mobilization role. All health centres provide services to an MHO. A virtual pool for all MHOs has been established as District Risk Pool and National Risk Pool to address pooling fragmentation. FSD is funded by MHOs, LGAs, FNG and Donor funds. FNG is funded by the government, insurers (MOH, RSSB, MMI and private insurers) and Donor funds.

Contribution rates have been changed from RWF 2,500 – 3,500 in 1999 to equal payment of RWF 1,000 between 2005-2011. From 2011, contribution rates are categorized into three groups: (i) indigent – RWF 2,000 (paid by the government), RWF 3,000 with co-payment for middle income group forming majority of the population (68.8%) and RWF 7,000 for the high income individuals.

Despite the success of the Rwandan HIS, some challenges still persist in the categorization for different contribution categories (Ubudehe - a community targeting mechanisms is currently used which categorizes the population according to revenue and vulnerability into 3 tiers) and in regard to drop-outs for those who cannot afford or will lack incentive to renew membership.

**Kenya** has many features similar to Tanzania including progress towards health financing reforms that are still underway, population size, structure of the health insurance market and geographical variations. Health insurance coverage is only at 18% of the population, with the National Health Insurance Fund covering 2.8m members, the PHI covering 700,000 members and CBHIs covering 450,000 members<sup>36</sup>. Regulation is fragmented amongst the NHIF board, the Ministry of Health and Insurance Regulatory Authority (for PHI).

The ongoing reforms intends to expand coverage of social health insurance to achieve UHC by expanding coverage to the poor and informal sector, revisit the NHIF Act and its role, increase efficiency in tax financing, compensate rural facilities and removing user fees, improve resources and infrastructure and strengthen PHI.<sup>37</sup>

#### **Lessons from LICs:**

- Strong government and good stewardship are essential for success and sustainability.
- Reaching the informal sector and poor households requires building on existing community structures.
- Conflict of interests must be avoided such as public health staff owning private health facilities and MoH owning public health facilities.
- Processes must be simplified to fasten process to avoid backlogs in payment.
- Controls especially through the use of HMIS for the collection of premiums and the processing of claims reduce abuse.
- Identification of the poor is difficult.
- Earmarked taxes enhance sustainability of the schemes and the inclusion of the poor.
- Fragmentation must be controlled by creating virtual pools.

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<sup>36</sup> See, UKE, 2013, Kenya Health Policy 2012 – 2013, Ministry of Medical Services and Ministry of Public Health Sanitation

<sup>37</sup> Ong'uti, E. (2012), Towards Universal Health Coverage in Kenya: Draft Health Financing Strategy, Ministry of Health

- A successful system depends also on the context of a particular country.

### **Middle income countries (MICs)**

Two lower middle income countries are presented as HIMS' examples. Both have contribution based health insurance and strive for UHC. In both countries, the poor informal sector is sponsored from general an/or local taxes. Thailand (see Text Box 2) has achieved UHC with the establishment of a Universal Coverage Scheme (UC) in which all have been invited to enroll who are not mandatory enrolled in the Social Security Scheme (SSS) for the private formal sector or in Civil Servants Medical Benefits Schemes (CSMBS), without making any contribution. Funding from the UHC comes directly from the MOF, i.e. it is fully tax based. The other two have their resources from an income dependent payroll tax. The three schemes have their own pools of funding for their own enrollees. The SSS and CSMBS were first established and the gap in coverage for the poor and informal sector was subsequently noted and closed albeit that the BPs of the schemes differ. The Philippines has a single national insurance (PhilHealth) which is mandatory for the formal sector. Others can enroll voluntary and the poor can get their contributions paid by local governments. This latter with mixed success (see Text box 3). The geography of the Philippines, consisting of 9000 islands, also plays a role, making communications difficult. The particulars are in Table 3.

**Table 3 Health Insurance Market Structure in Middle Income Countries**

HIMS/HICs <sup>38</sup>	Thailand <sup>39</sup>	Philippines <sup>40</sup>
General		
• Population	74M	96.5 M
• life exp/birth	74.3	69
• HDI ranking:	103	114
• TI ranking	172	105
• THE % GDP	4 (2008)	4.1
• PHE % GDP	2.9	2.9
• Pop. below \$1.25 PPP per day (%)	0.4	18.4
Coverage MBP	Universal but BPs differ SSS (15% Pop); CSMBS (8% ); UC (75%) Relatively comprehensive	83% Pop
• Breadth	14	Relatively comprehensive
• Depth/OOP % THE		56
Funding source	T (mostly), P & C	T, P & C
Payer	Multiple Public Non-competing SSS (private sector), CSMBS (civil services) & UC (remainder of Pop.) via a multitude of ministries, public agencies and e.g. hospitals acting as payers of PHC.	Single national public HIF with subsidies from LGAs for enrolling the poor + individual premiums

<sup>38</sup> General info based on UN data 2012, Transparency International Corruption Perception Index 2012

<sup>39</sup> Based on: a) Lindelow, Magnus et al: Government Spending and Central-Local Relations in Thailand's Health Sector. Health, Nutrition and Population Discussion Paper, World Bank, 2011. b) Hanvoravongshai, P: Health financing reform in Thailand- Towards universal coverage under fiscal constraints. World Bank UNICO Study Series No.20.2013.

<sup>40</sup> Based on: a) Philippines, Study on Local Services Delivery, World Bank, March 2011; b) PhilHealth Statistics [http://www.philhealth.gov.ph/about\\_us/map/phro8/statsncharts/stats&charts\\_April2012.pdf](http://www.philhealth.gov.ph/about_us/map/phro8/statsncharts/stats&charts_April2012.pdf) . c) Bultman, Jan: Philippine Health Insurance Corporation, Road

HIMS/HICs	Thailand	Philippines
Public HI offers	Public Mandatory HI Formal Sectors Voluntary HI Informal sector in UCS scheme	Public mandatory HI Formal sectors (64% enrolled) Voluntary enrolments of professionals and the informal sector Substitutive PHI
Premiums set by Collected by	GOVT Tax office	Law Philhealth
Reinsurance	NA	NA
Position insured	Differences in utilization due distribution of services	Members can file complaints. Enrolment of indigents depends of local politicians. Choice from all available providers, and no referral system
Cost control	Effective with purchaser provider split, but challenges: OP: FFS IP: DRGs Capitation (UC & SSS) HTA~MBP	Limited due to reimbursement system with partially covering costs. Ineffective claims control. No purchaser provider split
QA/Accreditation	Standards for structure and staff of providers. Inspectors. Independent Nat. Public voluntary Accreditation Program; necessary for getting contracted and paid by public schemes. All care levels. JCI accredits tourist hospitals CQI HTA	Implemented by PhilHealth as condition for contract. Provider performance & claims review. HTA used for MBP decisions QPG development
Regulation Supervision	MOH UCS: National Health Security Board (NHSB) ; National Health Security Office (NHSO) Participatory approach	DOH DOH Nat Accounting Authority
Evaluation	Impressive results but highly fragmented fin system; inefficient; inequality in access due to Nat/LGA allocation issues and GOT paying staff salaries. Differing BPs across schemes. Ill-tuned national and sub-national GOVT and payer levels due to decentralization process with duplicating responsibilities.	Dual structures of National HI and Decentralized Govt and volatile sponsor program lead to ineffective health services distribution and uncovered indigents. Limited depth of BP: "PhilHealth offers me a nice discount" . Balance billing by providers, i.e. when reimbursement levels to insured go up and hence OOP should go down, providers increase their fees.

Thailand's schemes use provider payment systems that differ from each other. CSMBS is the one using a fee for services system to which its relative high costs are ascribed. In general, the combination of centralized cost-control via the monopsony position of NHSO and because of its GDP growth has helped in covering the poor and informal sector, supported by an effective mechanism for identifying the poor.

Comparing the two countries shows that both struggle with balancing the roles of national authorities on the one side and national organized insurance on the other side. This is most striking in the Philippines where local authorities behave quite independent and where the system is politicized, see Text Box 3 .

Political will and good governance with clear responsibilities and avoiding the frictions of territorial decentralization (devolution) of government and the functional decentralization of financing are key aspects in realizing an effective and efficient system. The Philippine system has limited financial protection, hence the high OOP, and has limited means for cost control due to the existence of a reimbursement system based on BP and the absence of tariff control. The Philippine PhilHealth operated accreditation system but discussions are going on already for a number of years to outsource accreditation to an independent body. Thailand has an independent public accreditation body<sup>41</sup> for voluntary accreditation, striving at continuous quality improvement. Some top-level hospitals offering services to foreigners have been accredited by the Joint Commission International from the United States.

Thailand and the Philippines show that it is impossible to cover the poor but from general government revenues. Both countries could gain by further aligning their governance and regulatory framework for health insurance and by adjusting the payment mechanisms to incentivize the providers while preventing unnecessary use of services. The Philippines could gain from using selective contracting and better options for fee control, preventing "balance billing".

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<sup>41</sup> Jiruth Sriratanaban: Hospital Accreditation as a System Regulatory Mechanism: A case of Thailand . [http://ps4h.org/baliday3r/Jiruth%20Sriratanaban\\_Case%20\(BARU\)\\_Session%204.pdf](http://ps4h.org/baliday3r/Jiruth%20Sriratanaban_Case%20(BARU)_Session%204.pdf)

## **Text Box 2      Thailand**

### **Thailand's "Pathway toward Universal Coverage"**

*The historical development of the health insurance system toward universal coverage in Thailand can provide useful lessons for other lower- and middle-income countries. Even though the major coverage increase happened with the introduction of the 30-Baht Policy (subsequently UCS) in 2001, Thailand had introduced many health insurance programs and schemes over at least three decades, with mixed success. Since the early 1990s, there have been regular debates and discussions about how to achieve universal coverage, and particularly how to cover the informal sector.*

*The first major health insurance program was implemented in 1975 to cover the poor. The Medical Welfare Scheme was established by the MOPH to exempt the poor from user fees at government health facilities. The program later expanded to cover the elderly, children, and other underprivileged groups. Although helpful for the underprivileged groups, the program suffered from ineffective targeting and was seriously underfunded (Pannarunothai and Mills 1997).*

*Following the Medical Welfare Scheme, there were additional health insurance schemes for formal sector employees. The Civil Servant Medical Benefit Scheme (CSMBS) was established in 1980 to cover civil servants, public employees, and their families. The Social Security Scheme (SSS) for private employees was first introduced in 1990. Efforts to expand coverage to informal sector workers were tried with community financing schemes in 1983 and the Voluntary Health Card Scheme in 1991. However, neither program was successful due to the problems of adverse selection and moral hazard that derived from their voluntary nature.*

*It was clear to policy makers and technocrats that relying on the Voluntary Health Card Scheme or existing schemes (CSMBS and SSS) to expand their coverage to the uninsured population would not be successful. There was strong opposition from SSS beneficiaries, especially employee advocacy networks, which strongly opposed expanding the SSS to other groups out of fear that the existing fund would be used to subsidize the remaining population. The Social Security Office was also concerned about the actuarial feasibility and limited support from its tripartite stakeholders (especially employers). In fact, the SSS was reluctant to expand to small enterprises (that is, those with less than 10 employees) or to employees' dependents, let alone to the informal sector. At the same time, the CSMBS was for a specific population (civil servants) that would be incompatible with the informal sector. Also, the scheme was in itself inefficient and unaffordable to be used for the uninsured. The chosen approach, therefore, was to abolish the Medical Welfare Scheme and the Voluntary Health Card Scheme, and to reform the health financing systems to create a new financing scheme for the non-CSMBS and non-SSS population.*

*Thailand's path toward universal coverage relied on a common approach of starting with the poor and informal sectors. It soon realized that, like in most countries, expansion to the informal sector was a serious challenge. Voluntary health insurance is not an option unless there is a strong sense of solidarity in the community because of serious adverse selection problems. The existing health financing schemes were too rigid to expand to the broader population because they were not designed to deal with the "big picture" of providing a health financing system for the entire population.*

*Nevertheless, Thailand learned many lessons from previous health, welfare, and insurance schemes. The development of a health financing infrastructure and technical know-how from the experience gained from previous schemes allowed the system to adopt a new scheme for universal coverage when the political environment was open to a major change. Political leadership was necessary. Having committed policy champions to drive the movement toward universal coverage on both the technical and political fronts was instrumental. With a supportive political climate, policy champions, and infrastructure, Thailand achieved universal coverage in 2002. However, there is still some degree of fragmentation, and there are still problems of inequity across insurance schemes, which the country is struggling to address.*

*It may not be feasible or affordable for a low- or middle-income country without major health insurance schemes to design a comprehensive universal coverage scheme for the entire population, to be implemented all at once. The country will likely be required to make a tradeoff between having a comprehensive benefits package for specific populations or providing limited benefits for the entire population. Thailand chose to start with comprehensive benefits coverage for specific populations, starting with the poor and informal sectors. The Thai experience shows that it is important to ensure, from the beginning, that all emerging schemes share a "game plan," local technical capacity, and a similar vision of a harmonized health financing system to achieve universal coverage."*

Source: Hanvoravongchai, P: Health financing reform in Thailand-Towards universal coverage under fiscal constraints.

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The bolds in the text box hereafter are from the authors of this report . LGUs are local government units.

**Text Box 3      Philippines**

*The National Health Insurance Act of 1995 assigned the responsibility of identifying and enrolling indigents in the PhilHealth social health insurance program to LGUs. In practice, however, the case study LGUs showed limited interest in expanding coverage until either the national government or a local congressman provided additional financial contributions. **One reason for the LGUs' lack of interest in expanding PhilHealth coverage is political. From local politicians' perspective, funding the enrollment of indigents to the national health insurance program ran counter to the pervasive local political culture where local politician extend direct assistance to poor constituents who seek assistance for emergencies. Simply put, local officials would much rather reserve discretionary funds to provide personalized, direct assistance to their poor constituents rather than allocate these to support the full coverage of indigents under a national program.** These anecdotes from the case study LGUs indicated a very unstable base of indigent health care coverage at the local level and suggested that the enrollment of indigents in the national health insurance program was strongly contingent on national-level support. For their part, local health staff were not as interested in receiving PhilHealth patients because the reimbursements from PhilHealth did not usually flow to the facilities where the services were provided but instead into the LGU's treasury. This practice significantly weakened the potential of health insurance payments as a source of incentive for better and most cost effective service delivery at the facility level.*

*Source: World Bank: Philippines, Study on Local Services Delivery, March 2011*

Some **key lessons**<sup>42</sup> can be drawn from the Thailand example which apply also to the Philippines and most likely also to Tanzania:

- *"In countries with a large informal sector, general tax revenue is the most practical source of funding for universal coverage*
- *Adequate and appropriately distributed health infrastructure and staffing and a primary health care approach provide the foundation for universal coverage*
- *Management through an autonomous national agency strengthens the purchasing function, assists cost control and raises proper service quality*
- *Building institutional and human resources capacity for management of universal coverage schemes is essential."*

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<sup>42</sup> Chris Bates & Peter Annear: Lessons learned from Thailand's universal health care scheme: Institutional and organisational arrangements. Nossal Institute for Global Health, University of Melbourne. Issues brief May 2011



## **High Income Countries (HICs)**

Table 4 hereafter depicts some high income countries showing different ways of paying health services while all have a good life expectancy. **England** shows for the year 2010 the lowest THE% of GDP with the lowest OOP while population and health staff are happy with the NHS and its results are seen as good<sup>43</sup>. The English system is mainly funded from general taxes and a special health insurance tax which also goes into the national tax pool. **France** has a multiple but non-competing system of insurers of the MBP with mutuals offering voluntary insurance, mainly to cover the OOP since the national mandatory system does not pay the full costs of services. It is worth noting that French voluntary insurance is forbidden to cover the copayment necessary for self-referrals to hospital or to a medical specialist, other than the "chosen doctor" the insured has registered with as his referral doctor. This "chosen doctor" needs not to be a generalist (GP) but can be e.g. a cardiologist or diabetologist, preferred because of some chronic disease. The three other countries have systems of mandatory insurance implemented by competing insurers but differ in the organization of their system and their systems of risk equalization between the insurers.

*"In **Switzerland**, a uniform benefit basket is defined and insurers are not allowed to modulate it. Insurers are required to collect uniform premiums from all their enrollees but can offer lower premiums in exchange for "managed care plans" or higher cost-sharing.*

*In the **Netherlands**, insurers are allowed to modulate the benefit basket only upwards. The basic insurance package is set by the national government; insurers cannot fall below this level of coverage. Insurers can offer a lower premium (up to 10% lower) to people enrolled via a collective contract. Collective contracts can be "closed" (e.g. negotiated by an employer and reserved to his employees) or "open", i.e. negotiated for instance by a consumer group and open to everybody who wants to enroll. Premiums can also vary according to the coverage model (in-kind benefit versus reimbursement)*

*In 2007, **Germany** adopted an important reform which took effect in 2009. Health insurance funds now collect contributions as a uniform percentage of gross wage or income. Contributions are pooled in a central national fund, together with tax-financed subsidies paid by the federal government to cover children. The central fund then re-distributes a uniform capitation rate to health insurance funds, adjusted for age, gender and about 80 chronic conditions. Funds are given more flexibility to define benefits covered. Funds can offer plans with additional benefits in exchange for higher cost-sharing or acceptance of a set of constraints, such as restricted provider networks, or specified health care pathways (7.4% of the insured were enrolled in such plans in 2008). Funds can also offer options with lower premiums and higher cost-sharing, as well as no-claim bonuses. Health insurance funds with a financial surplus are also permitted to offer additional benefits or premium rebates while funds with a deficit may be obliged to charge their enrollees an additional premium, capped at 1% of the insured's gross wages or income"<sup>44</sup>.*

The details of these three countries' regulation and equalization systems are described in more detail in Annex 6. Suffice it here to note that the insurers are strictly regulated to prevent and compensate for potential market failures. None of these systems have fully succeeded in the prevention of risk selection, thus people in ill health still run the risk of either limited access or having to pay higher contributions for their main and/or their supplementary/complementary insurances (see chapter 7). All countries struggle

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<sup>43</sup> Delamothe, Tony: NHS at 60, How the NHS measures up BMJ 2008;336:1469-1471 (28 June).

<sup>44</sup> Paris, V., M. Devaux and L. Wei (2010), "Health Systems Institutional Characteristics: A Survey of 29 OECD Countries", OECD Health Working Papers, No. 50, OECD Publishing. <http://dx.doi.org/10.1787/5kmfxfq9qbnr-en>

to keep their health care costs in check. The French mandatory system has run a deficit of currently around 2 Billion Euro, which adds to the French National debt. All countries use health technology assessment of current and emerging health interventions, medical procedures, drugs and supplies in the decision making about their BPs and/or the reimbursement of these technologies.

In none of the 5 countries has health insurance a mandate in the organization and implementation of accreditation of health services providers, which is obvious for England. France has a mandatory system, the other systems are voluntary. France is also doing credentialing of medical specialists to restrict high risk medical procedures to specialists with proven experience. In the Netherlands insurers are beginning to use in their contracting of hospitals volume standards for interventions that show a high variation in e.g. survival rate. These volumes are set in consultation with the associations of medical specialists and aim at improving quality of care. Low volume hospitals are not selected for these interventions.

**Table 4 Health Insurance Market Structure in High Income Countries<sup>45</sup>**

HIMS/HICs <sup>46</sup>	CH <sup>47</sup>	D <sup>48</sup>	F <sup>49</sup>	GB <sup>50</sup>	NL <sup>51</sup>
General					
• life exp/birth	82.5 (2012)	80.6	81.7	80.3	80.8 (2012)
• HDI ranking:	9 (2012)	5	20	26	4 (2012)
• TI ranking	6	13	22	17	9
• THE % GDP	11.4 (2009)	11.64 (2010)	11.8 (2010)	9.6 (2010)	14.9 (2010)
Coverage MBP	Universal	Universal	Universal	Universal	Universal
• Breadth	STC ++; LTC +	STC ++; LTC +	STC ++, LTC +	STC++, LTC +	STC++;LTC++
• Depth/OOP	30%THE (LTC)	13.2% (STC)	7.3%	<4% (STC)	10.7%; LTC
Funding source	T & P	T & P	T & P	T & P (HI Tax)	T&P
Payer	Multiple PHI	Multiple competing Non-profit	Multiple non comp. SHI, enterprise type	NHS via NHS Commissioning Board.	Multiple PHI
• Single (pub/priv)	Non profit	SHI & For profit PHI	organized	NA	For Profit
• Multiple	Competing	Ex Ante RE/CF, separate for SHI & PHI.	Cross Subs.		Competing/STC
○ Non	Ex Ante RE/CF	Cross Subs	- Budget		RE: Ex ante & ex post
○ Comp	LGA subsidizes hospitals	- Budget	-Sin taxes		via CF
○ Comp	Cross Subs		-Soc Security		Insurers pay
○ RE	- Budget				investment costs
	-Non-HI				

<sup>45</sup> All countries have a purchaser-provider split or are realizing such. Most medicines cost control is on national level via negotiations, claw back system and external and internal price reference systems and the use of generics

<sup>46</sup> General info based on UN data 2012, Transparency International Corruption Perception Index 2012

<sup>47</sup> Based on Camenzind, Paul: The Swiss Health Care System, 2012. Commonwealth Fund, international profiles of health care systems, 2012.

[http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Switzerland\\_profile\\_2012.pdf](http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Switzerland_profile_2012.pdf)

<sup>48</sup> Based on Bluemel, Mariam: The German Health Care System, 2012. [http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Germany\\_profile\\_2012.pdf](http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Germany_profile_2012.pdf)

<sup>49</sup> Based on: Durand-Zaleski, Isabelle: The French Health Care System, 2012. Commonwealth Fund, international profiles of health care systems, 2012.

[http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/France\\_profile\\_2012.pdf](http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/France_profile_2012.pdf)

<sup>50</sup> Based on: Harrison, Anthony: The English Health Care System, 2012. Commonwealth Fund, international profiles of health care systems, 2012.

[http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/England\\_profile\\_2012.pdf](http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/England_profile_2012.pdf)

HIMS/HICs <sup>52</sup>	CH <sup>53</sup>	D <sup>54</sup>	F <sup>55</sup>	GB <sup>56</sup>	NL <sup>57</sup>
Public HI offers <ul style="list-style-type: none"> <li>• mandatory HI</li> <li>• Supp HI</li> <li>• Comp HI</li> <li>• Non comp</li> </ul> PHI offers <ul style="list-style-type: none"> <li>• Mandatory HI               <ul style="list-style-type: none"> <li>○ Comp</li> <li>○ Non comp</li> </ul> </li> <li>• Substitutive HI</li> <li>• Supp HI</li> <li>• Comp HI</li> </ul>	Separate HI Separate HI	(85% Pop)  (10%Pop) <sup>58</sup> , i.e. also Subst.	(100%)  (95% Pop) (95% Pop)	NA  (11%Pop)	
Premiums set by Collected by	Insurers Insurers	Nat Govt Income based to Nat. Pool Flat rates to SHI & PHI	Nst GOVT Income based	English GOVT Tax Office	Nat Govt. Tax Syst. (%) HI (flat rate)
Reinsurance	NA	NA	NA	NA	NA
Position insured	HI Choice & switching Choice between in-kind and	High earners & self employed may chose PHI Low earners in SHI	No free choice of SHI. Free choice of "referral doctor" , i.e. not only from GPs.	Provision oriented system Complaints via Healthwatch England	HI Choice & Switching. Choice between in-kind and reimbursement system. (at a fee)

<sup>52</sup> General info based on UN data 2012, Transparency International Corruption Perception Index 2012

<sup>53</sup> Based on Camenzind, Paul: The Swiss Health Care System, 2012. Commonwealth Fund, international profiles of health care systems, 2012.

[http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Switzerland\\_profile\\_2012.pdf](http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Switzerland_profile_2012.pdf)

<sup>54</sup> Based on Bluemel, Mariam: The German Health Care System, 2012. [http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Germany\\_profile\\_2012.pdf](http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Germany_profile_2012.pdf)

<sup>55</sup> Based on: Durand-Zaleski, Isabelle: The French Health Care System, 2012. Commonwealth Fund, international profiles of health care systems, 2012.

[http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/France\\_profile\\_2012.pdf](http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/France_profile_2012.pdf)

<sup>56</sup> Based on: Harrison, Anthony: The English Health Care System, 2012. Commonwealth Fund, international profiles of health care systems, 2012.

[http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/England\\_profile\\_2012.pdf](http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/England_profile_2012.pdf)

<sup>57</sup> Based on Westert, Gert: The Dutch Health Care System, 2012. Commonwealth Fund, international profiles of health care systems, 2012.

[http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Netherlands\\_profile\\_2012.pdf](http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Netherlands_profile_2012.pdf)

<sup>58</sup> 5% Population, e.g. police/army personnel are in Special schemes

	reimbursement system (at an extra fee). Legal entitlements				Legal entitlements
HIMS/HICs <sup>59</sup>	CH <sup>60</sup>	D <sup>61</sup>	F <sup>62</sup>	GB <sup>63</sup>	NL <sup>64</sup>
Cost control	Limited selective contracting	Limited selective contracting by individual HI.	Limited RBF Fee control BP scrutiny Referral system. No PHI covering co-payment for bypassing referral system.	Nat. Budget NHS. Capped Local budgets. GP fees set on Nat Level + RBF Specialist care purchased by Local CCGs with limited RBF/DRGs	Fee Regulation Selective contracting
QA/Accreditation	No HI role	Nat. Standards Voluntary Accred. Checking compliance by HI. Mandatory Q reporting by providers	Mandatory Accred by High Health Authority (HAS) which also develops guidelines and does HTA	NICE: guidelines. Nat basic standards for licensing of providers set & compliance check by CQ Commission . HealthWatch Voluntary accredited.	Voluntary Accred. & Nat Body PHI via individual provider performance
Regulation Supervision	Fed Law Nat Inst	Fed Law Selfregulation by Ass. Of Insurers & Providers	Nat Law MOH Regional Health Agencies (merger of SHIs	DOH	Nat. Law National Bank )for licensing) Comp. Auth

<sup>59</sup> General info based on UN data 2012, Transparency International Corruption Perception Index 2012

<sup>60</sup> Based on Camenzind, Paul: The Swiss Health Care System, 2012. Commonwealth Fund, international profiles of health care systems, 2012.

[http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Switzerland\\_profile\\_2012.pdf](http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Switzerland_profile_2012.pdf)

<sup>61</sup> Based on Bluemel, Mariam: The German Health Care System, 2012. [http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Germany\\_profile\\_2012.pdf](http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Germany_profile_2012.pdf)

<sup>62</sup> Based on: Durand-Zaleski, Isabelle: The French Health Care System, 2012. Commonwealth Fund, international profiles of health care systems, 2012.

[http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/France\\_profile\\_2012.pdf](http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/France_profile_2012.pdf)

<sup>63</sup> Based on: Harrison, Anthony: The English Health Care System, 2012. Commonwealth Fund, international profiles of health care systems, 2012.

[http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/England\\_profile\\_2012.pdf](http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/England_profile_2012.pdf)

<sup>64</sup> Based on Westert, Gert: The Dutch Health Care System, 2012. Commonwealth Fund, international profiles of health care systems, 2012.

[http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Netherlands\\_profile\\_2012.pdf](http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Netherlands_profile_2012.pdf)

			and State Auth ) HAS		Care Auth (fees & SPN)
HIMS/HICs <sup>65</sup>	CH <sup>66</sup>	D <sup>67</sup>	F <sup>68</sup>	GB <sup>69</sup>	NL <sup>70</sup>
Evaluation	Pop. ++ RE -- , start in 1996. No Competition authority, only formal licensing of HI. RS via policy differentiation. Political interference in fee setting.	Pop ++ RE + , start in	Ranked best in WHR 2000 despite cost control issues	Pop. and BMJ appreciate and want to keep NHS. Frequent change of policies and organizational set up hinder in-depth M&E of system.	Pop. ++ RE +, start in 1994 RS via VHI Providers side regulation not tuned

<sup>65</sup> General info based on UN data 2012, Transparency International Corruption Perception Index 2012

<sup>66</sup> Based on Camenzind, Paul: The Swiss Health Care System, 2012. Commonwealth Fund, international profiles of health care systems, 2012.

[http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Switzerland\\_profile\\_2012.pdf](http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Switzerland_profile_2012.pdf)

<sup>67</sup> Based on Bluemel, Mariam: The German Health Care System, 2012. [http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Germany\\_profile\\_2012.pdf](http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Germany_profile_2012.pdf)

<sup>68</sup> Based on: Durand-Zaleski, Isabelle: The French Health Care System, 2012. Commonwealth Fund, international profiles of health care systems, 2012.

[http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/France\\_profile\\_2012.pdf](http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/France_profile_2012.pdf)

<sup>69</sup> Based on: Harrison, Anthony: The English Health Care System, 2012. Commonwealth Fund, international profiles of health care systems, 2012.

[http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/England\\_profile\\_2012.pdf](http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/England_profile_2012.pdf)

<sup>70</sup> Based on Westert, Gert: The Dutch Health Care System, 2012. Commonwealth Fund, international profiles of health care systems, 2012.

[http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Netherlands\\_profile\\_2012.pdf](http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~media/Files/Topics/Country%20Profiles/New%20Folder/Netherlands_profile_2012.pdf)

The referred country cases, published by the independent Commonwealth Fund and used for the above table, offer excellent short summaries of country health system characteristics: <http://www.commonwealthfund.org/Topics/International-Health-Policy.aspx>

The above teaches that:

- It is possible to have good health outcomes in tax based national health systems.
- Mandatory health insurance is co-funded from taxes to achieve UHC and to keep payroll taxes in check.
- Systems with competing health insurers offer no visible benefits as regards cost-containment, come with high administration costs while the regulation of such markets is complicated and risk-equalization between insurers is far from perfect to avoid risk selection.
- The regulatory framework and regulatory capacity are key for the operation of health financing and health insurance systems.

## 10. Decisions to make in structuring the health insurance market

The possible characteristics of health insurance and the choices in shaping a health insurance system have been discussed in chapter 6 and in more detail in Annex 5. These need to be taken into account when considering the future structure of the HIM. To assure that explicit decisions are being made, several steps and decision points should be considered. The following list is meant to systematically pay attention to the differing choices and their possible consequences. In essence it is a list of attention points also to be taken into account when moving to the stage of regulation of the insurance market and the different insurances. The main successive steps and attention points in decision making on segmenting health insurance are:

1. **Benefits:** Segmenting and deciding the benefits covered, e.g.
  - a. Basic/essential, i.e. the MBP as defined )
  - b. Expanded or supplementary packages, on top of MBP (broadening it, i.e. more services)
  - c. Complementary to MBP (deepening it, i.e. more financial coverage and hence less co-payments)
2. **Mandatory and/or voluntary.**
  - a. What will be **mandatory** insured, and for whom e.g.
    - i. MBP for all, MBP for designated categories of the population or regionally differentiated based on availability of health services.
    - ii. Expanded packages, including MBP, for designated categories of the population, e.g. employees and/or self employed
  - b. What can be **voluntary** insured
    - i. Integrated MBP plus top up packages, complementary and/or supplementary
      1. In case of the legal possibility of opting out of the mandatory system, i.e. the person who opted out does not have to pay contributions into the mandatory system, which does lose revenues especially since it mostly concerns high earners who opt out. Such opting out limits solidarity between rich and poor.

2. Duplicative option, if this would be made possible by law. In this case the person who chooses this insurance has to continue paying contributions into the mandatory system, i.e. not limiting solidarity
  - ii. Single supplementary packages
  - iii. Single complementary packages

**3. Who will be mandated to insure MBP**

- a. Single National insurer, or
- b. Multiple insurers
  - i. **Non-competing**, segmented
    1. Geographically
    2. According to sectors of society, e.g.
    3. Employment status, e.g.
      - a. civil servants (possibly differentiated according to government level or type of duties)
      - b. Formal private sector,
        - i. as such, open for all enterprises and all willing to join
        - ii. according to type of enterprise
      - c. Formally unemployed
      - d. Retired
    4. Children and students
    5. Informal sector and self-employed
    6. According to income level of insured
    7. Individually: Medical savings accounts (MSAs)
- c. Multiple insurers **competing** for the same clientele, allowed to also
  - i. offering mandatory health insurance of a more extended BP
  - ii. offering voluntary
    1. supplementary health insurance
    2. Offering complementary health insurance

**4. Who will be mandated to insure the expanded mandatory covered health insurance packages,** broader than the defined MBP in mandatory insurance. This suggestion for a decision is based on the assumption that, most likely, the defined MBP will not be as broad and/or deep as the benefits packages that are currently covered via the mandatory insurances of NHIF and NSSF.

- a. Insurers, possibly including MBP, currently NHIF and NSSF-SHIB
- b. Others, such as the private insurers

**5. Who is allowed to voluntary insure the expanded packages**

- a. Substituting (offering an opt out possibility for the insured) or duplicating (no opting out and paying the contributions for the mandatory insured packages:
  - i. Mandatory insured MBP
  - ii. Mandatory insured MBP together with mandatory extended packages
    1. supplementary
    2. complementary
    3. both
  - iii. Additional to mandatory insured packages
    1. Supplementary
    2. Complementary

**6. Decide the entity of enrolment in mandatory insurance as**

- a. individuals
- b. families



- c. other, such as employees of enterprise and their families
  - d. If enrolment is per family then the term family needs to very precisely describe to prevent that people fall between the cracks.
- 7. **What will insurance pay for**, decide whether insurances include payment of
  - a. investment costs and repairs (including interest payments and depreciating costs)
  - b. salaries of staff, drugs and supplies
- 8. Decide **level of autonomy of public providers** and connected with this
  - a. Decide mandate of MOH in financing health services provider's operational costs: continuing current practice or leaving this to the health insurance agencies:
  - b. Decide mandate of LGAs in financing health services provider's operational costs: continuing current practice or leaving this to the health insurance agencies
- 9. Decide **legal status of insurer** of
  - a. Mandatory insured MBP
    - i. Public
    - ii. Private (including NGO, mutual or cooperative)
      - 1. for profit
      - 2. not for profit
  - b. Mandatory insured extended BP
    - i. Public
    - ii. Private (including NGO, mutual or cooperative)
      - 1. for profit
      - 2. not for profit
  - c. Voluntary packages
    - i. public
    - ii. private
- 10. **Decide sources of finance of mandatory insurance**
  - a. Contributions
    - i. flat rate
    - ii. income based
    - iii. combination
  - b. Cross subsidies
    - i. General tax revenues/Budget
    - ii. Other insurances
    - iii. Other
  - c. General deductible
  - d. OOP
- 11. **Decide level of flexibility in setting contribution level of above sources**
- 12. **Who collects contributions** in mandatory insurance
  - a. Insurer
  - b. Other
    - i. Tax office
    - ii. Employer
    - iii. Bank
    - iv. Other
- 13. **Who collects co-payments**
  - a. insurer
  - b. provider
  - c. other

14. **Decide who administers** the collected revenues
  - a. Individual insurer
  - b. Dedicated national health fund (in case of insurers competing to offer mandatory insurance and when operating a risk-equalization fund)
15. Decide **where to pool revenues**, including reserves of insurers, implementing mandatory insurance
  - a. General or District Treasury/MOF-National Bank
  - b. Special account at General Treasury/ MOF-National Bank
  - c. Banks (commercial)
  - d. Designated investment options
16. Decide method of determining **level of reserves for different health insurances**, related to their relative risks, i.e. based on the entitlement character of the benefits package (in kind or reimbursement system) and the specific features of health insurance as compared with other types of insurances i.e. a pay as you go system), the actual risks of the insurer and the chosen mechanisms to balance the budget of the insurer, taking into account the possible back up from the general budget or a stop loss system, including reinsurance.
17. **Decide mandates re assessment of quality of health services providers** and/or their different services in general and of their medical interventions on the patient level in particular.
  - a. Independent Inspectorate
  - b. National accreditation body
  - c. Insurers, offering certification based on their particular mandates.
18. **Decide purchasing tools** of mandatory insurers, will they be allowed to:
  - a. Specifying benefits in case of global description of the MBP, the expanded mandatory insured and other BPs. Even when detailed positive lists are being used there may still be questions whether a certain medical intervention is included, e.g. in internal medicine or in surgery. A conflict resolving mechanism will be useful in case of differing opinions.
  - b. Selecting public and/or private providers of mandatory insured package, i.e. possibly leaving some without a contract at all.
  - c. Selecting specific services of selected providers, thus excluding some other services, based on considerations of need, fee levels and/or quality of services.
  - d. Determining volume of selected services per provider, based on needs
  - e. Negotiating payment systems, budget, FFS, case based, per capita, RBF etc. or mixed
  - f. Negotiating payment/fee level or mandating this to a public body or payment advisory commission.
  - g. Review the financial claims of providers or insured for provided care and the appropriateness of care, based on
    - i. MBP and expanded BP entitlements
    - ii. Medical need
    - iii. Individual need to consume the particular care at the chosen level of services (PHC or referral care)
    - iv. Adopted algorithms, clinical practice guidelines, medical protocols and clinical pathways.
19. **Decide mechanisms to enhance cost-effectiveness** in UHC/BP access and client orientation of insurer or insurers, offering mandatory insurance
  - a. **Non-competing insurers**, taking into account the choices made regarding decision point 3 (above)
    - i. Regulation of insurer
      1. Mandate of insurer
      2. Licensing requirements

3. Consider the selection of insurer via bidding procedure.
4. Selection and appointment of Board/CEO
  - a. Open ended
  - b. Based on performance criteria and management contracts
- ii. Determine parameters on which funding of regional insurers will be based, i.e. a health risk adjustment<sup>71</sup> between non-competing insurers, e.g. age, gender, numbers of residents in each age/gender quintile, morbidity and related costs of prevention and treatment.
- iii. Oversight and auditing
  1. Financial
  2. Client oriented implementation of insurance, e.g. guaranteeing access to necessary care for insured and adequate complaints handling
  3. Benchmarking, in case of multiple insurers.
  4. Mobilizing the community:
    - a. participation in boards of insurers and review panels
    - b. enforcing transparency and accountability of insurer operations
    - c. publicising wanted and unwanted performance
    - d. Household surveys
    - e. Free press
    - f. Improving health literacy among population
- b. Competing insurers**, offering MBP and/or mandatory insured expanded packages, in case the country wants this for covering the MBP or wants to continue the NHIF/NSSF competition.
  - i. Regulation, aiming at possibly making it effective and efficient<sup>72</sup> in order to:
    - a. Preventing risk selection
      1. Obligation to accept any person who wants to enrol
      2. No risk rating
      3. Free choice of insurer
      4. Guaranteed access to MBP and extended packages. The latter packages should be equal for all insurers, licensed to offer such mandatory insurances.
      5. Consumer information and market transparency
      6. Risk bearing buyers and sellers of insurance policies
      7. Contestable markets of insurers and health care providers
      8. Mandate re purchasing tools
      9. Effective supervision of quality of care, to prevent skimping by insurers and providers
    - b. Adequate licensing requirements
    - c. Effective competition (anti-monopoly) authority with capacity re health insurance and necessary tools.
    - d. Cross subsidies without opportunities for free riding

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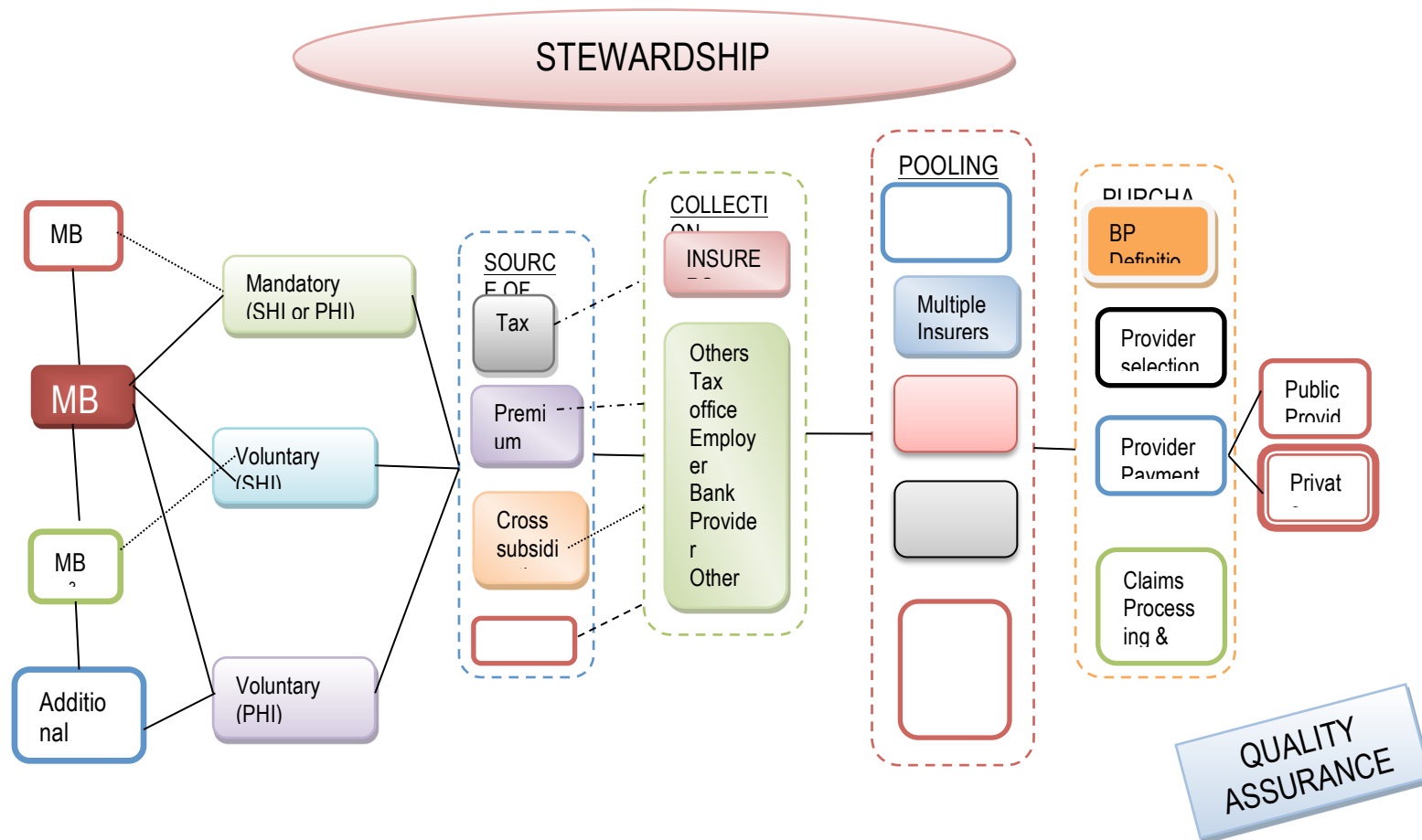
<sup>71</sup> "The use of information to calculate the expected health expenditures of individual consumers over a fixed interval of time and set subsidies to consumers or health plans (incl. Insurers) to improve efficiency and equity", from: Ven, Wynand van de, et al.: Risk adjustment, in Newhouse & Culyer: handbook of health economics.

<sup>72</sup> Ven, Wynand van de, et al: Preconditions for efficiency and affordability in competitive health care markets: are they fulfilled in Belgium, Germany, Israel, the Netherlands and Switzerland? Health Policy 109 (2013) 226-245

- e. Cross subsidies without incentives for risk selection. This makes it necessary to decide on the preparation and implementation of a health risk adjusted financial equalization mechanism between the insurers. This is discussed hereafter.
      - f. Oversight and auditing
    - ii. Financial
      - 1. Client oriented implementation of insurance, e.g. guaranteeing access to necessary care for insured and adequate complaints handling
      - 2. Benchmarking, in case of multiple insurers.
    - iii. Mobilizing the community:
      - a. participation in boards of insurers and review panels
      - b. enforcing transparency and accountability of insurer operations
      - c. publicising wanted and unwanted performance
      - d. Household surveys
      - e. Free press
      - f. Improving health literacy among population
20. In case of choosing for competition oriented health insurance market, decide **health risk adjusted per capita based equalization system** between competing insurers
- a. **Which institution will operate the system** and does comply or can be made to comply with conditions:
    - i. Not implementing itself health insurance
    - ii. Has the necessary human resources, infrastructure and business support system
    - iii. Has a functioning audit system with sufficient capacity and/or allowed to making use of exiting public and/or private audit capacity
    - iv. Operates a reliable sophisticated information system: providing costs per insured per age/gender category, disease profiles which forecasts future costs, such as chronic diseases, etc, the number of insured per insurer at the beginning, in the middle and in the end of the equalization period. This would need to be complemented by HMIS at the provider side, able to provide the requested info to the competing insurers.
    - v. Functioning audit system
    - vi. Adequate regulations: system fair for SF's and avoiding cream skinning
    - vii. Arbitration mechanism
    - viii. Functioning court system
  - b. Ex ante, ex post or both systems combined.
  - c. Which parameters will have to be used.
21. Decide which institution will be in charge of the monitoring and evaluation (M&E) of the decided restructuring of the HIM and, dependent of the chosen modalities, the indicators for process (milestones), outcome and impact on the effectiveness and efficiency of the health financing system itself and on the effectiveness and efficiency of health services delivery.

**NB some of the above steps can be taken in parallel.**

Figure 10.1 Decision Tree for HIMs



## 11. Options for the Health Insurance Market in Tanzania

Assuming that the planned minimum benefits package (MBP) will be defined and further to starting point the current Tanzanian health financing system and its actors as well as taking into the GOT's health policy, social policy and economic objectives and the lessons learned from countries described in this report, the following options are recommended for consideration, which should be noted that opting for the current national health services system, funded from revenues such as exists in e.g. the UK would be the simpler one:

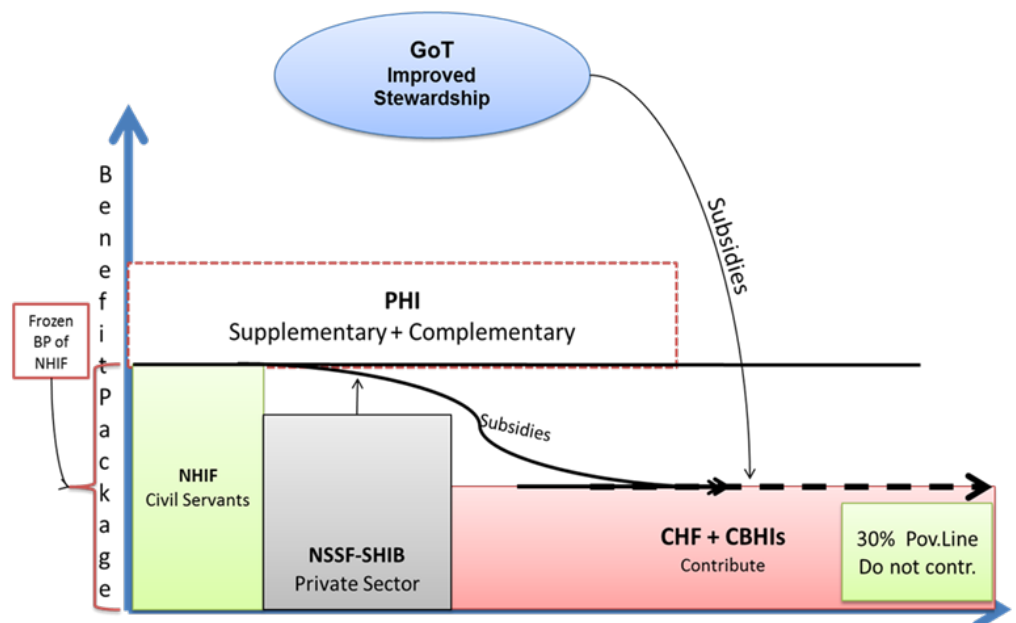
### 1. Existing gradual change model,

Gradually improved and ultimately leading to convergence of insurances, including CHF enroller mandatory health insurance for all residents offering a gradually expanding MBP, while private insurance is offering voluntary duplicative, complementary and supplementary insurance, the latter sharply delineated from MBP:

#### a. Step 1

- i. Strengthening oversight
- ii. Until decision on competition-based HI and possibly setting the context for it:
  1. NHIF is restricted to insuring civil services staff and dependents for its basic minimum package
  2. NSSF-SHIB is restricted to formal private sector employed
- iii. Stop on expansion of NHIF & NSSF BPs
- iv. Continued and gradually increasing GOVT subsidies for CHF/MBP, which will be preparing merging into NHIF/NSSF successor.

**Figure 11.1 HIMS Option 1 – Step 1**



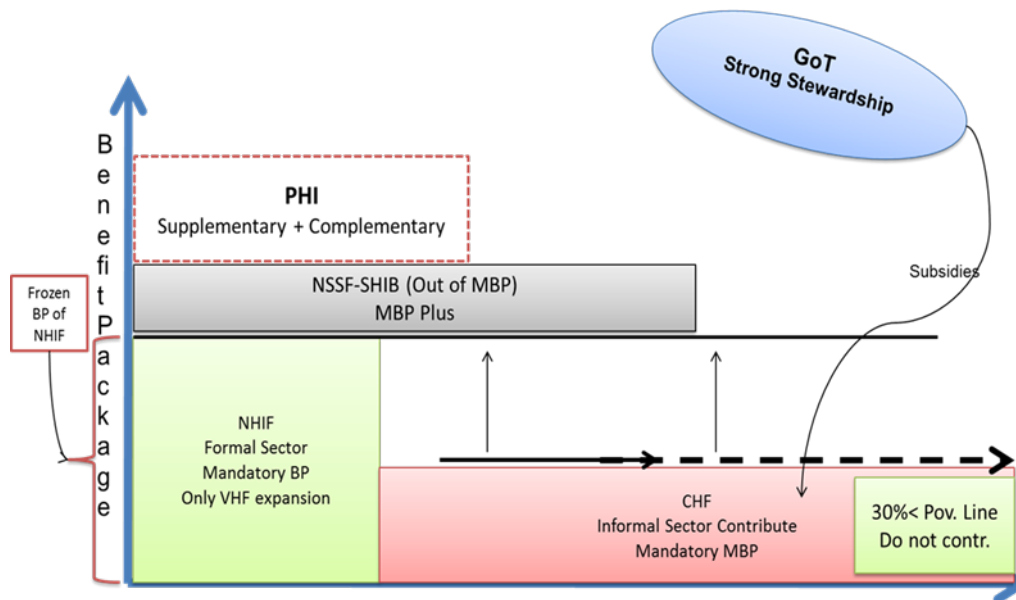
Source: Authors, 2013

**b. Step 2:**

i. Step 1 plus:

1. Mandatory enrolment for all non-insured with NHIF and/or NSSF-SHIB into CHF, merging with CBHI & micro-insurance, which cover the set MBP and is implemented by NHIF
2. NHIF is restricted to only offer its basic package and focuses on MBP expansion. The top-up services are left to private insurance.
3. BP of NHIF/NSSF is kept frozen and can only continue to rise when MBP equals the NHIF/NSSF BP and then rise together
4. NHSSF-SHIB and Private insurance continue, stay out of MBP as covered by CHF, but can offer voluntary duplicative health insurance to formal private sector and self-employed.

**Figure 11.2: HIMS Option1 – Step 2**



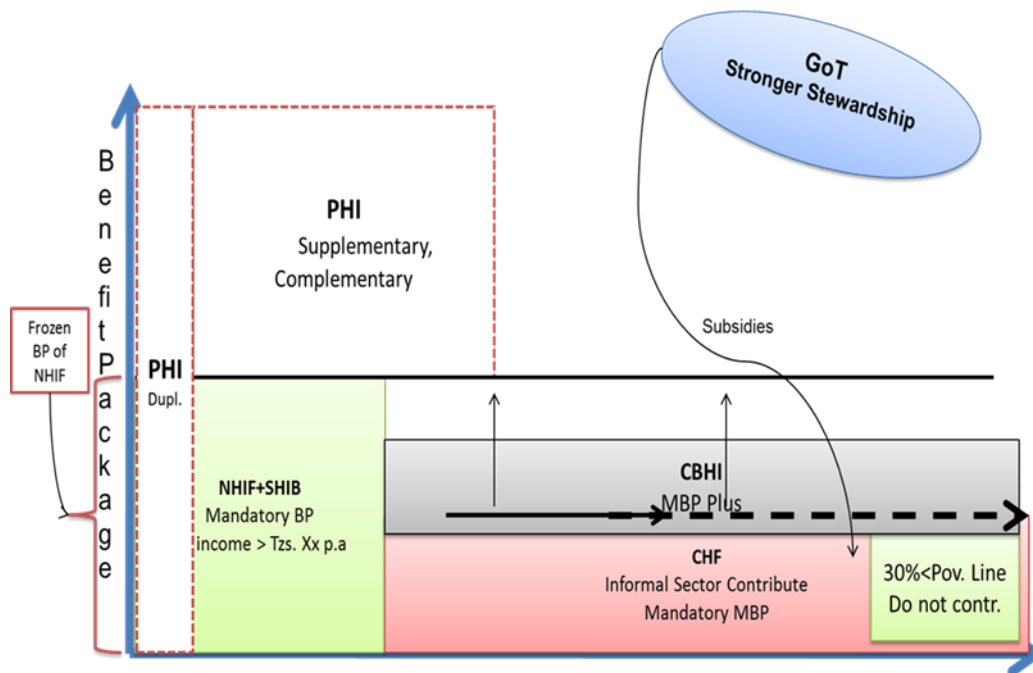
**Source: Authors, 2013**

**c. Step 3**

i. Step 2 plus:

1. NHIF and NSSF merged into one and offering mandatory insurance for formal sector (civil & private)
  - a. Formal sector includes self-employed with income above a defined threshold.
  - b. BP of NHIF/NSSF is frozen and can only continue to rise when MBP is equal and can rise together.
  - c. NHIF/NSSF stay out of private insurance market
2. Enhanced regulatory capacity
3. Private health insurance can offer duplicative, supplementary and complementary insurance, covering extra amenities and medical interventions not covered by NHIF/NSSF packages and MBP

**Figure 11.3 HIMS Option 1 – Step 3**



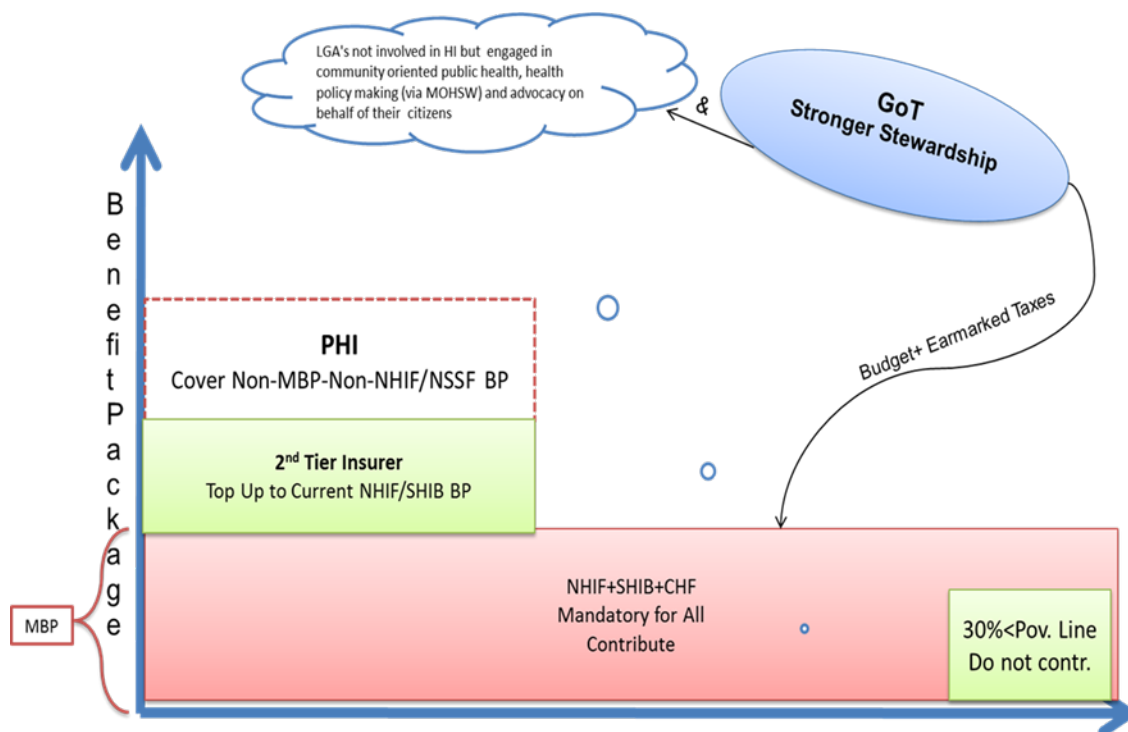
Source: Authors, 2013



**2. NHIF-NSSF merger, becoming the sole social insurer,** incorporating CHF and CBHIs, therewith simplifying mandatory insurance reducing the admin costs of CHF and CBHIs and solving the current problems with differences in the covered services and with the lack of portability, thus and enhancing effectiveness and efficiency in insurance and health services by creating a single purchaser. In essence Model 2 is the big bang approach towards model 1 plus the disappearing role of the LGA's in health financing. This latter step can obviously also be made as part of Model 1.

- a. Mandatory for all residents, including the informal sector.
- b. incorporating CHF and CBHIs, simplifying mandatory insurance and enhancing effectiveness and efficiency in insurance and health services
- c. Mandatory for all residents
- d. Implementing MBP (LGA's will not anymore be involved in HI but stay engaged in community oriented public health, health policy making (via MOHSW) and advocacy on behalf of their citizens.)
- e. No role in covering non-MBP benefits
- f. Second tier insurer takes over mandatory insurance of current top-up NHIF/NSSF packages
- g. Private Insurers can cover Non-MBP-Non-NHIF/NSSF BP
- h. stronger oversight and enhanced regulatory capacity and requirements for PHI

**Figure 11.4 HIMS Option 2**

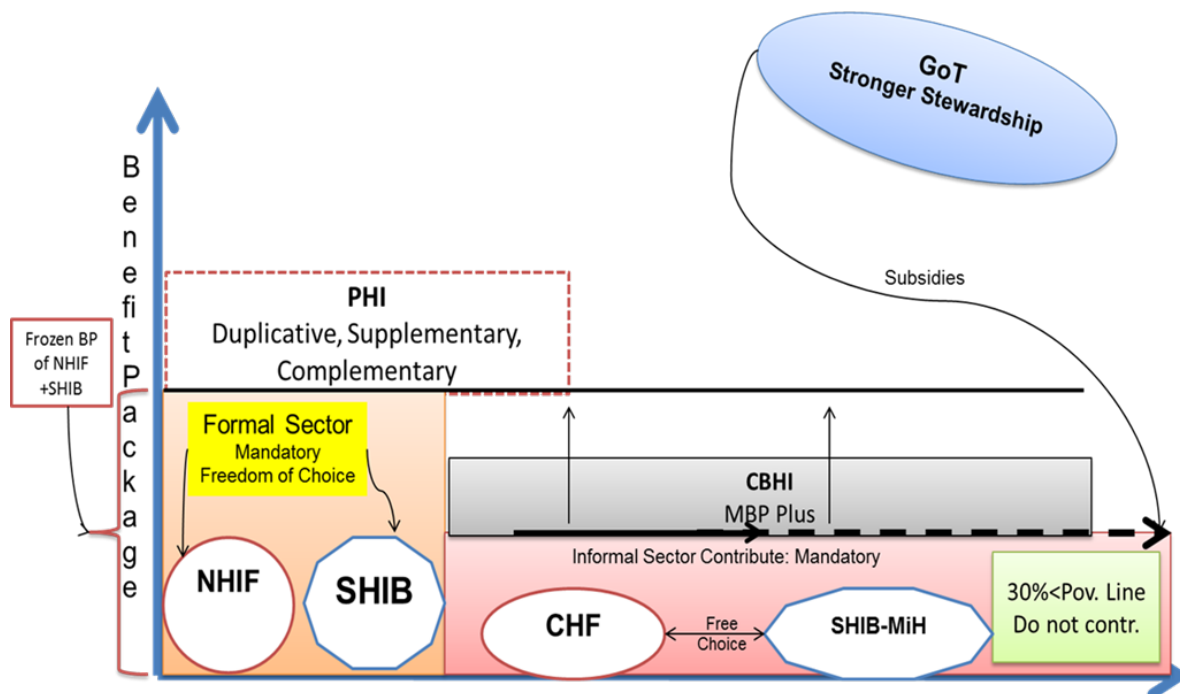


Source: Authors, 2013

### 3. NHIF-NSSF competition, aiming at more efficiency and client orientation:

- mandatory for MBP and formal sector workers, offering merged NHIF/NSSF BP
- Free choice for insured between NHIF and NSSF.
- MOHSW/MOFDP will operate a risk-equalization scheme between NSSF and NHIF.
- NHIF-NSSF BP is frozen and can only continue to rise when MBP is equal and can rise together
- NSSF-SHIB introduces its Micro Health scheme for low income h/holds.
- Private Insurers can cover Non-MBP-Non-NHIF/NSSF
- stronger oversight and enhanced regulatory capacity

**Figure 11.5 HIMS Option 3 – NHIF-NSSF Competition**

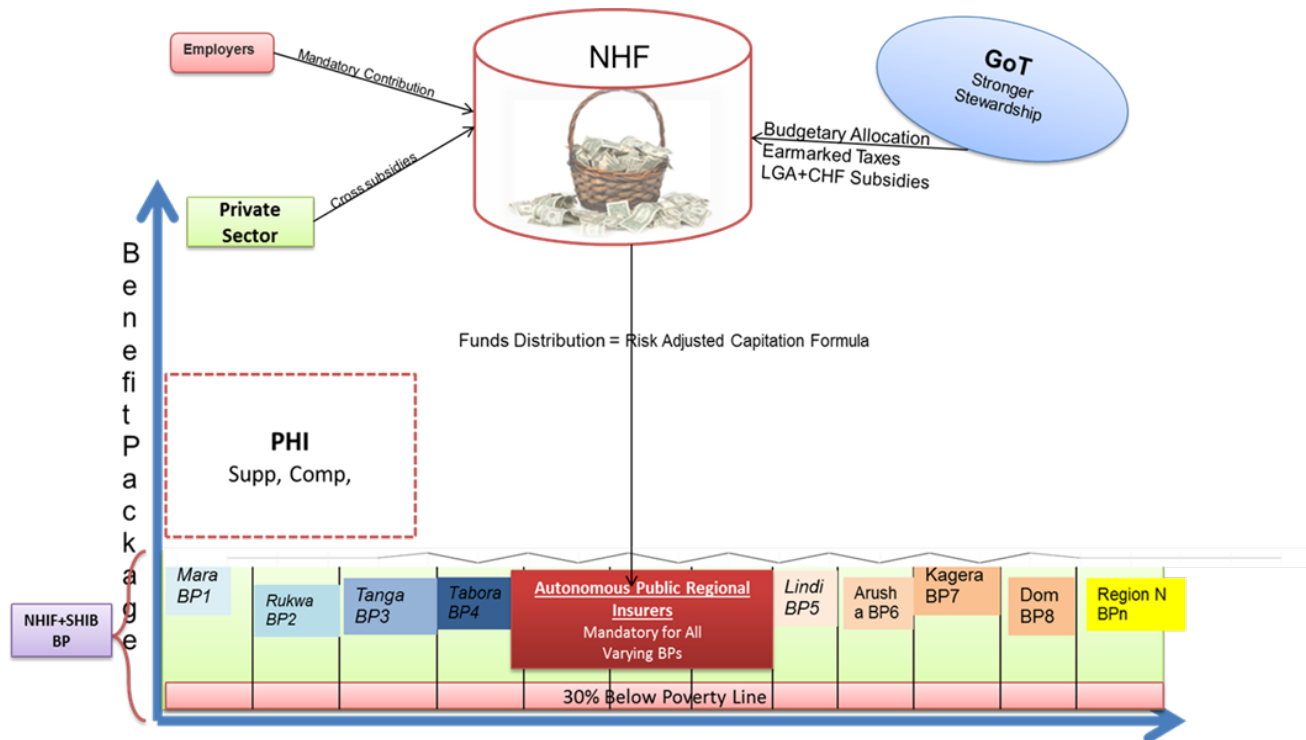


Source: Authors, 2013

**4. Creation of single health fund**, with multiple geographically divided MBP insurers not being satellites of the single fund:

- Collects all mandatory contributions directly from employers
- Receives all government funding for individual health services which currently flows into health sector, including conditional cash grants to LGA's and subsidies for CHF.
- Receives cross subsidies from private insurers
- NHIF and NSSF-SHIB will become the National Health Fund
- Licensing autonomous regional health insurances with public status, which offer MBP and BP of former NHIF-NSSF
- Distributes funds over regional HIs according to risk-adjusted capitation-based formula
- NHIF-NSSF BP is frozen and can only continue to rise when MBP is equal and can rise together
- Private Insurers can cover Non-MBP-Non-NHIF/NSSF
- Stronger oversight and enhanced regulatory capacity

**Figure 11.6 HIMS Option 4 – Creation of single health fund**

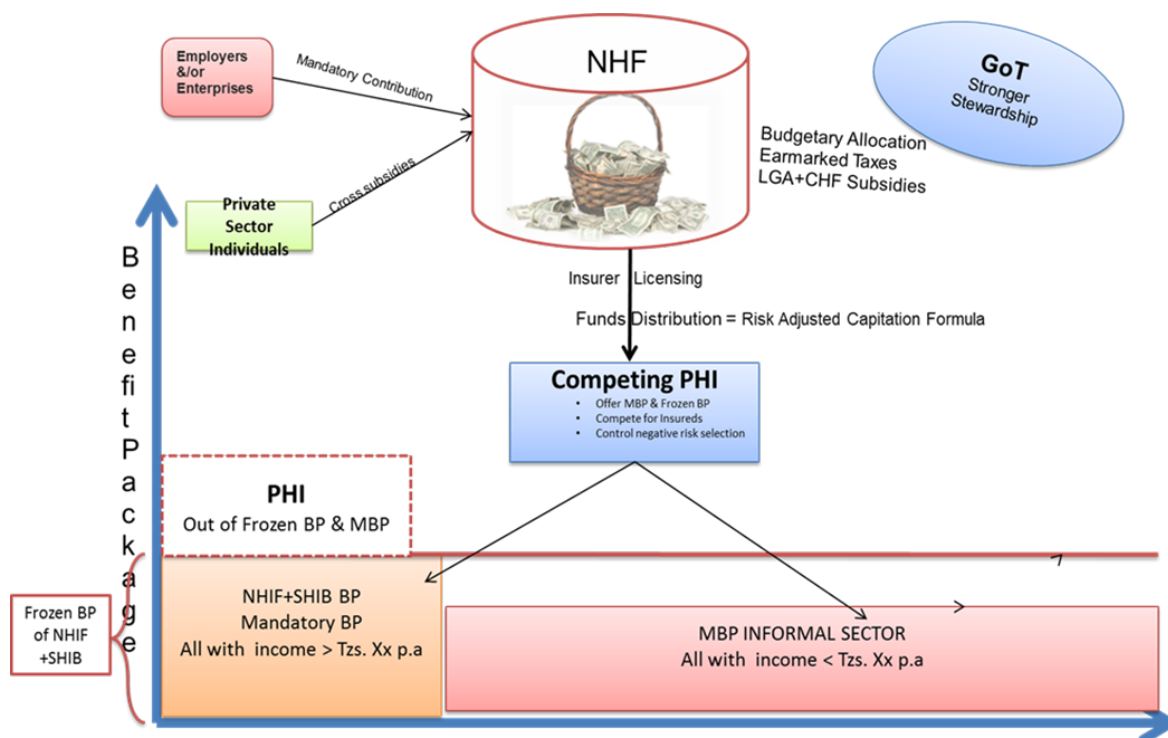


Source: Authors, 2013

**5. Creation of single health fund**, facilitating the implementation of health insurance of the defined MBP by either public or private competing insurers:

- a. collects all mandatory contributions directly from employers
- b. receives all government funding for individual health services which currently flows into health sector, including conditional cash grants to LGA's and subsidies for CHF.
- c. NHIF and NSSF-SHIB will become the single health fund
- d. All residents are mandatorily insured
- e. BP
  - iii. Those in the formal sector and those above a set income threshold receive the former NSSF/NHIF BP
  - iv. Those under the set threshold (somewhere above the poverty level) receive the MBP
- f. Licenses private health insurers which
  - iv. offer MBP together with BP of former NHIF-NSSF
  - v. compete for insured
  - vi. comply with all conditions to prevent risk selection
- g. Distributes funds to private insurers according to risk-adjusted capitation-based formula
- h. NHIF-NSSF BP is frozen and can only continue to rise when MBP is equal and can rise together
- i. Private Insurers cannot cover both MBP/NSSF/NHIF BPs and Non-MBP-Non-NHIF/NSSF supplementary and complementary insurance.
- j. Stronger oversight and enhanced regulatory capacity

**Figure 11.7 HIMS Option 5 – Creation of single health fund**



Source: Authors, 2013

The specific features of the elements, constituting the above models can be chosen using the in Chapter 10 elaborated decision points.

## Pros and Cons

The pros and cons of the 5 models are summarized in table 5 hereafter

**Model 5** is the most complicated, given the current situation. It will require the most profound changes and requires the most as regards additional regulation and regulatory capacity, the most detailed information and a sophisticated information system to run a risk equalization system and therefore will take the longest to implement. Neither social health insurance scheme in Tanzania has currently the tools to operate in a system with regulated competition and participate in a risk equalization scheme. This latter is due to the absence of a insured-based health services consumption related information system. The conditions for competing health insurers, as described in Chapter 10 will all need to be fulfilled. Even if these are fulfilled then its advantages are not clear as compared with improving the current system and building on it. Similar to other countries which spend a lot of effort, time and admin costs on their competing health insurance systems, people still may fall between the cracks due to risk selection and/or risk rating by insurers, thus possibly preventing equal access for all.

**Model 4** Is a bit less complicated than model 5 but still requires quite some changes, i.e. the transformation of some of the current NHIF/NSSF satellite offices into autonomous health insurance entities with all the features of e.g. the current NHIF national level office. It will also require the adjustment of legislation and implementation regulations, including those related to oversight. It offers the possibility of benchmarking the regional insurers. This can be used for efficiency improvement and client orientation of the insurers. Since these regional insurers will need to get a legal status the option exist to define performance criteria and recruitment, evaluation and discharge procedure for the senior management, the stage can be set for making benchmarking effective and preventing complacency. The transformation of NHIF and NSSF-SHIB into a national health fund in charge of the risk adjusted financial resources to the regional funds will also offer the possibility to overcome the problems in the current distribution of monies from the central to the district governments<sup>73</sup>. The scale of the regions would need to be carefully chosen to allow the inclusion of existing or to be established referral hospitals (approximately 1 M people or more) or the portability and the use of top level facilities elsewhere guaranteed via e.g. a money follows the patient system to avoid that costs of patients in one region would be shifted to another one.

**Model 3** is in essence formalizing the status quo in which NHIF and NSSF are already competing though not explicitly regulated and therewith having the possibility of risk selection. It may enhance efficiency and client orientation but that would come at the cost of more regulatory arrangements and would require capacity building and time to establish it albeit less than in model 5 while still running the same risks for the residents as pointed out for that model. The simpler and hence less costly option is:

**Model 2** which unifies the administration systems of NSSF and NHIF, creates a powerful single purchaser and, if well regulated, offers the most efficient and fast way to get value for money and covering the

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<sup>73</sup> Boex, Jamie & Selemani Omari: Strengthening the Geographical Allocation of Resources within the Health Sector in Tanzania: Towards Greater Equity and Performance; Report to the Tanzania Health Financing Technical Working Group, MOHSW Tanzania. Draft, March 2013

whole population. It is in essence the big bang variant of Model 1. To realize such big bang requires quite some preparation as regards capacities of NHIF and requires regulatory changes.

**Model 1** is the gradual-change option which offers nevertheless the end point of the process which would help all actors to prepare themselves for this. It offers also the possibility of a regionally differentiated MBP, which could be necessary due to differences in geographically available health services.

**Table 5 Pros & Cons/SWOT of options, proposed for consideration**

	<b>1 Existing</b>	<b>2 NSSF/NHIF merger</b>	<b>3 NSSF-NHIF competition</b>	<b>4 Single HF Non Comp. HI</b>	<b>5 Single HF Comp. HI</b>
<b>Achieving UHC</b>	+	+	+	+	+
<b>BP breadth &amp; depth</b>	+	++	+	++	+
<b>Effective &amp; efficient insurers</b>	+	+	–	++	+
<b>Effective &amp; efficient health services</b>	+	+	–	++	–
<b>Simplicity in HIM and implementation</b>	++	++	–	+	– –
<b>Realization period</b>	ST	ST	ST	MT	LT
<b>Capacity requirements</b>					
<b>Additional regulatory burden &amp; costs</b>	L to M	M	M to H	M to H	H
<b>Cost-effectiveness HIM</b>	+	+	–	+	?
<b>Acceptance</b>					
• <b>Insurers</b>					
○ <b>public</b>	++	++	++	–	– –
○ <b>private</b>	+	+	+	+	++
• <b>Providers</b>	+	+	+	+	+
• <b>Public</b>					
○ <b>Poor</b>	+	+	+	++	–
○ <b>Non-Poor</b>	+	+	+	–	++
• <b>GOVT</b>					
○ <b>Nat</b>	+	+	+	+	–
○ <b>LGA</b>	+	+	+	–	–

UHC Universal health coverage, i.e. access for all and no risk of impoverishment

BP Benefits package

HIM Health Insurance market

Nat national

LGA Local Government Authority

ST Short term

MT Mid term

LT Long term

L Low

M Moderate

H High

+ Possible or likely

+ More or less; or neutral

– Negative or less likely

## 12. Regulatory aspects of options

Dependent of the preferred option the regulatory framework will differ together with the capacity enhancements needs. The simpler the option, e.g. a national single insurer of MBP and of additional packages that are part of mandatory insurance, the lesser the regulatory burden will be as is indicated in the above table (5)

However, the current regulatory system is already in need of improvement as is shown in the MOHSW and SSRA commissioned 2012 regulatory review<sup>74</sup>. Its main findings and recommendations (included in Annex 9) still hold and are advised to be taken into account for any of the preferred options.

This report points also to the different requirements of competing and non-competing systems, summarized on pages 9 & 10 of the review report.

### Additional Regulation & Capacity Building

As mentioned above, additional regulation and capacity building will depend on the preferred HIM option.

Amending laws and regulations will require close cooperation between national and regional policy makers, current regulatory authorities and national lawyers while offering representatives of current HI implementers the possibility to contribute from their respective technical perspectives.

Major topics will be the rewriting of the mandates of PMO-RALG, MOFE, MOLE, MOHSW, LGAs, BOT, TIRA and SSRA while using framework laws to allow for flexibility in implementation and easy adjustment based on M&E results re the implementation of the new HIMS. The capacity to amend the laws and regulations is available. Managing the process in a consistent and timely way will require additional staff and the coordination by a leading Cabinet Minister who reports to the PM and the Cabinet of Ministers to allow for decisions re contentious issues between main actors that stall the process of law adjustment.

***Opting for a competition based system*** (models 3 and 5) will require meeting the conditions as described in Chapter 7 of this HIM report. Besides setting the regulatory framework, capacities of SSRA and TIRA will need to be strengthened; far beyond what is already recommended in the above cited Regulatory review report. Also the existing Fair Competition Authority (FCC) will need strengthening. The FCC has just started its orientation of the health sector and has so far not developed a policy.

It will be necessary to create a level playing field for insurers, which besides

1. Ensuring that insurers accept all people as members, irrespective of their health status and health risks,
2. Establishing a basic benefits package that would need to be implemented by all insurers,

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<sup>74</sup> Bultman, Jan et al: Tanzania Health Insurance Regulatory Framework. Review on request of the Ministry of Health and Social Welfare and the Social Security Regulatory Authority. GIZ/P4H. Dar es Salaam, March 2012



3. Establishing a financial equalization mechanism,
4. Creating an adjusted health management information system (HMIS),

also will need to solve the differences in the financial start position of the insurers, i.e. in their reserves to prevent price dumping by the insurers with the bigger war chests. The existing reserves, surpassing a fixed amount per insured/insurer can be transferred to fill the equalization fund.

NHIF has a provider oriented administration system related to the payment of services, i.e. consumption costs per enrollee and reasons for consumption of specific health interventions are not known and hence it is not possible with the current admin system to create a sophisticated health-risk based equalization system between NHIF and NSSF-SHIB. It will take time and it requires additional admin costs to create such system. Private insurers have an insured-oriented admin system which would lend itself easier for a start with a risk equalization system.

The auditing capacities of TIRA, SSRA, BOT and FCC will also need to be strengthened to cater for a competing system to prevent the many possible negatives of such system and to assure the right implementation of a risk equalization system.

Opting for model 4 would, most likely require the creation of capacity of the insurance entities that will implement the mandatory insurance in the to be defined regions. The capacity of the current NHIF and NSSF branch offices is not reviewed by the authors of this HIMS study. In case option 4 is chosen then it makes sense to build on the existing capacities in the regions. The mandate in HMIS, if any, of the LGAs will also need to be decided upon and subsequently, regulations and capacities adjusted.

### **Provider Supply Side Regulation**

For the preferred HMIS to function the supply side needs also to receive attention from policy makers to allow the insurers for strategic and effective purchasing of services, especially in case of a competition oriented model which would need to allow insurers to compete on efficiency in services delivery and client orientation. In general, indeed only in general terms as attention points, this presupposes the regulation of:

- a. Autonomous health-care providers (public and private) to allow freedom:
  - I. for their management to hire and fire staff (according to needs),
  - II. to spend financial and other resources in the most cost-effective way
  - III. to generate other resources such as from exploiting a parking lot, offering catering services to neighbouring health facilities operating a cafeteria or restaurant for patients and visitors etc.
- b. A level playing field for private and public health services providers, requiring a system for payments of investments to prevent public providers having an advantage over private ones where their investments are funded out of the Government budget,
- c. Selective contracting with providers (public and/or private),
- d. Bankruptcy of hospitals;
- e. Establishing a national health services provider planning and licensing system?
  - I. Giving special attention to high-risk/high-tech interventions for reasons of cost-effectiveness and quality of care

- f. One national accreditation system

### **Regulation of provider payment systems, fees and prices**

Because there is no ideal provider payment system, mandates should be set to establish adjustable payment system flexible enough to incentives good provider performance and disincentive inappropriate care. To this end the establishment of a forum or authority to discuss, advice or possibly decide about fee schedules and levels would be useful. This implies that insurers would need to have the mandate to either take over the advice of the forum or authority or would be obliged to implement the decided payment system and fee levels.

The setting of fee levels would not only concern the medical interventions done by health facilities and individual providers but also overall budgets of providers and the prices that can be charged for medicines and supplies. This would also help in combatting unjustified medical price inflation.

### **Monitoring and Evaluation**

In the implementation of a decided HFS, the M&E of the implementation of a revised HIMS will require special attention. The milestones, monitoring indicators, responsibilities and reporting requirement should be clearly defined and

The feasibility of proposed options and the time horizon within which these can be implemented depend of a number of **constraining/facilitating factors** such as:

- Economic growth and growth of enterprises most likely offset or preceded by a withdrawal of donor funds as budget support for the health sector.
- Capacity as regards governance/management of the health financing sector and speed of the lawmaking and regulatory processes
- Availability of reliable data
- Income classification of informal sector
- Resistance to change among the current stakeholders.
- Individual ability to pay and to enroll into insurance
- The level of insurance literacy among the population
- Supply side aspects such as human and infrastructure resources distribution and the level of autonomy of providers

The possible **time horizon** for achieving the preferred option will depend of the chosen implementation approach:

- a **big bang approach** setting everything straight at once in the HIM. Such approach will most probably lead to massive resistance and disruptions, or
- an **evolving path towards UHC of a reasonably broad and deep BP**, arbitrarily divided in periods of about 5 years which are, more importantly, decided by achieving defined milestones. However, it may be useful for all actors to have a **defined end-goal** and future HIM structure in order to know future perspectives and allow for investments. This seems to most realistic approach.

## 12. Annexes

### *Annex 1      Terms of Reference*

#### **Structure of the Health Insurance Market**

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##### **1. Background**

Tanzania is entering a new phase of health financing reforms based on the reforms undertaken since the early 1990's. The first phase of reforms moved the Tanzanian health financing system from a purely budget financed system to a mixed financing model with the hope of increasing availability and quality of care. In this first phase, user-fees (in 1993), Community Health Funds (CHFs – from 1997 onwards) and the National Health Insurance Fund (NHIF – in 1999) were introduced in order to leverage additional funds, build community ownership and create stronger accountability of service providers. The system now has countrywide coverage albeit with differing enrolment rates of the population.

At the same time, Tanzania has gone through a period of administrative decentralization with profound effects on the way budget financing works. Management and (partly) financing of social services, including primary and first level referral health care, moved to Local Government Authorities (LGAs) and a system of central-local intergovernmental transfers (Block Grants) was introduced, together with a pooled funding mechanism for donor funding (the Health Basket Fund).

A third development has been the overall increase in health expenditure. Total Health Expenditure (THE) increased from US\$734 million in 2002/03 to US\$1.75 billion in 2009/10 (National Health Accounts 2009/10). Per capita expenditure doubled from US\$21 to US\$41. A strong influence on this has been the immense increase in donor funding, which grew from US\$200 million per year to nearly US\$700m per year (while the share of donor funding increased from 27% to 40%).

While these developments have helped to achieve very significant health gains by containing the HIV/AIDS epidemic, reducing Malaria and child mortality, and other successes, challenges remain. There is a large body of evidence that shows that spending from public sources, especially domestic, is still too low to finance a package of essential health services, user-fees are a barrier to access when coverage of pre-payment schemes is low, funding is not distributed equitably between and within districts, and the limited funds available are not used efficiently to achieve the maximum effect. Accountability and transparency can also still be improved.

In order to meet these challenges in an environment in which citizens demand more and better services, and in which development aid is reducing, Tanzania is now embarking on a new round of health financing reforms that will build on the foundations of previous reforms, strengthen existing systems, and develop new approaches where needed.

In 2003, the Government of Tanzania adopted a *Health Policy* with the policy vision “to improve the health and well being of all Tanzanians with a focus on those most at risk [...]”. This vision remains still valid, and the GOT is committed to moving towards *Universal Health Coverage* and to ensure that all citizens have access to quality services and be protected from financial risk. As part of *the Health Sector Strategic Plan III*, a decision was taken to develop a Health Financing Strategy to ensure that this vision would become reality.

Oversight for the development of the Strategy has been given to an Interministerial Steering Committee (ISC), comprising of key ministries and departments, to ensure that proposed reforms be comprehensive, accepted and supported by all stakeholders, and implemented with the support of all stakeholders. To achieve this aim, the ISC has identified key areas for reforms and requested several reports to inform the development of the Strategy. These are:

1. Minimum Benefit Package(s): options to sustainably structure access to benefits;
2. Insurance Market Structure: options for the Social and Private Health Insurance architecture;
3. Performance financing: options for linking allocations to performance of service providers;
4. Equity-based financing: options for improving the equity targeting of (esp. budget) resources;
5. Inclusion of poor & vulnerable: options for identification and financing of services for this group;
6. CHF reforms: options for the re-design of the CHF system;
7. Private sector resources: options strengthening equitable funding from the private sector;
8. Financial management: options for improving accountability and timely availability of funds;
9. Innovative financing and fiscal space: options for increasing public financing for health;

Terms of Reference (TOR) have been developed and approved by the ISC for each focus area. This set of TOR guides the assignment in the area of Insurance Market Structure.

## ***2. Status of Focus Area***

The insurance market is currently split between a social health insurance sector, comprising of the NHIF, the NSSF-SHIB, and the CHF (although strictly speaking, the CHF is better characterized as a local-government based prepayment scheme than an insurance), and a private health insurance sector that can be divided into microinsurance schemes and the standard commercial private health insurance. In addition to this, it is reported that some employers are running own employee health schemes without separating the risk taking function from their core business. No information is available on these schemes, however. In the following, a short description of the main schemes are given.

**NHIF** - Established by Act in 1999 under the Minister of Health. It covers formal public sector employees and, as of 2010, has opened up for the private sector. It covers about 2.5m people and has grown by an average of 11% per year. Premiums are 6% of the basic salary, shared 50-50 between employer and employee. Service coverage is comprehensive and the provider network includes all public plus selected private facilities. It uses fee-for-service for reimbursement of claims. Income has consistently exceeded expenditure and the NHIF has accumulated a large financial reserve.

**NSSF-SHIB** - Health benefit of the NSSF, added in 2006. With the overall NSSF, it is under the Minister of Labour. It aims at the formal private sector. The SHIB premium is included in the general 20% deduction by NSSF (split 50-50 between employer and employee), but only 10% have completed the separate enrolment and are thus able to access the benefit. SHIB individually accredits facilities and pays a capitation fee. A comprehensive set of services is included in the benefits.

**CHF** - With the system established by Act in 2001, district governments establish a CHF through by-laws. They are managed by the local council administration. Coverage is about 3.5m people nationwide; coverage ratios vary strongly between districts. District councils define premiums and the benefit package. Primary level services are included in all districts, services at the first referral level in some. Premiums vary by Council from TSh 5,000 to TSh15,000 per family of six per year. The CHF is meant to serve as the vehicle for poverty based fee-waivers. GOT pays a 100% matching grant for each member to the council. All funds enter the council budget and there is no direct reimbursement to facilities.

**Microinsurance schemes** – Small, self-contained insurance schemes often set up by cooperatives or other non-profits. Often, benefits and premiums are limited and schemes face sustainability issues. Coverage is negligible nation-wide.

**Private health insurance** - A limited amount of commercial insurers offer risk-based (often by company) insurance to the formal sector. Benefit packages are often comprehensive and include services at premium providers. Premiums are accordingly high. Total coverage is below 150,000 and stagnant (while costs and premiums have escalated).

### ***3. Steering & Oversight***

The assignment is aimed at informing the ISC, which will have the final say in all issues related to the process, assisted and supported by the ISC Secretariat and the TWG HF. The TWG HF will develop TOR, pre-select consultants and pre-approve reports for submission to the ISC. The ISC will give final approval of TOR, consultants and report.

The financing organization will ensure that contracting and compliance with contractual obligations from both sides will be fulfilled. The ISC Secretariat will support on these issues.

### ***4. Scope***

The present assignment is meant to focus on the macro-level of the insurance market, rather than the micro-level of institutions. It is aimed at clarifying the structure and necessary rules and conditions to be set for achieving the policy goals established in terms of effectiveness and efficiency. While specific shortcomings of existing institutions should be noted and flagged for change, it is not meant to be an institutional assessment of insurance and regulatory institutions in Tanzania.

International evidence will play a key role in this assignment. Instructive examples for single- and multi-payer systems may be Korea and Estonia and the Netherlands, Germany, Switzerland and France. The latter could also serve as an example for clarifying the different roles PHI can take on, together with the United Kingdom. The example of Rwanda should be incorporated into the analysis. Other examples from middle/low income countries may include: e.g. Philippines, Thailand, Ghana. All key functions of insurances should be explored, including collection, pooling, and purchasing, benefit package formulation, accreditation, etc

### ***5. Objectives and tasks***

The overall objective of this assignment is to develop comprehensive, adequate and feasible reform strategies / options for the focus area Insurance Market Structure to be presented to the ISC for feeding into the Tanzanian Health Financing Strategy.

The specific objectives and tasks of this paper are:

- To describe and visualize the status quo of the health insurance market, with reference to population coverage and wealth/income levels;<sup>75</sup>
- To assess in detail the current roles and responsibilities of different segments of the health insurance market and ambitions and views on the "market";

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<sup>75</sup> SHIELD

- To describe the policy goals of the Tanzanian Government in the health and health insurance and labour market areas to establish a frame of reference against which to assess possible performance of reform options;
- To describe and assess the insurance market structure in other countries with a social health insurance sector; including high, middle and low income countries with a view to population coverage, benefit coverage, and cost coverage;
- Investigate international experiences with single and multi-payer social health insurance (SHI) and of addressing fragmentation of SHI markets where several providers co-exist (including ways to manage risk selection, adverse selection and other risk-pool related issues; and use of risk equalization schemes to mitigate such issues);
- Investigate international experiences with the role private health insurance (PHI) can play in systems with SHI, taking into account complementary, supplementary and substitutive PHI, and the role of public-private risk equalization and subsidization;
- Develop options for re-insurance in proposed market structures, and the feasibility and/or desirability of re-insuring locally schemes with smaller risk pools (e.g. CHF) through insurers with larger risk pools and/or financial depth.
- Assess the ability to control costs (service and administration) of different systems internationally, and if possible, compare cost developments (and their drivers) in different insurance market segments (social vs private, formal vs informal) in Tanzania;
- Assess in how far common systems, e.g. quality assurance / accreditation, claims verification, IT, monitoring and evaluation systems could be used under different insurance market structures;
- Establish technical and M&E requirements in order to implement risk equalization schemes and assess the extent to which these exist, or capacities to establish these exist in Tanzania;
- Assess in how far and in which way regulatory frameworks and institutions would need to differ under different insurance market structures, and where the current framework and institutional landscape would need to be changed;
- Present between three and five reform options / scenarios for the insurance market that are specific enough to bring out differences and general enough to allow for use in a strategic document and adaptation and modification in implementation. Each of the options / scenarios is to be backed up by a SWOT analysis presenting internal strengths and weaknesses and external opportunities and threats (with reference to the GOT policy goals established) to allow the ISC to assess the different options/scenarios and to make a choice.
- Present reform options in a way that can be included in a draft health financing strategy

## **6. *Methods***

The report will rely on literature reviews, data to be provided by health insurers, the HI regulatory bodies and key stakeholder interviews. The literature review will include Tanzania and other selected countries (to be proposed in the inception report). Stakeholder interviews will be conducted in Tanzania and may be in other countries examined. However, country visits will be limited to Tanzania, stakeholder interviews in other countries will need to be conducted remotely. Primary data collection through surveys is not foreseen, while focused group discussions with key stakeholders and (potential) insurance users can be considered. Key stakeholders are expected to include: NHIF, NSSF, Ministry of Finance, Ministry of Labour, Ministry of Trade & Industry, SSRA, TIRA, etc.

## **7. *Timeframe and Deliverables***

The suggested timeframe for this assignment is 1<sup>st</sup> of April to 30<sup>th</sup> of June.

#	Deliverable	Weeks after signing
1	Inception report incl. report outline	2 weeks
2	Draft report incl. executive summary, options and SWOT	8 weeks
3	Presentation to ISC	10 weeks
4	Final report incl. executive summary, options and SWOT	12 weeks

## **8. Relevant materials**

Relevant materials include:

- National Health Accounts 2009/10 (MOHSW 2011)
- Health Sector PER – various editions (MOHSW 2011)
- Tanzania Health Systems Assessment (MOHSW with HS2020, 2011)
- (Draft) Health Financing System Analysis (TWG HF 2012)
- Making Health Financing Work for the Poor (World Bank 2011)
- Regulation Study 2012
- Regulation Study 2008
- Social Health Insurance Regulation (NHIF, NSSF, CHF and other relevant Acts)
- SHIELD reports (IHI, various years)
- CENFRI paper on insurance market diagnostic
- Country reports on CH, D, F, UK & NL of the European Observatory on Health Systems and Health Policies

## ***Annex 2 Literature***

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**Annex 3. Schedule of meetings and people met**

Date & time April	Counterpart name & position
<b>9 April - TUE</b> 09.00 – 11.00	Health Care Financing Committee Kick off meeting
12.00 – 13.00	Permanent Secretary MOHSW, Mrs. Regina L. Kikuli
<b>10 April - WED</b> 09.00 – 10.00	Francois Van Der Merwe CEO- Strategis Health Insurance Company
10.15 – 10.50	Ansgar Mushi, Director Research-SSRA
11.00 – 12.00	Mr. E. Mdee, Dep. Director General NHIF Mr. Rehani, Dir- CHF
14.00-16.00	Mr. Jonathan Kasembe, FSDT (Microinsurance)
<b>11 April THUR</b> 08.30 – 09.00	Mariam Ally Econ, Health Financing Unit
14.30 – 16.00	Ms Maryane Mugo Chairperson-ATI
<b>12 April FRID</b> <b>12.30 - 14.00</b>	Mrs. Pricilla Karobia, CEO - Outtassurance
<b>15 April MON</b> 07.30 – 9.00	CSSC Mr. Maduko
10.00 – 12.00	Dr. Mohamed A. Mohamed, Dir. Inspection/QA MoHSW Dr. Ngonyani, Dep. Dir Inspection/ QA
12.45 – 13.50	APHFTA, CEO- Dr. Sam Ogillo
15.00-16.00	Mr. Arthur Mndolwa, AAR- Business Dvt Manager Mr. Palmaram Nkya, AAR – Health Insurance Consultant
<b>16 April TUES</b> 10.00 – 11.00	Dr. Donan W. Mbwambo, Acting. CMO MoHSW
12.00 – 13.00	Mr. Kaali , Commissioner for Social Security -MoLE
15.00 – 16.00	ATE - Dr. Aggrey, Mlimuka
<b>17 April WED</b> 11.00 – 12.00	Mr. Izrael Kamuzora CoI TIRA
<b>Tues 18<sup>th</sup> April</b>	
09.00-10.00	Mr. Yatera Mbaga PMO-RALG-Econ
11.00 – 12.00	Edward Sungula, MOIT – Dir P&P

14.30 – 16.00	NHIF Mgt
19 April 14.00 - 1600	Inception meeting/briefing
<b>05<sup>th</sup> June</b> 10.00 – 12.000	Godfrey Gabriel Head of Research Department – Fair Competition Commission
03.00-04.20	Ansgar Mushi Director Research & Actuarial - SSRA
11 <sup>th</sup> June 09.30 – 11.00	Mr. Hamis Mdee, Phineas Mato, Ali Othman, Beatus Chijumba, Dr. Frank Leakey NHIF Management
11.30 – 01.00	Alfred Mapunda, Dr. Ishebabi, Dr. Phidea Mgina, Gaitan Mrimi, MOIT
13 <sup>th</sup> June, 2013	Wrap Up Meeting

#### **Annex 4      OECD Definitions of functions of Private health insurance**

- **"Primary PHI:** private insurance that represents the only available access to basic health cover because individuals do not have public health insurance. This could be because there is no public health insurance, individuals are not eligible to cover under public health insurance, or they are entitled to public coverage but have chosen to opt out of such coverage:
- **Substitute:** private insurance for health costs, which substitutes for cover which would otherwise be available from a social insurance or publicly financed insurance or employer's scheme<sup>8</sup>.
- **Principal:** private insurance for health costs, which for the insured individual represents the only available access to cover where a social security scheme does not apply. This includes employer's compulsory schemes if cover is privately insured or self-insured.
- **Duplicate PHI:** private insurance that offers cover for health services already included under public health insurance. Duplicate health insurance can be marketed as an option to the public sector because, while it offers access to the same medical services as the public scheme, it also offers access to different providers or levels of service, such as: i) access to private health facilities that are not accessible through public insurance when the full cost of the service is paid by private insurance; ii) access to fast/privileged cover by bypassing queues in public system; iii) Access to care independent from referral and gatekeeper systems; iv) choice of doctor, hospital, or other health provider. It does not exempt individuals from contributing to public health insurance.
- **Complementary PHI:** private insurance that complements coverage of publicly insured services or services within principal/substitute health insurance, which is intended to pay only a proportion of qualifying care costs, by covering all or part of the residual costs not otherwise reimbursed (e.g., co-payments).
- **Supplementary PHI:** private health insurance that provides cover for additional health services not covered by the
- public scheme. Depending on the country, it may include services that are uncovered by the public system such as
- luxury care, elective care, long-term care, dental care, pharmaceuticals, rehabilitation, alternative or complementary
- medicine, etc., or superior hotel and amenity hospital services (even when other portions of the service (i.e. medical
- component) are covered by the public system)."

Source: OECD (2004)

## **Annex 5      *Health insurance typology and definitions***

The typology of insurance modalities and the characteristics that they can have follows hereafter<sup>76</sup>. The relative effectiveness and efficiency of the indicated characteristics, options and tools are indicated. References are made to international examples when discussing features

3. **Health insurance** is "a way to distribute the financial risk associated with the variation of individuals' health care expenditures by pooling costs over time (pre-payment) and over people (pooling)". It differs from
  - a. Out of pocket payments (OOP) which has no pre-payment and does not pool.
  - b. Individual medical savings accounts (MSA) which offer pre-payment but no pooling<sup>77</sup>.
4. Health insurance shows many other features, besides pre-payment and pooling:
  - a. **Goal orientation:**
    - i. primarily **business oriented**, money making, can be left to private initiative and the private market and will be regulated like any other private insurance. Such regulation would aim at consumer protection against swindle and the consequences of bankruptcy. NB the terms business and money-making are not to be seen as disapproving. This type of private health insurance responds to demands in the market and has its role. However only those who can pay the contributions can enroll unless subsidized by another party such as the state or an employer.
    - ii. primarily **health oriented**. Such health insurances can have either private or public status. It is characterized by regulation that is more than just aiming at consumer protection against financial loss and swindle by an insurance entity. Key regulated element in such health oriented insurance is the package of benefits. The regulator implements health policy by setting requirements for the BP.
    - iii. **social/financial security oriented**: preventing impoverishment due to the consumption of necessary health services. Although business oriented health insurance also prevents unexpected and substantial financial losses it does not focus on sectors of society that lack the means to pay into health insurance or have other priority expenditures e.g. for food and education. Business oriented private health insurance uses flat rates while social security oriented insurance mostly use income-dependent (percentage based) contributions or cross subsidies from private schemes or the state budget which both include the transfer of money from the rich to the poor. Enforced solidarity between the rich and the poor and between the singles and the families (in case dependents are co-insured for free) with the aid of income dependent contributions characterizes so-called social health insurance.
  - b. **Legal status**, can be:
    - i. public
    - ii. private:

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<sup>76</sup> The quoted definitions are mainly from OECD's Proposal for a taxonomy of health insurance. Op Cit.

<sup>77</sup> This option is not discussed in this report because it has no solidarity element and hence is no solution to solving the health services access problems for the poor. MSAs can be found in e.g. Singapore and the USA, where enrollment offers a tax deductible <http://www.irs.gov/pub/irs-pdf/p969.pdf>

1. for-profit
2. not-for profit, e.g.
  - a. NGO
  - b. Mutual or cooperative

**NB:** an insurance entity can implement any type of insurance irrespective of its legal status. The differences are brought about by the **regulatory environment** in which the health insurer has to work or is licensed to work and can implement health insurance. This means that a private health insurer can also implement a mandatory health insurance, commonly called social insurance. This is the case in e.g. Switzerland with not-for-profit private insurers and in The Netherlands which has for profit private insurers. In other words, the legal status of an insurer does not determine its orientation, the cover it offers or the level of financial protection. What matters is the regulatory environment that determines the mandate of the licensed insurer.

**c. Sources of financing:**

- i. general revenues, tax based
- ii. Earmarked taxes, sometimes as "sin taxes" on e.g. alcohol, tobacco and other products potentially harmful for health.
- iii. pre-paid contributions
  1. flat rate
  2. income (%) based
  3. combination of 1. and 2.
- iv. OOP payments at the points of services and a general deductible, possibly income related.
- v. Combinations of i., ii. and iii.
- vi. Subsidies from other sources, e.g. from other health insurers or indemnity insurers
- vii. Other

**NB,** the source of finance does not define the orientation of health insurance or the level of coverage or social protection offered. Private health insurance can also be funded from income based contributions and public insurance from flat rate premiums in countries such as the Netherlands and Switzerland.

Most countries have mixed sources of financing. Even countries of which one would easily assume that these would be fully funded from general taxes have dedicated other sources, such as the NHS in the UK which is partly funded from a special health insurance tax. The reverse is the case in the USA where private health insurance seems to be dominant but where about half of total health expenditures (THE) come from general taxes, such as for Medicare, Medicaid and the Veterans Health System.

**d. Determining level of resources**

This depends, besides of the composition of the MBP and its estimated costs, of the sources of financing and of the characteristics of the BP: a) provision oriented (such as the English NHS), b) reimbursement system or c) an in kind system with the main difference between these being the existence of enforceable entitlements and fixed budget or open-ended funding system.

A **provision oriented system is supply oriented**. It has most likely a fixed budget (or fixed contribution rate) and the realization of benefits is dependent of the capacity of the health facilities which is restricted due to their fixed budgets; Such system is mostly seen in national health systems.

A **reimbursement system** reimburses the insured the incurred costs of care, provided the received care was covered and the insured has an indication for the used care. This system leaves it to the insured to find a willing health services providers and, if not finding one, his insurer has no obligation to provide for one unless a sufficient number of contracts with providers is used to guarantee access; The insured has no certainty in advance whether he will get reimbursed. This system is common in private health insurance. However, private insurers can also opt for contracting providers and offer its insured cashless access to providers. By doing this they increase the certainty to the insured about receiving care and getting it reimbursed but it does not grant them a right to access to services: the insurer is not obliged to guarantee this. Meanwhile the insurer will save admin costs because he does not have to deal with lots of bills of his insured but deals with bulked billing by providers all at once. A reimbursement system is not only administratively more costly than an in-kind contract supported system it has also less possibility to influence the fee levels and it offers less protection to patients as regards charging high fees as the example of the Philippines health insurance system shows (See annex 6).

An **in-kind system** obliges the insurer to pay directly to the providers it has contracted to guarantee access. The insured don't have to pay at the point of service (POS) except possible copayments or when his deductible is not yet exhausted. The contracted provider will have the obligation to inform the insured upfront whether the care to be provided is covered by the insurer. This system offers the best guarantee to insured of getting access to services and to know in advance what he has to pay for. It is found in most so-called statutory or social health insurance systems. From the point of the insured this is the best system for enforcing his rights.

An **in-cash system** pays the insured a predefined sum of money in case an insured event happens. It is left to the insured to spend the money either on its intended purpose or to his own liking. Such systems are seen in indemnity insurance as well as in long term care arrangements and for medical aids and supplies for the handicapped.

#### **Fixed or open-ended**

A system of legally enforceable entitlements is mostly combined with an open-ended financing system with adjusters for balancing revenues and expenditures. These adjusters can be: the introduction or increasing of copayments, the reduction of benefits, the reduction of provider fee levels or the adjustment of the contribution rate. Temporary balancing can be done from reserves, bank-loans or government back up. Estimating finance needs to be done by:

- i. one-time costing study of intended BP, leading to fixed budget and/or contribution rates with possible adjusters due to inflation of prices and increasing demands for the set MBP. The validity of such study doesn't last long because of e.g. increasing demand, new health technologies, price inflation and



the uptake of new or revised medical protocols. Such costing study need therefore regular updating which can be done by

- ii. regular actuarial-estimates based setting of contribution rates with regular adjustments of insurance budget, contribution rates and/or cross-subsidization levels.
- iii. costing studies or health technology assessment to estimate the consequences of the introduction of new medical technologies, which can range from new drugs, the use of new equipment for diagnosis and therapy to new surgical and other medical or paramedical procedures and care arrangements.

**e. *Types of contribution rate setting***

All contributions are based on an estimate of the risks the insurance runs in covering its insured. This can range from individual risk rated contributions, via family risk rating, community risk rating, enterprise-related risk rating to risk rating for all enrollees in a system.

- i. ***income based*** with percentage fixed for all contributors progressively or regressively set for identified income brackets, sometimes combined with
  1. maximum income level above which no contributions are paid.
  2. minimum income level up to which no contributions are paid.

This type rate can be easily done for formal sector employees and in countries with an effective tax system for self-employed and people in the informal sector, possibly combined with a proxy means testing system.

- ii. ***flat premiums*** which can be risk rated in all possible variants as mentioned above
- iii. a ***combination*** of income based and flat rates

Individual flat rates can be increased with fixed amounts to cross subsidize e.g. from private health insurance for the well off to public mandatory health insurance for the not well off categories of the population.

NB. ***Taxes and income based premiums imply the highest level of solidarity.*** Cross subsidies from private insurance can also enforce some level of solidarity. But, unless these are income-dependent, they will not imply the same level of solidarity. OOPs and individual risk-rated contributions have the lowest levels of solidarity.

Adjustability of contribution rates is warranted in a system with enforceable entitlements while at the other end of the spectrum it can prevent too high fixed contribution rates, possibly leading to unnecessary high reserve funds at the insurer such as in Tanzania's NHIF.

**f. *Collection of revenues or contributions***

- i. by health insurance entity directly from insured
- ii. by intermediary
  1. general tax collection system
  2. employer
  3. other

NB. Although the direct payment of contributions to the insurer is supposed to create and maintain a more direct relation between insurer and insured in mandatory employment-based health insurance it is mostly automatically deducted by the

employer from the insured's salary and sent to the indicated health insurance fund or other collector. The insured would hardly notice unless big changes in the rate are affecting net income. **Direct collection via the tax-collector would be the more efficient system**, practiced in NHIF's system, as compared to a system in which the insurer has to establish and implement its own contribution collection system whereby this in enterprise related enrolment goes easier than in case of individual enrolment .

**g. Pooling of revenues:**

- i. by insurance entity
    1. own bank account
    2. national or regional treasury system. This variant has the advantage of not being dependent of commercial banks with their risks of bankruptcy. **It makes an efficient combination with the tax system collecting the insurance contributions.** Obviously, such pooling needs to be well governed, transparently and with full accountability towards insurers and insured.
  - ii. by a health fund, also called central fund or health and equity fund. Such fund can pool contributions directly from insured, from one or more health insurers, from the state and from other sources. Such fund can be used for cross-subsidization of the insurance for those who are defined as unable to pay themselves the contributions or not in full or it can act as a vehicle for risk-adjustment between health insurers to decrease the incentive of risk-selection by insurers and improve equal access to insurance.
- h. **Reserves** to be built and kept will be required from contribution based health insurers to guarantee their insured access to covered services. The level of reserves is dependent of the extend of the risks the insurer is running and of the existence of a government funded back up or stop loss system. Private health insurers in Tanzania are required to have reserves in accordance with the same formula as used for pension insurance or life insurance while the character of health insurance, being a pay as you go system, is rather different and needs not the substantial reserves as in these other insurances with long term obligations.
- i. **Purchasing.** Besides **what kind of services** (BP) insurance has to pay for, the actual tools it has at its disposal to purchase will co-determine the cost-effectiveness of health services delivery, i.e. the **freedom to select providers, to select specific services of selected providers and in specified volumes, using competition between providers and selection as instrument for enhancing efficiency in health services delivery; can it determine the remuneration system and negotiate the fee levels; is it able to review the financial claims of the providers or insured?** The more an insurer has of these instruments and the freedom to use them the more effective he can be in cost-containment and quality assurance on the supply side. Of course selection can only happen in case of oversupply and multiple providers in an area small enough to allow access for all. In Tanzania this is only the case in urban areas and even there "oversupply" is relative given the general shortages in facilities and services.

**Benefits package** design and maintenance can be done by the legislator, with details possibly mandated to the Minister of Health, or left to the insurer. The first option is seen in mandatory insurance, the second one also in mandatory insurance, to some

extent, and obviously in private voluntary insurance. Dependent of the level of detail in a legally determined BP, such detailing can also be left to statutory insurance bodies and providers in order to accommodate progress in medical science and technology and to include emerging new health technologies or the application of existing ones for new indications as part of the BP. Of course, obsolete health technologies can also be dropped. This is done e.g. in Germany by the National Joint Committee of providers and insurers<sup>78</sup>. However, more and more countries are using explicit decision making procedures supported by health technology assessment results to possibly accept the inclusion of new interventions in the benefits catalogue and to avoid automatisms<sup>79</sup> and hence uncontrolled cost increases. Also in developing countries HTA is being used e.g. in the Philippines<sup>80</sup>.

In a system of **mandatory insurance with competing insurers** it is important to have a centrally set and detailed BP with absolute clarity on what's covered in order to avoid risk selection by insurers via manipulation of the BP and hence limiting access to necessary care. Interpretation problems re the BP should be set by an independent body which can either do this spontaneously or on request/complaints of involved parties or with a combined mandate as is the in the Netherlands with its Health Care insurance Board (College voor Zorgverzekeringen)<sup>81</sup>.

**Contracting** between health insurers and providers is an important tool in purchasing. This is common in statutory health insurance and also used in private health insurance. Contracts can be made on the national level, e.g. as models outlining the general aspects, and on the individual level incorporating all the necessary details.

If, when contracting, a health insurer is allowed to select providers, based on the needs of its insured and on the perceived quality and performance of providers than such selection option supports the insurer in making health services more efficient and of better quality: selective contracting as incentive for **competing health services providers**. If such selection is possible, can the insurer **select between public and private providers** for the same type and quality of services and does a level playing field exist to allow for fair competition between all providers irrespective of ownership status? This latter aspect touches upon the way investments in health services infrastructure and equipment are financed. This question is not only important for an effective role of insurance to enhance effectiveness and efficiency among providers but also for the possible role of private health institutions in delivering the MBP as mentioned before.

**Fee levels.** One of the challenges health insurance is confronted with is the question of reasonableness of the fees requested by providers for specific health interventions or admission days. Although line-item budgeting of public providers helps in getting insight in costs of providers, this method does not provide information about the cost-effectiveness of the medical interventions and does not give insights into the necessary labor and in ways to increase productivity. Actually paid fees seldom reflect the real

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<sup>78</sup> <http://www.english.g-ba.de/>

<sup>79</sup> Gibis, Bernard; Pedro W. Koch-Wulkan & Jan Bultman: Shifting criteria for benefits decisions in social health insurance systems; in: Social Health Insurance Systems in Western Europe; Saltman, Richard B., Reinhard Busse & Josep Figueras, eds. European Observatory on Health Systems and Health Policies. 2004

<sup>80</sup> <http://www.ncbi.nlm.nih.gov/pubmed/20586975>

<sup>81</sup> <http://www.cvz.nl/en/cvz>

costs of interventions. Overhead costs are arbitrarily divided over the different health interventions. Productivity and efficiency may change over time after the introduction of new interventions due to learning phase problems and delegation to lower paid staff. So, adjustability is key.

Besides costing studies to determine a benefits package, many countries use **health technology assessment** to base decisions on for the introduction of new health technologies into the benefits package, such as the UK's National Institute of Clinical Excellence and Care. Such assessments not only address the costs per intervention or e.g. a new drug in the necessary dose but can also provide information on the expected volume of use, i.e. about the expected yearly costs of an intervention. This information can be used by insurers in fee negotiations with providers and for the calculation of contribution rates and/or cross-subsidies.

**Centralized fee setting.** Although the determination of fees can be left to the individual insurer and its negotiations with providers, only a monopolist insurer will have full insight in the production and performance of providers. In countries with multiple national insurers an insurer will not have such comprehensive oversight and insight in provider performance. Reviewing whether requested fees or their increases are reasonable requires expensive capacity at the insurers. It is therefore efficient to set fees on the national level by either negotiations between representatives of insurers and providers, such as in Germany, or ultimately by a national public authority such as in The Netherlands until 2005. A capable secretariat or an independent outside institution can support the underpinning of the fee levels. Centralized fee setting was also proposed in Tanzania during the preparation of the Health Insurance Regulatory Review<sup>82</sup>.

**Provider performance review.** An important task of an insurer is the review of submitted claims by providers or their insured, checking whether the provided care is included in the BP; whether the claimant or its patient is entitled to reimbursement; whether there is a justified medical indication for the health intervention for which reimbursement is claimed; whether the provider has delivered the care in accordance with agreed or nationally accepted standards of care, algorithms and medical protocols and whether the requested fee level is in accordance with the pre-determined level? Several conditions would need to be met to accommodate effective and efficient review of providers: the existence of nationally endorsed services delivery standards, algorithms, clinical practice guidelines, medical protocols and clinical pathways as well as a suitable administrative infrastructure at the provider and the insurer using a nationally agreed coding system. Obviously, the insurer should have the necessary capacity for review of claims and provider performance.

- j. **Level of compulsion.** This does not address the insurance entity but refers to people belonging to categories of the population that are obliged by law to enroll in insurance. This can be either in a public or a private scheme. It can be into a single insurance in a particular country or region or in one of many insurances, possibly competing with each other. It can be bound to the type of enterprise or conditions of employment or compulsory for the population at large. **The level of compulsion is a decisive factor in**

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<sup>82</sup> Bultman, Op. Cit.

**achieving UHC**, unless enrolment is for free, such as for the poor in the Universal Coverage Scheme (UHS) in Thailand . The definition of who is "mandatory insured" can go and probably has to go into great detail as part of the regulatory process and dependent of the type of insurance, e.g. as regards exempted categories in an formal employment sector related insurance system for diplomatic staff, persons on short term contracts, stand-by contracts or working minimal hours per months. The term "employer" will also have to be described in an employer/employee based system, e.g. is a person which has a domestic aid worker once per week an employer.

- k. **Contributor-beneficiary split.** Distinction and possible separation between paying into a contribution based HI and enjoying the benefits is happening around the world. One can be beneficiary while exempted from paying contributions such as in case of co-insured dependents or non-paying categories such as children, pensioners, unemployed etc).
- l. **Accreditation of health services** is one of the external assessment systems of quality of health care services. it is defined as " *“A public recognition of the achievement of accreditation standards by a healthcare organisation, demonstrated through an independent external peer assessment of that organisation’s level of performance in relation to the standards.”*<sup>83</sup>

Accreditation is not a key insurance function or a universal feature of insurers or insurances. In most countries, especially with multiple insurers, accreditation is done by an outside body. However, **insurers should make sure that they contract providers able to provide quality services according to generally endorsed standards.** Being accredited should be an important feature in the selection of providers and contracting their services.

In a situation of multiple insurers, such as in Tanzania, it will be confusing for providers and patients if different standards exist, besides cumulating admin costs.

As part of its purchasing function an insurer would have to care for the review of the performance of contracted providers vis a vis the BP and the appropriateness of the provided services against agreed standards. Claims review is an important vehicle for such review. These purchasing functions should be more in the focus than accreditation, which can be left to an outside body. Besides this, the Tanzania MOHSW has established a Quality of Care Department. It is working, based on the MOHSW quality strategy<sup>84</sup>, on a program of stepwise going to accreditation, supported by international accreditation agencies. This could lead to the establishment of a national accreditation body, posing the question whether separate accreditation systems of different insurers should remain in Tanzania. In case accreditation is done by a national accreditation body then contracting by insurers can be based on the external quality assessment of such body and the standards used for accreditation.

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<sup>83</sup> Shaw, Charles D. Toolkit for accreditation programs, some issues in the design and redesign of external health care assessment and improvement systems. The International Society for Quality In Health Care Melbourne 2004

<sup>84</sup> MOHSW: The Tanzania Quality Improvement Framework in Health Care 2011-2016. October 2011

## ***Types of insurance***

The above description of insurance characteristics illustrates that calling insurance public or private is not decisive for achieving UHC and for having an efficient health financing system. It is the regulatory framework that makes the difference in gearing the mandate of health insurers, the level of compulsion, the chosen collection and pooling of resources and the provided tools for purchasing all towards the potential of UHC. Obviously implementation capacity matters too. The sources of financing as such do not matter that much but the poor cannot be covered without income transfers, solidarity from the rich via either a progressive tax system and/or an income based individual contribution system, possibly combined with an income dependent system of copayments when using services.

Nevertheless different countries have organized their health insurance systems in different ways and with health insurances that differ in the above mentioned characteristics. The main distinction is between mandatory and voluntary systems.

The **mandatory systems** can have different features, described above.

The voluntary systems can be:

- **Substitutive** for the mandatory insurances in case people have either the possibility to opt out of the mandatory system or are not belonging to a category of the population that is mandatory covered.
- **Duplicative** when people, although already mandatory insured, chose to also voluntarily join a private insurer offering voluntary insurance with a BP of possibly the same breadth and depth as the mandatory system or even more.
- On top of the mandatory system:
  - **Supplementary insurance** pays for the residual costs of mandatory insured but not fully reimbursed benefits. It extends the depth of coverage.
  - **Complementary insurance** covers those benefits and services that are not covered by mandatory systems. These can be e.g. private rooms and amenities in as such mandatory covered hospital care or medical interventions and national or international providers that are not covered by the mandatory system. It extends the breadth of the coverage

This report will use the above definitions of mandatory and voluntary insurances in conformity with the OECD's Taxonomy of Health Insurance although also other and different definitions are used<sup>85</sup>. (See Annex 4 for a more detailed quote of OECD's taxonomy. Besides the referred OECD taxonomy paper on health insurance, a World Bank published handbook also offers valuable additional definitions and concepts<sup>86</sup>.

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<sup>85</sup> e.g. by Mossialos & Thomson their book on Voluntary Health Insurance in Europe (EU Observatory 2004; <http://www.euro.who.int/en/who-we-are/partners/observatory/studies/voluntary-health-insurance-in-the-european-union>;

4. **Substitutive**: cover that would "otherwise be available from the state
5. **Complementary**: "cover for services excluded or not fully covered by the state (including cover of copayments imposed by the statutory health care system)"
6. **Supplementary**: "provides cover for access and increased consumer choice"

<sup>86</sup> Wang, Hong et al: Health Insurance Handbook, how to make it work. World Bank Working Paper 219. Washington, 2012

**Community based health insurance** does not principally differ from other insurances except for its scale. It is mostly voluntary and uses flat rates.

***Choosing the best health insurance arrangements and market structure: who is allowed to operate which type of insurance with which characteristics?***

The above described possible features of health insurances and the indicated advantages of some features as compared with others will be used further on in this report to offer options for the insurance market and may help in choosing the best options in accordance with Tanzania's health policy goals, values and existing market and stakeholders, including the GOT as payer, owner and deliverer of health services.

## **Annex 6      *Competition between health insurers***<sup>87</sup>

Several countries have embarked on using competition between mandatory insurers and hope that this works as an instrument for improving client orientation and efficiency in health insurance administration and the delivery of health services as included in the MBP. However, the supposed effects on efficiency have never been proven and have shown to be difficult to evaluate due to many concomitant other interventions in country health systems<sup>88</sup>. Given the market failure in health care as regards guaranteeing access to basic care, countries that care for access and affordability of care have regulated the competition of health insurers.

### ***Challenges***

Those countries that have embarked on competition between insurers in the implementation of mandatory health insurance have been faced with many challenges, most of all with the problem of risk selection by insurers, also called "cream skimming". To stay within their budget, risk selection is easier to do than trying to reduce health services expenditures by improving efficiency of health services providers via purchasing and in-depth provider performance review. It is for the insurer a more effective and efficient policy to stay within budget and prevent premium increases and loose out in the competition. However, ***risk selection reduces access to health insurance and hence to health care for those most in need.***

***Risk selection*** comes in many forms, e.g.:

- v. Selective marketing by focusing on the relatively healthy, e.g. the young, the well off and going for collective contracts with enterprises in non-health-risky sectors, and avoiding to focus on the high risk categories: elderly and chronically ill.
- vi. Selective contracting, e.g. not with medical specialists preferred by the chronically ill.
- vii. Using enrolment barriers to supplementary insurance to fend off the chronically ill, in case statutory competing insurers are allowed to also offer voluntary insurance for which they can do risk rating and excluding the high health risks.
- viii. Giving discounts on other insurances, offered in a package together with health insurance, especially via collective contracts with companies

### ***Pre-conditions.***

To respond to the posed challenges several conditions need to be met, which e.g. neither Belgium, Germany, Israel, the Netherlands and Switzerland have done yet in full despite many years of implementation of a system of competitive health insurance.<sup>89</sup>, see table 2.

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<sup>87</sup> This section draws heavily from the articles of Ven de Ven and Thomson and from the study of Schneider, quoted hereafter as well as from the personal experience while working in the Dutch health insurance system from 1981 till 1998, and a later study of one of the authors of this report on "Risk adjusted funding in the Netherlands, Bultman, World bank, December 2004.

<sup>88</sup> Thomson, Sarah et al. Statutory health insurance competition in Europe: A four-country comparison. Health Policy, 1020130 20-225

<sup>89</sup> Ven, Wynand van de, et al: Preconditions for efficiency and affordability in competitive health care markets: are they fulfilled in Belgium, Germany, Israel, the Netherlands and Switzerland? Health Policy 109 (2013) 226-245.



**Table 2: To what extent are preconditions fulfilled in five reviewed countries**

(0= not fulfilled at all; 2 = hardly fulfilled; 5 = moderately fulfilled; 8 = largely fulfilled; 10 = completely fulfilled)

Precondition	Belgium		Germany Social HI		Israel		Netherlands		Switzerland	
	Aver age	(st. dev.)	Aver age	(st. dev.)	Aver age	(st. dev.)	Aver age	(st. dev.)	Aver age	(st. dev.)
1. Free consumer choice of insurer										
1.1. No refusal or exclusions	10	(0.0)	9	(0.5)	10	(0.4)	10	(0.0)	10	(0.8)
1.2. Sufficient choice options	3	(1.6)	6	(1.3)	5	(1.3)	9	(0.9)	8	(0.5)
1.3. The ease of switching	10	(0.4)	9	(1.0)	6	(1.1)	10	(0.8)	9	(1.1)
1.4. Switching basic insurance not hindered	9	(0.8)	9	(0.5)	8	(1.0)	6	(0.8)	6	(0.9)
2. Consumer information and transparency										
2.1. Insurance products	5	(0.8)	7	(1.1)	5	(1.1)	7	(1.3)	7	(1.3)
2.2. Medical products	3	(0.8)	5	(0.5)	1	(0.9)	6	(0.5)	4	(1.0)
3. Risk-bearing buyers and sellers	5	(0.9)	8	(0.6)	7	(1.0)	9	(0.7)	8	(0.6)
4. Contestable markets and sufficient supply										
4.1. Market for basic health insurance	1	(1.0)	1	(0.9)	1	(0.8)	9	(1.5)	5	(1.8)
4.2. Market for hospital services	2	(0.5)	4	(1.3)	1	(0.8)	6	(1.3)	2	(1.1)
4.3. Markets for freestanding providers	5	(1.4)	5	(1.3)	3	(1.8)	7	(1.5)	5	(0.9)
5. Freedom to contract	0	(0.8)	3	(0.8)	8	(1.1)	8	(0.7)	5	(0.9)
6. Effective competition regulation										
6.1. Market for basic health insurance	0	(0.8)	2	(0.8)	0	(0.8)	8	(0.5)	0	(0.8)

6.2. Market for hospital services	0	(0.8)	7	(0.9)	0	(0.8)	8	(0.5)	0	(0.8)
6.3. Market for freestanding services	0	(0.8)	6	(0.9)	0	(0.8)	9	(0.8)	0	(0.8)
7. Cross-subsidies without incentive for risk selection										
7.1. Presence of cross-subsidies	7	(0.9)	9	(0.8)	6	(0.5)	9	(0.8)	8	(0.6)
7.2. No incentives for risk-selection	9	(0.8)	7	(0.8)	4	(0.6)	8	(1.0)	4	(1.0)
8. Cross-subsidies without opportunities for free riding	10	(0.5)	7	(1.5)	10	(0.0)	8	(0.6)	6	(0.9)
9. Effective quality supervision	7	(1.1)	8	(0.9)	8	(1.0)	8	(0.6)	3	(1.3)
10. Guaranteed access to care	10	(0.8)	7	(1.0)	7	(0.8)	10	(0.8)	10	(0.8)

These conditions are costly to meet and comprise:

- ii. Developing and implementing regulations, aiming at making a competitive system effective and efficient and capable to prevent risk selection by setting the following conditions:
  - a. Obligation for the insurer to accept any person who wants to enrol.
  - b. No risk rating by the insurer for individuals or specific categories of enrolees, i.e. charging the same premium to all who want to become insured.
  - c. Free choice of insurer and freedom to change at any time or once in a set period. However, chronically ill and elderly are less inclined to switch because of fear of losing their favourite provider<sup>90</sup>. In turn, insurers will have less incentive to go for more efficiency and service quality in care for these categories of insured.
  - d. Guaranteed access to well defined BP, the same for all insurers, licensed to offer such mandatory insurances.
  - e. Consumer information on offers and performance of insurers and market transparency as well as on the services and quality of the providers that are contracted by a particular insurer. This latter condition is difficult to meet because of the inherent difficulties of measuring quality of services. But, e.g. differences in waiting time are easier to measure and report. Besides this, hospitals may excel in one type of service, e.g. cancer surgery, but offer substandard care in other specialty areas.

<sup>90</sup> Thomson. op cit

- f. Risk bearing buyers and sellers of insurance policies, i.e. people need to have an interest in looking for the cheapest and best performing insurer, including their contracted providers.
  - g. Contestable markets of insurers and health care providers. This means that there is access for newcomers if they can comply with the requirements. Competing in insurance presupposes competing between health services providers.
  - h. The insurer should have a broad mandate in purchasing to contract the providers that offer the most cost-effective care and of good quality.
  - i. Effective and independent supervision of quality of care, to prevent skimping by insurers and providers.
- iii. Adequate licensing requirements
- iv. Effective competition (anti-monopoly) authority with mandate and capacity regarding health insurance and providers and the necessary tools to e.g. prevent competition decreasing mergers.
- v. Cross subsidies without opportunities for free riding, i.e. in case an insured should directly pay a contribution to his insured but fails to do this his access to care is restricted until payments have been made sometimes together with paying a fine and the interest over the missed period of payment. Legal enforcement procedures of contribution payment can also decrease the number of non-payers.
- vi. Cross subsidies without incentives for risk selection. This makes it necessary to decide on the preparation and implementation of a health risk adjusted financial equalization mechanism between the insurers. This is discussed hereafter.
- vii. Sophisticated information system.
- viii. Prevention of price dumping by insurers using their vast reserves as compared to their competitors.
- ix. Regulations to protect privacy of insured and the business-competition relevant information of insurers.
- x. Effective oversight and auditing capacity and processes
  - a. Financial
  - b. Client oriented implementation of insurance, e.g. guaranteeing access to necessary care for insured and adequate complaints handling
  - c. Benchmarking, in case of multiple insurers.

### ***Competition tools.***

Assuming that all the above conditions are met, the following instruments can be used by the insurer as instrument for competition and to distinguish itself from its competitors, if the regulation grants these tools or doesn't prevent their use:

- xii. Selective independent purchasing by an insurer of a sufficient number of providers to allow access to necessary care for its insured and using with all possible purchasing features as described above. This does not mean that insurer and providers need to become adversaries. The insurer can reward good performance of providers which offer good quality care, from a professional and a patient perspective. In e.g. Belgium such independent contracting does not exist, all contracts are centrally negotiated. The trade-off in selective purchasing can be the lack of trust in the insurers among insured who fear that they may lose their favorite provider or particular doctor

- xiii. An alternative to purchasing is the integration of health services providers into the health insurer as is done by Kaiser Permanente<sup>91</sup> in the USA with mixed success<sup>92</sup> and is also allowed in the Netherlands.
- xiv. Giving free choice of provider to the insured. This obviously contradicts the selective purchasing power of the insurer.
- xv. Giving an insured the choice between an in kind system and a reimbursement system, the latter more costly to operate.
- xvi. Offering additional benefits on top of a defined minimum package, which is not a supplementary insurance with additional premiums.
- xvii. Offering different levels of general deductible to insured within legally set margins.
- xviii. Being the advocate of the insured, e.g. in finding suitable providers in case of long waiting times for elective treatment.
- xix. Being friendly to its insured in explaining his rights and obligation, and being easily accessible.
- xx. Charging a low contribution rate to insured.
- xxi. Offering an attractive supplementary insurance. However, if not regulated, insurers can do risk rating and/or exclude people from access to this insurance, thus reducing the possibility for those people to switch insurers and consequently limiting competition.
- xxii. Offering discounts on other products the insurer may have on offer.

Obviously, purchasing tools will only work if insurers have the freedom to contract or not to contract and if providers have some level of autonomy to respond to the challenges of purchasers and to improve the quality and cost-effectiveness of their services. Selective purchasing presupposes also some level of oversupply in order to have something to choose from. However, such oversupply comes at a cost, i.e. for additional infrastructure and training of staff, luxuries that are hard to afford in developing countries.

In case providers get their investments paid or subsidized by e.g. the government than they have less incentives to economize their care.

Countries differ as regards the extent they regulate competition and offering more or less instruments for insurers and more or less options for insured to choose from<sup>93</sup>. However, countries can adjust their systems based on evaluation results. Resistance from providers, secrecy from insurers and political opposition impact regulation and its effectiveness. Differences on supply side regulation also have an effect on the regulation of insurers.

#### ***Risk adjusted capitation based funding of insurers.***

Such system requires:

- i. A **central fund** that distributes **ex ante** or redistributes **ex post** the resources, in part or in full, available for the implementation of a mandatory health insurance system between insurers based on ex ante estimated health risks differences between the portfolios of insurers or on the manifest differences between health insurer's expenditures in an ex post system. Ex ante and ex post equalization can also be combined.

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<sup>91</sup> see [http://www.kaiserhealthnews.org/?utm\\_source=khn&utm\\_medium=internal&utm\\_campaign=nav-bar](http://www.kaiserhealthnews.org/?utm_source=khn&utm_medium=internal&utm_campaign=nav-bar)

<sup>92</sup> Abelson, Reed. The Face of Future Health Care New York Times, March 20, 2013; [http://www.nytimes.com/2013/03/21/business/kaiser-permanente-is-seen-as-face-of-future-health-care.html?pagewanted=all&\\_r=0](http://www.nytimes.com/2013/03/21/business/kaiser-permanente-is-seen-as-face-of-future-health-care.html?pagewanted=all&_r=0)

<sup>93</sup> Ven, Wynand van de. op cit

- ii. In both systems info is needed on the **number of insured**, which varies over the equalization year and thus needs an agreed method to decide the average numbers. These numbers need to be audited to prevent fraud.
- iii. Both systems also need to make sure that insurers cannot offer their insured more or other **benefits** than in the legal BP to prevent charging these costs to the collective of insurers and the central fund while getting an edge in the competition with other insurers. Hence, auditing of payment for benefits needs to be done.
- iv. In an **ex ante system**, which offers more incentives for efficiency to an insurer because an insurer would need to live within its budget than an ex post system, the expected costs of the persons enrolled with a particular insurer need to be estimated, preferably with the greatest possible accuracy. This requires the identification of easily collectible predictors of such costs which help in the best possible way and with the least efforts towards reasonable estimates. The parameters can be as simply as age, gender and employment status of insured towards clusters of chronic diseases and/or handicaps, consumption in past years of e.g. medicines related to overall costs of an insured etc. This system is the basis for the equalization system in the Netherlands.
- v. In an **ex-post system**, the differences in costs per insured across health insurers will be equalized after the expenditures have been made as far as these expenditures can be justified, i.e. audited. This system requires less data on relative health risks of the insurers. It offers, as mentioned above also less incentive to be efficient.
- vi. It also needs a decision:
  - a. whether all overall costs of an insured should come from the central fund or if part of these costs need to come from flat rate contributions from insured. The difference in flat rates would be the expression of the admin efficiency of the insurer and of its effectiveness in purchasing. The difference in flat rates are supposed to be an incentive for people to carefully chose their insurers and for insurers to economize and be client friendly. This latter does not necessarily mean being rational in providing health services.
  - b. on the **categories of costs that are up for equalization**. In general, only those costs that can be directly or indirectly influenced by insurers and in turn by the providers should be considered, i.e. the variable costs of providers. So, if insurers have no say in investments than these need to be left out. Same for staffing numbers and salary costs if e.g. MOH or a district authority decides these. In Switzerland insurers bear the full risk of outpatient care and the risk of inpatient care is shared with the local authorities (Cantons).
  - c. Administration costs can be left out or incorporated, based on a fixed and equal amount per insured.

Despite the long trying to improve systems, especially information systems, and to meet the conditions, no system of ex ante risk equalization between insurers is able to fully predict the health risks, the best is explaining only a meager 22% of expenditures<sup>94</sup>. It took the Dutch 15 years to build a reasonable risk equalization scheme and to still arrive at such meager outcome of 22% prediction. This is caused by the complexity of such system, the vast amounts of required data, spread over 73 cost-categories, and the need to periodically update the set of parameters due to perceived unjustified budget distribution over the insurers because of not incorporated costs for unevenly spread high cost insured. That's why, besides ex ante also ex post equalization for high costs cases was introduced, further adding to the complexity of

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<sup>94</sup> Schneider, Pia et al: Health Insurance and Competition. World Bank, Report N0.44316-ECA, May 5 2009

the system and hence its admin costs. The total cycle took in 2005 four years, from predicting the costs, setting the budgets for the different insurers, paying advances, auditing the numbers of insured and the designated costs, to adjusting the budgets based on actual numbers and acceptable costs and settling on the final amount. The imperfections in the equalization systems in the five review countries offer still substantial incentives for risk-selection by insurers<sup>95</sup>.

Besides elaborating on an equalization system a decision needs to be taken on which institution will operate the system, complying with conditions:

20. Not implementing itself health insurance
21. Independent and impartial
22. Trustworthy for contributors and insurers
23. Necessary human resources capacity, infrastructure and business support systems.

***In conclusion***, using competition between insurers requires quite some regulations and regulatory and supervisory capacity and hence budget while the advantages as compared with a non-competition based system are thus far unproven (See text box 1)

**Text box 1**

<p style="text-align: center;">MBP INFORMAL SECTOR All with income &lt; Tzs. Xx p.a</p>
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***Alternatives for competition.*** "If countries have to decide between overhauling the whole insurance system or changing some elements of the existing system to make it more efficient, the latter may provide a larger pay-off"<sup>96</sup>. Instead of competition, countries can also consider improving the existing insurance system or establishing a non-competitive multi-payer system which are adequately regulated and supervised on the payer and supplier sides. A non-competitive multi-payer system would also offer the possibility of benchmarking insurers and taking action on the outliers.

Mobilizing the community is also helpful

- a. participation in boards of insurers and review panels

<sup>95</sup> Ven, Wynand van de. op cit

<sup>96</sup> Schneider, op cit.

- b. enforcing transparency and accountability of insurer operations
- c. publicising wanted and unwanted performance
- d. Household surveys
- e. Free press
- f. Improving health literacy among population

***Equalization in non-competing models.***

A health risk adjusted equalization scheme can also be useful in case of non-competing multiple insurers, geographically distributed with uniform income based contributions such as in Austria, or along enterprise-sector lines as Germany had where insurers directly charge the contributions to their enrollees to compensate for the differences in health care costs between the insurers.

***Best insurance model***

For now it seems that the least fragmented insurance mechanism, i.e. a single payer, paid from either taxes, income-dependent contributions or both sources collected via the tax collection system, pooled at the treasury, with mandatory enrolment for all, covering the government set MBP as in-kind system, no financing of operating costs by the government, with comprehensive purchasing tools for the insurer, is the most cost-effective option to realize UHC of an MBP. Of course such mechanism requires effective oversight to keep the single payer focused, assuring the delivery of the MBP by autonomous qualified providers and cost-effective in its administration.

## **Introduction**

The consultants presented the draft report articulating the assignment, methodology employed, objectives of the GOT and the Ministry, status quo of the health insurance market in Tanzania, lessons from international examples of LICs, MICs and HICs, Competition pre-requisites, equalization fund, viability of options and finally the structure options for the health insurance market with their SWOT analysis. It was underscored that the objective is to provide options rather than recommending options.

Issues raised during discussions were:

- i. Where (which ministry) should the equalization fund be placed in the Tanzanian context borrowing from Rwandese example?  
*"A possible risk equalization fund could be administered by a to be established central health fund while the money can posted at the MOFDP/Treasury."*
- ii. How should investments in health care facilities be dealt with vis a vis the private providers?  
*"The decision will depend on what costs are to be covered by insurance, whether only actual operational cost of services or also investment and HRM costs."*
- iii. If NHIF should be merged with NSSF-SHIB, who should have the responsibility to accredit health providers?  
*"Based on international experience, the accreditation function would not be done by the insurer, especially in case of embarking on a multiple insurers option."*
- iv. What are the cons of the various models presented?  
*"The report details the anticipated challenges of each model, and the swot analysis indicates weaknesses and threats for each model."*
- v. As regards the proposed merger between NHIF and NSSF-SHIB, have the concerned parties been consulted, and what was their reaction?  
*"NHIF has been consulted twice, and is open minded to a possible merger with SHIB. NSSF-SHIB could not meet with the consultants in both missions, but efforts are still on going to have a consultation."*
- vi. What are the eligibility criteria for the indigent 30% of the population?  
*"Identification of the poor is outside the TOR of the assignment, however the MoHSW is working with TASAF to improve on methodologies used to identify the poor."*
- vii. How can the informal sector which is of a bigger size be motivated to join the insurance schemes.  
*"Marketing activities are out of the TORs of the assignment; however learning from case studies involvement of the communities in mobilization of resources and enrolment in e.g. CBOs and FBOs has proven to be successful"*
- viii. Which is the best option amongst the five options?  
*"The consultants are not positioned to recommend a best option. The preferences of the ISC will be dependent of the political economy, on its perceived conditions and the contextual factors on the ground."*
- ix. Can the Consultants include South Africa and Ethiopia in the case studies?  
*"South Africa and Ethiopia are not in the TORs, and given the time limit on the assignment it will not be possible to include these case studies."*
- x. If a current member of NHIF/NSSF-SHIBI wants to access benefits above the MBP, would s/he be required to pay additional premiums?



*“When introducing an MBP, benefits should not be taken away from existing members of the schemes. Introduction of co payments and contribution from formal sector insurance schemes would improve the benefit package in the informal sector.”*

## **Resolutions**

After the discussions were concluded, it was resolved that:

- The ISC will review the report and provide feedback to the consultants in a period of not more than one week from the date of the meeting.
- The consultants will submit the final report by 30th June, 2013.

## ***Annex 8      Excerpts from international examples***

Hereafter follow some short papers, all summarizing key country and health insurance market characteristics which may provide the reader some further background information. These papers are short. These have not been further summarized by the authors of this study. The reports are referenced in the literature list, annex 2, of this report.

### **1.      Low income countries**

#### **Ghana<sup>97</sup>**

"The National Health Insurance Scheme (NHIS) in Ghana is one of the legacies of the John Kufuor administration. During the 2000 elections, he promised to abolish what was known as the "cash-and-carry system" of health delivery. Under that system, patients—even emergency cases—were required to pay money at every point of service delivery. People died either because they did not have the money or because friends and relatives were not around to make the required advance payment. For those who survived, the fees represented a significant burden, often driving people into poverty.

Under the new law, a National Health Insurance Authority (NHIA) licenses, monitors, and regulates the operation of health insurance schemes in Ghana. Ghana has three main categories of health insurance. The first and most popular category is the district mutual health insurance scheme, which is operational in every district in Ghana. Under this public and noncommercial scheme, any resident in Ghana can register. Anyone who registers in "District A" and moves to "District B" can transfer the insurance policy and still be covered in the new district. The district mutual health insurance scheme also covers people considered to be indigent—that is, those who are too poor, are without a job, and lack the basic necessities of life to be able to afford insurance premiums.

In addition to premiums paid by members, the district mutual health insurance schemes receive funding from central government. This central government funding is drawn from the NHIF. Every Ghanaian worker pays 2.5 percent of the social security contributions into this fund; 2.5 percentage points from the value-added tax in Ghana also goes into the fund. People sign up for the district mutual health insurance scheme at the district assembly in their district or at the offices of the scheme.

The second category of health insurance comprises private commercial health insurance schemes that are operated by approved companies, which do not receive subsidy from the NHIF and which must pay a security deposit before they start operations.

The third category of health insurance is known as the private mutual health insurance scheme. Under this scheme, any group of people (such as members of a church or social group) can come together and start making contributions to cater for their health needs, thus providing for services that are approved

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<sup>97</sup> This overview is from World Bank: Making Health Services Work for Poor People in Tanzania: a Health financing Policy Note. September 9, 2011

by the governing council of the scheme. Private mutual health insurance schemes do not get a subsidy from the NHIF.

People who register under any of the schemes are given a card that can be used to seek treatment in any hospital in the country. There are no copayments unless extra services, such as a private ward, are used. Bills are then sent to the scheme provider (district, private scheme, or mutual scheme), which then pays the hospital. The card can also be used to buy prescribed drugs at accredited pharmacies or licensed chemical shops without paying at the point of delivery. The pharmacy then contacts the scheme provider to claim reimbursement. Regardless of the form of health insurance, the benefit package consists of at least the following:

- Outpatient services—general and specialist consultations and reviews, general and specialist diagnostic testing including laboratory investigation, X-rays, ultrasound scanning, medicines on the NHIS medicines list, surgical operations such as hernia repair, an physiotherapy
- Inpatient services—general and specialist services in patient care, diagnostic tests, medication-prescribed medicines on the NHIS medicines list, blood and blood products, surgical operations, inpatient physiotherapy, accommodation in the general ward, and feeding (where available)
- Oral health—pain relief (tooth extraction, temporary incision, and drainage) and dental restoration (simple amalgam filling, temporary dressing)
- Maternity care—antenatal care, deliveries (normal and assisted), Caesarean section, and postnatal care
- Emergencies—crises in health situations that demand urgent attention such as medical, surgical, pediatric, and obstetric and gynecological emergencies, as well as road traffic accidents

The health insurance schemes have the following exclusions:

- Appliance and prostheses including optical aids, heart aids, orthopedic aids, and dentures
- Cosmetic surgeries and aesthetic treatment
- Anti-retroviral drugs for HIV
- Assisted reproduction (for example, artificial insemination) and gynecological hormone replacement therapy
- Echocardiography
- Photography
- Angiography
- Dialysis for chronic renal (kidney) failure
- Organ transplants
- All drugs that are not listed on the NHIS list
- Heart and brain surgery other than those resulting from accidents
- Cancer treatment other than breast and cervical
- Mortuary services
- Diagnosis and treatment abroad
- Medical examinations for purposes other than treatment in accredited health facilities (for example, visa application, education, institutional, driving license)
- VIP ward (accommodation)

Recently, there have been reports of hospitals and pharmacies turning patients away, complaining that the public schemes owe them significant amounts of money. Some hospitals have issued warnings that

their operations could grind to a halt if the NHIS does not speed up payment of their claims. The NHIS has repeatedly assured the public and providers that it is working on the problems and, in due course, they will be resolved.

In response to the increasing concerns over fiscal pressures, the NHIS outlined its immediate strategic objectives to meet the challenges posed by systemic abuses and fraud and by the consequent exponential cost escalation in the NHIS. Announcing the measures, the chief executive officer identified cost containment as one of the key objectives in the drive for sustainability of the NHIS. Subsequent to this objective, he detailed various strategies designed to combat abuse and fraud responsible for the financial hemorrhage in the scheme, which, together with other challenges, had necessitated comprehensive arrangements to plug the leakages in the system, to strengthen internal controls, to inject accountability into the NHIS, and to ensure that the scheme gets value for money from service providers.

Consequent key reform initiatives being implemented include the following:

- The setting up of a Consolidated Premium Account that would be operational from July 2010—Scheme managers will be required to deposit all premiums collected into a centralized account in either of two designated banks (Ghana Commercial Bank and Agricultural Development Bank) with a nationwide reach and with an identification code for each scheme account. The schemes have been directed to close all other accounts. This move would redress the current situation where more than 70 percent of premiums collected are *not* properly accounted for.
- The establishment of a Consolidated Claims Management Centre in Accra—This pilot project will manage claims from the teaching hospitals and 10 regional hospitals. It was operational from July 2010 and was staffed by experienced and competent claims personnel. This change would provide a greater capacity for vetting of claims and efficient payment of service providers. If successful, the format would be rolled out in zonal claims processing centers across the country.
- Requirement for a payment plan before the disbursement of funds—To combat irregularities in payments arrangements, scheme managers will henceforth be required to produce and forward a payment plan in advance to the authority for endorsement and before funds are released for disbursement to service providers.
- Introduction of a standardized NHIS prescription form—The form will require the personal identification number (PIN) of the prescriber and of the dispenser and will identify the scheme involved. The form is also designed to check systemic abuse and fraudulent practices in the dispensing of medicines.
- Ways to streamline procedures for registration under the free maternal care program—Following the streamlining, pregnant women would be required to register—for free—before accessing care. The program went into effect from July 2010 and is intended to eliminate abuse of the program.
- Withdrawal of accreditation from all private health care facilities run by full-time staff members of public health facilities—This change will eliminate conflicts of interest and double billing of the NHIA for services to patients.
- Introduction of capitation for outpatient department services in primary health care facilities following a pilot program that is to be carried out in a selected region and is scheduled to start

by the end of 2010—Capitation would be based on research into utilization rates and costs, would be projected over a whole quarter, and would involve advance payments to service providers subject to periodic reviews and adjustments. It is expected that capitation would introduce efficiency and drive down costs in primary health care delivery.

- Implementation of a unitary system of contracting with service providers—Under the review, contractual arrangements will involve apex bodies such as the Ghana Health Service, the NHIS, the Christian Health Association of Ghana, and other service providers.

A new financial and operational reporting tool has been developed by the authority to streamline and standardize the electronic recording and timely transmission of accurate data by the schemes to the authority. This tool is expected to improve financial and operational discipline at the schemes and to ensure prompt processing and payment of claims to service providers. Trends in the data would also be useful for evaluation and monitoring purposes."

### **1.5 Rwanda<sup>98</sup>**

"Since the introduction of user fees in public health facilities in 1996, Rwanda has pioneered major programmatic, organizational, and health financing reforms aimed at improving the quality of care and, ultimately, the health status of the population in Rwanda. The reforms have a particular focus on the most vulnerable segments of the population.

Prepaid financing in Rwanda was organized in the form of mutual health organizations (MHOs). In 1998, there was only one initiative that could be identified with a community MHO and with scattered experiences among provider-based health insurance schemes to facilitate access to care in a context of poverty. The Ministry of Health (MoH) launched pilot prepayment systems in three health districts in 1999 as an initial experimentation phase, which is part of developing a policy to promote MHOs in the country, and the MoH provided leadership to the overall process. MHOs were developed under the supervision of the MoH and its partners (USAID, WHO, the European Union, the Catholic relief and development organization Caritas, and other NGOs). Together, they closely involved community actors in the design and ensured that those actors would be in charge of managing MHO systems.

The scale-up was quite rapid, from 1 in 1999 to 53 in 2002, covering about 100,000 beneficiaries. Initially, MHOs began by providing coverage for the indigent, vulnerable groups and for people living with HIV while using funds from several NGOs and a few administrative districts. The pilot experiences were evaluated between 2001 and 2003, after which Rwanda moved to implement the recommendations of the evaluations. The main recommendation was to adapt MHO organization to fit within the decentralization model that was being developed in Rwanda. As in the pilot phase, the adaptation phase received technical supervision from the MoH and subsequently from the Ministry of Decentralization and Local Affairs (MoDLA), which supervised the decentralized authorities and has social protection as part of its mandate. The involvement of the MoDLA and its agencies in promoting MHOs anchored them in the community and facilitated the mobilization of local authorities in the various administrative districts and district subdivisions. This involvement also resulted in the involvement of NGOs and religious leaders, which raised the population's awareness of the importance of enrolling in MHOs. The institutional arrangements for MHOs and local MHO networks were aligned with the environment of the decentralized authorities during this adaptation phase.

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<sup>98</sup> This overview is from World Bank: Making Health Services Work for Poor People in Tanzania: a Health financing Policy Note. September 9, 2011

Also, beginning in 2003, leadership at the central level was strengthened with the backing of the highest authorities in government. The MoH established a policy and strategic plan, and an MHO technical support unit to support MHO development and expansion. As part of mobilizing the local leadership in efforts to expand MHO-based health insurance, the degree of MHO promotion was made one criterion for evaluating the performance of the administrative districts.

The number of MHO beneficiaries increased from 556,000 by the end of 2003 (7 percent of the country's population) to 3,686,000 by the end of 2005 (44 percent of the country's population). This growth was a result of the expansion of MHOs to the entire country and of increasing the penetration of target populations. There was also an expansion of the package of benefits covered by MHOs. Until mid-2006, most MHOs covered only minor risks treated in health centers and only a limited package of major risks treated at district hospitals. In mid-2006, benefit packages were expanded, and coverage for the indigent, vulnerable groups and persons living with HIV was institutionalized by the government and foreign partners. The benefit packages now covered primary health care, secondary care, and tertiary care, which dramatically improved the price-quality ratio for MHO services.

The quantitative expansion of MHOs grew quickly in the second half of 2006, reaching a coverage level of 6,283,000 beneficiaries by the end of December 2006 (73 percent of the country's population). By the end of August 2007, some 6,497,000 Rwandans were covered by MHOs (74 percent of the country's population), and in 2008 it reached 85 percent.

The actual number of MHOs climbed from 88 in 2003 to 226 in 2004, 354 in 2005, and 392 in 2006. In 2006, all the health centers in the country had a partner MHO under the community health center partnership. Each administrative district had a district MHO that served as a mechanism to pool the major risks for the primary MHOs.

In June 2006, Rwanda established a National Guarantee Fund (FNG) and a District Solidarity Fund (FSD) to bolster financing mechanisms for MHO expansion in the country. The FNG/FSD system strengthens equity of access to and financing of health insurance coverage in the country through two mechanisms.

First, the system supports the functional expansion of MHOs to harmonize the coverage benefits received by MHO beneficiaries and the benefits received by the beneficiaries of the social insurance systems (Rwanda Health Insurance Company [Rwandaise d'Assurance Maladie, or RAMA] and Military Medical Insurance, or MMI).

Second, the system supports the expansion of MHOs by providing care for the indigent identified by communities and for people with HIV/AIDS who have HIV-related opportunistic infections. The FNG is financed through contributions from the government, RAMA, MMI, private insurance systems, and foreign partners, including the Global Fund. The FSD is financed by the contributions of MHO chapters, administrative districts, transfers from the FNG, and contributions from the development partners that are involved at the district level.

In addition to the MHO experience, Rwanda also led in the development of performance-based financing (PBF). In 2006, PBF became a major pillar of the MoH's strategy. It was implemented to provide additional resources and incentives to health workers so as to improve efficiency and the quality of care. PBF is currently implemented at three levels: health center, hospitals, and community levels. In the national model for health centers, payments for performance are based on the quantity of outputs achieved conditional on the quality of services delivered. At the hospital level, performance is assessed through a peer-evaluation mechanism. Finally, the community PBF consists of decentralized control and

decision making and of payment for a community health worker cooperative after performance has been assessed.

An evaluation of the PBF approach by the World Bank concluded that it had a large and significantly positive effect on institutional deliveries and preventive care visits by young children, and it improved quality of prenatal care. The authors found no effect on the number of prenatal care visits or on immunization rates. The overall effect was greatest for those services that had the highest payment rates and needed the lowest provider effort. The financial performance incentives that were evaluated were found to be able to improve both the use of and the quality of health services.

Key lessons from the Rwandan experience and from factors contributing to the successful implementation of reforms can be formulated to provide a stronger base for future action:

- Strong government leadership, vision, and regulatory framework at all levels will foster the short- and long-term sustainability of health sector reforms.
- In light of the changing macro and health sector environment, the ability of government to adapt strategies is needed to strengthen health services.
- Independent controls and quality checks are essential for monitoring and evaluation of health facility performance.
- Cultural and social factors, particularly solidarity within communities, contribute to the success of several health service delivery innovations.
- Key reforms need to include provisions for financial protection and other support for indigent populations.
- Government coordination of donor funding is critical to ensure that aid is used effectively and is aligned with national priorities."

## **1.6 Kenya<sup>99</sup>**

" Although the previous examples highlight reforms that have already taken place, the example of Kenya presents some of the evolving thinking on health financing in a system that is similar to the one in Tanzania in many respects. The health financing strategy in Kenya was developed over several years, using a process that drew heavily on the previous failure to reform the health financing system. In 2005, the then health minister prepared a plan for mandatory health insurance and was able to obtain approval by parliament for the enabling legislation. The finance minister objected to the scheme by saying the government did not have money to fund it, and various employer and trade union groups also opposed the bill on the grounds of inadequate consultation and potential reductions in competitiveness and personal incomes. President Kibaki later refused to assent to the bill that sought to establish the scheme, arguing that the government could not afford it, and the bill expired when parliament rose for the election.

In contrast, the new health financing strategy is the result of a broad consultation process, which included a wide variety of stakeholders and drew on both extensive analytical work and reviews of health financing systems in other parts of the world. While the strategy has been discussed at the National Economic and Social Council and a number of key principles endorsed at that level, there are

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<sup>99</sup> This overview is from World Bank: Making Health Services Work for Poor People in Tanzania: a Health financing Policy Note. September 9, 2011

ongoing discussions on the organization and structure of the new health financing system. Based on the process undertaken to date, the current version of the health financing strategy includes the following elements, which are designed to be mutually supportive and reinforcing:

- Improving efficiency, accountability, and transparency
- Strengthening revenue collection
- Having more effective risk pooling
- Harnessing the informal sector financing potential
- Broadening the benefits package
- Strengthening provider incentives
- Protecting the poor and vulnerable groups
- Improving aid effectiveness
- Ensuring sustainability

The strategy identifies a number of areas where efficiency can be improved. First, it indicates that demonstrating the most effective use of the current resources is the best approach for securing support from the government, development partners, and the general public for increased health care financing in the future. A central element of the drive for improved efficiency is to ensure that each component of the health system focuses on what it is best at and that it leaves other activities to other parts of the health system. For example, the strategy proposes that the MoH should act primarily as steward of the health system, thereby providing overall direction and guidance and setting the overarching policies of the system, but it should not be involved in the day-to-day management of health service providers. Having the MoH play the role of both regulator and service provider inevitably leads to conflicts of interest, especially in a system where various types of providers are needed to deliver necessary health services.

Strong quality assurance and accreditation mechanisms are extremely important for ensuring that the services provided meet essential quality standards. Strengthening the referral system will also lead to efficiency improvements, which will include ensuring (a) that each level of care provides the services that it is best equipped to provide and (b) that expensive secondary care resources are not used to provide services that can be delivered more efficiently and effectively at lower levels of care. Efficiency will also be enhanced by separating the purchaser from the provider of services, so the providers can focus on effective management of their facilities. This change will require increased autonomy for public health care providers, so that they have the ability to manage their facilities in the most cost-effective way and under the overall policy direction of the MoH.

The proposed move from providing inputs to purchasing services is expected to have several important effects. First, providers will have to deliver services to patients in order to receive funding, thereby increasing the incentive to ensure that necessary high-quality services are made available. Second, the method and conditions of payment will be developed in a clear and transparent way, so that the managers of health facilities will know what level of funding to expect for a given level of activity. This approach will facilitate better planning and management of resources. It also places the patient squarely at the center of health services delivery, because the funding will follow the patient and because providers who do not treat their patients competently will lose both patients and funds.

A substantial amount of investment will be needed (a) to develop a cadre of managers with the necessary skills and abilities and (b) to develop the governance and accountability structures that will be required in a more autonomous environment. The result will be that public health facilities will be run by



professional managers and overseen by management boards. Boards will be responsible for hiring the manager, setting facility policy, and monitoring execution of that policy.

There are not enough public facilities to deliver necessary health services to the people of Kenya. Thus, another key element of the health care financing strategy will be to make all health facilities (including FBO, NGO, and the private health providers) eligible for contracts to supply health services, provided they are accredited and willing to accept the standard contract terms. Of course, in some areas, there may be more providers than necessary; in those cases, selective contracting will be undertaken. Private health providers will be encouraged to cover underserved areas through various incentive mechanisms (for example, premiums on the specified tariff). The fact that many private providers are currently not fully using their capacity suggests that there is a potential for progress in those areas, if mutually agreeable terms can be established.

Given the resources that are currently available, the package of health services eligible for coverage would initially be limited, although it would be expanded as resources permit. For those services not included in the package, options would exist for people to take out supplementary private health insurance. Because this provision would be an important element of the overall health care financing and delivery system, it will be necessary to develop effective financial and quality oversight structures if the package is to ensure that private insurance remains sustainable.

Although the amount of funding is limited, it is still very important to ensure that providers are adequately compensated for the services they deliver. In addition to providers being an issue of longer-term sustainability, it is also expected that certain types of providers will not participate if they feel that the reimbursement rate is not adequate. Because all types of providers are needed to ensure coverage, this situation should be avoided. The strategy, therefore, proposes that a Benefits and Tariffs Board be established to work with purchasers, providers, and other stakeholders in developing appropriate reimbursement levels. An important aspect of this board will be ensuring transparency in its deliberations, so that the resulting tariffs and the rationale for determining them are clearly articulated and are available to anyone who may be interested.

The other important aspect of the board's operations will be the development of the basic benefit package or of those services that will be covered. Although this coverage will initially be a more limited set of services, as the economy grows or the total resources available for health increase, the package would be reviewed and expanded. Again, an important feature will be transparency and availability of information. In addition to stakeholder involvement, there will also be a critical role for expert advice, whether it is the effect of tariff changes or the consequences of insuring additional services. The board will need to regularly update the benefit package to reflect both changes in medical technology and updates in the available financing.

If health care is to reach informal workers and farmers, smaller risk pools in the form of community health funds may be established, but the NHIF would essentially act as a reinsurer for those funds, covering the full range of services for the members, regardless of the claims activity. Capacity will need to be developed in actuarial analysis to determine the appropriate or minimum premium levels for such schemes, as well as for the general population of insured persons covered through formal employment or other informal group arrangements.

The strategy suggests that premium levels clearly need to rise, but in the short run, this increase would have to be balanced against the public's perceived value with respect to the services provided or covered by NHIF and the public's ability to pay. This approach means that general revenue will continue to be an

important factor in the overall success of this risk-pooling structure. Initially, this change will take the form of redirecting the funds currently spent to finance inputs at the (public) facility level into the NHIF, so that it can purchase services from those facilities. The transfer of funds would be used to “top up” the premiums that are paid, to pay health insurance premiums for the poor, or to purchase certain “public goods” services as specified in national programs. Over time, as both the perceived value and the ability to pay grow, the premium subsidies would be reduced.

The strategy proposes that the NHIF progressively penetrates the informal sector and grows membership from the current 440,000 to 7.5 million members. This growth will have the effect of increasing coverage from the current 24 percent to about 70 percent (leaving out the 30 percent of the population considered to be indigents). According to the National Health Accounts and the 2005/06 rate, this change has the potential of channeling into the NHIF an equivalent of K Sh 38 billion annually (through conversion of out-of-pocket expenditures into health care savings). Harnessing this informal sector potential will entail incorporating entrepreneurs, self-earning professionals, freelance workers, and members from the *matatu*, agriculture, and *juakali* sectors into the NHIF. Using a suitable model, the NHIF will seek to assess the income of members from this sector to align the actual contributions to those in the formal sector.

The NHIF will pursue a pro-market strategy for increasing the participation of the informal sector that is two-pronged: communicating effectively and providing suitable incentives, particularly through attractive products. The latter will include defining the minimum package of care that is comprehensive and cost-effective and that includes preventive, health promotion, and outpatient care.

Through the introduction of a purchaser/provider split, the opportunity exists to give clear incentives to providers for delivering services of sufficiently high quality to meet the needs of the population. However, this quality depends very much on the incentives that are inherent in the underlying provider payment mechanisms. Accordingly, the strategy will pursue payment approaches that have been proven to provide the necessary incentives and have been proven to be feasible (in terms of data availability, collection, and processing) in countries at similar levels of development, including capitation for primary health care and case-based reimbursement for hospitals.

Protection of the poor is central to the overall strategy for financing health care, which means that the poor must be able to access necessary health services without either organizational or financial constraints. The evidence is clear that user fees at the point of service serve as a deterrent to accessing health services by the poor, so a central element of the strategy is the elimination of user fees for this group, with a view to possibly eliminating user fees for the rest of the population—as and when alternative resources permit. However, as noted earlier, user fee revenues from the nonpoor (defined as either the top three or four quintiles) are substantial, so it will be important to develop coherent approaches for replacing this revenue from other sources and, indeed, finding additional resources as financial barriers decline.

A critical issue will be the timely and accurate identification of the poor. By identification of the poor, it will be possible to ensure that, if necessary, those people can be registered with the social insurance system and that the contributions are made on their behalf through the joint efforts of the government and development partners. This approach will give the poor free access to necessary medical care, while ensuring that they do not face the barrier of user fees.

An important element is to make sure that health service providers do not face disincentives to treating the poor. Thus, it will be important to compensate providers for lost user-fee revenue when they treat

poor people. The registration card that members receive would both signal to the provider that no user fee should be collected and signal to the purchaser that the reimbursement should be augmented by the user fee that would otherwise have been paid.

Aside from user fees, other barriers to access need to be addressed. For example, selective contracting could be used to encourage health service providers to relocate to underserved areas, thereby improving physical access. Furthermore, the introduction of a functioning referral system should ensure that care is provided at the appropriate level and that necessary care at higher levels is not impeded by the inability to pay. User fees could be increased (or kept) for patients who have not obtained a referral, further strengthening the continuum of care and guarding against the overuse of higher levels of care.

The strategy indicates that full acceptance and support of the development partner community are an important determinant in how quickly the strategy can be implemented. Considering the involvement of development partners to date (on both the development of the health financing strategy and the increased use of country systems) and anticipating ongoing support in both of those areas, the role of development partners is fully integrated into the approach—from the investments needed to build capacity and improve the physical infrastructure of facilities to the support required to ensure equity and access so that the poor and nonpoor are able to receive essential health services. This integrated approach could include a potential new access and equity fund, which would receive funding from both government and development partners, thus ensuring that everyone in Kenya is able to obtain essential health services when they are needed. This full partnership in the implementation of the health care financing strategy is a unique opportunity for maximizing aid effectiveness across the health sector."

## 2. Middle income countries

### Thailand

**Lessons learned from Thailand's universal health care scheme: Institutional and organisational arrangements.** Chris Bates and Peter Annear, Nossal Institute for Global Health, University of Melbourne<sup>100</sup>

#### Introduction

Thailand is well known as a middle-income country that has made remarkable progress in establishing universal health coverage. A process of development that began in the 1960s has in recent years culminated in institutional arrangements that provide the Thai population with affordable access to health services (up to 98% of the population covered by 2002).

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<sup>100</sup> Chris Bates & Peter Annear: Lessons learned from Thailand's universal health care scheme: Institutional and organisational arrangements. Nossal Institute for Global Health, University of Melbourne. Issues brief May 2011

This Issues Brief describes the institutional and organizational arrangements of the Universal Coverage Scheme (UCS) managed by the National Health Security Office (NHSO). The UCS now covers three-quarters of the population, including the large informal sector. The UCS together with the Civil Servants Medical Benefit Scheme (CSMBS) and the Social Security Scheme (SSS) are the components of Universal Health Coverage (UHC).

Prior to establishment of the UCS in 2001, four social-protection schemes were operating. Under the Ministry of Finance, the CSMBS provided health financial risk protection for public sector workers and their dependents. The SSS, which ran alongside the Workmen's Compensation Scheme through the Ministry of Labour and Social Welfare, provided health care benefits at contracted facilities to private formal-sector workers funded by employer, employee and government contributions.

Using tax funding, the Medical Welfare Scheme, managed by the Ministry of Public Health (MoPH), offered coverage to vulnerable groups (e.g. the poor, elderly, monks), and the voluntary Health Card Scheme, which began as a Community-Based Health Insurance program in 1983 administered by village communities, provided access to health care for the self-employed on payment of a flat-rate fee per household.

While 80% of the Thai population were in the informal sector by the year 2000, only 49% were covered by a health insurance scheme. The aim, therefore, was to expand the UCS (known as the 30-Baht scheme until the nominal fee was abolished in 2006) to cover all citizens not enrolled in the two formal-sector schemes.

### **Institutional and organizational arrangements**

The legal structure for the UCS, including the autonomous NHSO governed by the National Health Security Board, was established by the National Health Security Act of 2002. The Minister of Public Health is the chairperson of the Board, which is drawn from various sectors. The

Act is clear but not comprehensive. Although it puts administrative authority in the hands of the NHSO (which has 13 regional offices nationwide), the rules for directing the operation of the UCS are based more on administrative procedures than on legislation.

Beneficiary enrolment is automatic, but UCS members must register in their catchment area with the contracted unit for primary care (CUP) (comprising a district hospital and health centres covering ~50,000 people) for outpatient services and with referral services for inpatient care. The benefit package is comprehensive, including curative services, health promotion, disease prevention and rehabilitation.

Health services are provided to UCS members mainly through MoPH facilities, which comprise more than 70% of all health services, though private providers may also be contracted. The 30-Baht co-payment was reintroduced in 2012 for patients who receive prescriptions and are willing to pay.

### **Purchasing of services**

Replacing the previous budget allocation from the MoPH to public health facilities, the NHSO now acts as a purchaser for the UCS, contracting with health providers for services offered to beneficiaries.

The NHSO receives government funds for the UCS, based on the estimated costs of service provision and the number of beneficiaries covered. First, the NHSO working group on budgeting prepares the estimated budget in discussion with the health financing sub-committee of the NHS Board. The Bureau of Budget of the Ministry of Finance is a member of both the health financing sub-committee and the Board. The estimated budget agreed by the NHS Board is then presented to the Cabinet for final approval.

Funds are channeled by the NHSO via its 13 regional offices to the 76 provinces. Different methods have been tried for pooling and budget allocations from the NHSO to facilities for outpatient and inpatient care as well as health promotion and prevention activities. Since 2012, the budget allocation (fund pool) for inpatient care has been calculated at the regional level after which funds pass directly from the NHSO to hospitals. Funding for outpatient care is pooled by the CUP. Funds for health promotion and disease prevention activities are directed to the four different levels of government and pooled for area-based activities at the Provincial Health Office.

The NHSO uses many different methods of provider payment, among which the most common are capitation (for outpatient services) and case-based payment (for inpatient care) with a global budget ceiling. The contract between each facility network and the NHSO allows for some variation in conditions: for example, the board of the network can decide to direct funds to the community hospital or to particular health interventions at specific health centres depending on the local health needs.

### **Lessons learned**

Thailand's path towards universal coverage was influenced by politics, finances and health systems development. The experience gained from earlier UHC schemes was crucial in developing the institutional arrangements for the three current schemes—the SSS, CSMBS and UCS.

The success factors included strong political commitment, long-term investment in health infrastructure and human resources (particularly in rural and remote areas), establishment of an autonomous NHSO as a purchasing agency, use of the primary care facility as the gatekeeper and contracting unit, use of closed-end provider payment methods (with precisely calculated capitation or case-based funding and a global budget ceiling) and competition between public and private health providers.

The design of the system rested on both long-term experience and a sound evidence base provided by local research institutes working in collaboration with the MoPH and political actors. While technical difficulties remain, the way in which Thailand has addressed the challenges of implementing a universal coverage system provides lessons to similar countries.

### **Key Messages**

- In countries with a large informal sector, general tax revenue is the most practical source of funding for universal coverage
- Adequate and appropriately distributed health infrastructure and staffing and a primary health care approach provide the foundation for universal coverage
- Management through an autonomous national agency strengthens the purchasing function, assists cost control and raises proper service quality
- Building institutional and human resources capacity for management of universal coverage schemes is essential"

## **3. High income countries**

The following are all from the Commonwealth Fund, as referenced in the literature list. The same format is used for all countries.

## **The German Health Care System, 2012, Miriam Blümel, Berlin University of Technology**

### **What is the role of government?**

Since 2009, health insurance has been mandatory for all citizens and permanent residents (previously, certain populations could choose not to have insurance, though few did so). It is provided by competing, not-for-profit, nongovernmental health insurance funds (called “sickness funds”) in the statutory health insurance scheme (SHI), or by voluntary substitutive private health insurance (PHI). States own most university hospitals, while municipalities play a role in public health activities and own about half of hospital beds. However, the various levels of government have virtually no role in the direct delivery of health care. A large degree of regulation is delegated to the self-governing bodies of the sickness funds and the provider associations. The most important body is the Federal Joint Committee, created in 2004.

### **Who is covered?**

Coverage is universal for all legal residents. About 85 percent of the population is covered by SHI and 10 percent by substitutive PHI. The remainder (e.g., soldiers, policemen) are covered under special programs. Undocumented immigrants are covered by social security in case of illness. All employed citizens (and other groups such as pensioners) earning less than €4,237.50 (US\$5,422.80) per month (€50,850.00 [US\$65,074.00] per year) as of 2012 are mandatorily covered by SHI, and their dependents (nonearning spouses and children) are covered free of charge. Individuals whose gross wages exceed the threshold, civil servants, and the self-employed can choose either to remain in the publicly financed scheme on a voluntary basis (and 75% of them do) or to purchase PHI

### **What is covered?**

**Services:** SHI covers preventive services, inpatient and outpatient hospital care, physician services, mental health care, dental care, optometry, prescription drugs, medical aids, rehabilitation, hospice and palliative care, and sick leave compensation. SHI preventive services include regular dental checkups, well-child checkups, basic immunizations, checkups for chronic diseases, and cancer screening at certain ages. All prescription drugs—including newly licensed ones—are covered unless explicitly excluded by law (mainly so-called lifestyle drugs) or pending evaluation. While the broad contents of the benefits package are legally defined, specifics are decided upon by the Federal Joint Committee.

Since 1995, long-term care has been covered by a separate insurance scheme (LTCI), which is mandatory for the whole population. Unlike SHI benefits, however, long-term care insurance benefits are a) dependent on an evaluation of individual care needs by the SHI Medical Review Board (leading either to a denial or to a grouping into one of three levels of care), and b) limited to certain maximum amounts, depending on the level of care. Beneficiaries can choose to receive either a cash amount or benefits in kind. As benefits are usually not sufficient to cover institutional care completely, people are advised to buy supplementary private long-term care insurance.

**Cost-sharing:** Within SHI, there were only a few cost-sharing provisions (mainly for pharmaceuticals and dental care) until 2004, when copayments were introduced for ambulatory care office visits (to GPs, specialists, and dentists) for adults age 18 years and older (€10 [US\$13] for the first visit per quarter or subsequent visits without referral). Other copayments include €5 to €10 (US\$6 to \$13) per outpatient prescription (unless the price is at least 30% below the reference price, meaning that over 5,000 drugs are effectively free of charge), €10 (US\$13) per inpatient day for hospital and rehabilitation stays (for the first 28 days per year), and €5 to €10 (US\$6 to \$13) for prescribed medical aids. Sickness funds can offer their insured a range of deductibles and no-claims bonuses. Preventive services do not count toward the deductible. SHI-contracted physicians are not allowed to charge above the fee schedule for services in

the SHI benefit catalogue. However, a list of “individual health services” outside the comprehensive range of SHI coverage may be offered to patients paying out-of-pocket. Out-of-pocket spending accounted for 13.2% of total health spending in 2010, mostly on pharmaceuticals, nursing homes, and medical aids (OECD 2012).

**Safety net:** Children under 18 years of age are exempt from cost-sharing. For adults, there is an annual cap on cost-sharing equal to 2 percent of household income; part of a household’s income is excluded from this calculation for additional family members. The cap is lowered to 1 percent of annual gross income for qualifying chronically ill people; to qualify, these people have to demonstrate that they attended recommended counseling or screening procedures prior to becoming ill. Unemployed people contribute to SHI in proportion to their unemployment entitlements; for the long-term unemployed, the government contributes on their behalf. In 2010, these tax transfers amounted to €15.4 billion (US\$19.7 billion) (about 8% of total SHI revenue).

#### **How is the health system financed?**

**Publicly financed health care:** In 2010, SHI spending accounted for 57.6 percent of total health expenditure (total public spending on health, including statutory long-term care insurance, statutory retirement insurance, statutory accident insurance, and taxes, constituted 77.1%). Sickness funds (there were 145 as of March 2012) are autonomous, not-for-profit, nongovernmental bodies funded by compulsory contributions levied as a percentage of gross wages up to a ceiling. Since 2009, a uniform contribution rate has been set by the government (and has been set in federal law since 2011). Earnings above €45,900 (US\$58,739) per year (as of 2012) are exempt from contribution. As of 2011, insured employees or pensioners contribute 8.2 percent of their gross wages, while the employer, or the pension fund, adds another 7.3 percent, so the combined maximum contribution is around €593 (US\$759) per month. This contribution also covers dependents (nonearning spouses and children). Sickness funds’ contributions are centrally pooled and then reallocated to each sickness fund based on a risk-adjusted capitation formula, taking into account age, sex, and morbidity from 80 chronic and/or serious illnesses. Since 2009, sickness funds have been able to charge the insured person an additional nominal premium if a sickness fund’s revenue is insufficient (or to reimburse patients in the case of surplus revenue). There is a growing amount of tax-financed federal spending on “insurance-extraneous” benefits provided by SHI (especially coverage for children). These expenses are considered to be of common interest and are therefore (partly) covered by general taxes.

**Privately financed health care:** There were 43 PHI companies in 2010, of which 24 were for-profit and 19 were nonprofit organizations. Substitutive PHI covers the two groups that are exempt from SHI (civil servants, who are refunded part of their health care costs by their employer, and the self-employed) and those who have chosen to opt out of the SHI scheme. All PHI insured pay a risk-related premium, with separate premiums for dependents; risk is assessed only upon entry, and contracts are based on lifetime underwriting. PHI is regulated by the government to ensure that the insured do not face large premium increases as they age and are not overburdened by premiums if their income decreases. Since January 2009, private insurers offering substitutive coverage have been required to take part in a risk-adjustment scheme (separate from SHI) to be able to offer basic insurance for people with ill health who are not eligible to return to SHI (e.g., because of their status as being either a pensioner or self-employed) and who cannot afford a risk-related premium. Recent legislation has also aimed to intensify competition between insurers. In order to slow the increase of premiums with age, private insurers are forced by law to set aside savings (aging reserves) from when the insured are young for use when those insured grow older. Previously, these aging reserves remained with the insurer if a person cancelled a policy or changed to another insurer. Since January 2009, however, individual aging reserves have been transferable.

PHI also plays a mixed complementary and supplementary role, covering minor benefits not covered by SHI, access to better amenities, and some copayments (e.g., for dental care). The federal government

determines provider fees in both substitutive and supplementary PHI through a specific fee schedule. There are no government subsidies for supplementary PHI. In 2010, all forms of PHI accounted for 9.3 percent of total health expenditure.

#### **How are health care services organized and financed?**

**Physicians:** General practitioners and specialists in ambulatory care offices are by law mandatory members of regional associations. Regional associations negotiate contracts with the sickness funds, are responsible for organizing care, and act as financial intermediaries. However, ambulatory physicians work in their own private practices—around 60 percent of them in solo practice and 25 percent in dual practices. Most physicians employ doctors' assistants, while other nonphysicians (e.g., physiotherapists) have their own premises. In 2010, of the 138,472 practicing SHI-accredited physicians in ambulatory care, 64,988 (44%) were practicing as family physicians and 78,075 (56%) as specialists.

Individuals have free choice among general practitioners (GPs), specialists, and, if referred to inpatient care, hospitals. Registration with a primary care physician is not required and GPs have no formal gate keeping function. However, since 2004, sickness funds have been required to offer their members the option to enroll in a family physician care model, which has been shown to provide better services and often also provides incentives for complying with gate keeping rules. In January 2007, about 24.6 million SHI insured had the option of subscribing to a family physician care model; about 4.6 million subscribed. About 1.8 million other insured took part in the nationwide model of the Barmer Ersatzkasse, a sickness fund that allows for exemptions from copayments for prescriptions if prescribed by their family physician.

Since 2004, specialized medical care provided by hospital specialists in outpatient care has been introduced. It includes treatment of severe progressive forms of disease and of rare diseases, as well as highly specialized procedures. The Federal Joint Committee will define details of this and the qualifications requirements by the end of 2012.

Physicians in ambulatory care (GPs and specialists) are generally reimbursed on a fee-for-service (FFS) basis with a fee schedule negotiated between sickness funds and physicians. Payments are limited to predefined maximum numbers of patients per practice and reimbursement points per patient. Pay-for-performance has not been established yet. In the fee schedule for PHI (set by the government), a maximum charge is set.

**After-hours care:** After-hours care is organized by the regional associations of physicians to ensure access to ambulatory care around the clock. Physicians are obliged to provide after-hours care, with regionally differing regulations. In a few areas (e.g., Berlin), after-hours care has been delegated to hospitals. The patient is given an overview of the visit to hand to his or her GP. There is also a tight network of emergency care providers (the responsibility of the municipalities). After-hours care assistance is also available via a nationwide telephone hotline.

**Hospitals:** Not-for-profit public hospitals make up about half of all beds, while private not-for-profits account for about a third. The number of private, for-profit hospitals has been growing in recent years (around one-sixth of all beds). Regardless of ownership, hospitals are staffed principally by salaried doctors. Doctors in hospitals are typically not allowed to treat outpatients (similar to hospitalists in the U.S.) but exceptions are made if necessary care cannot be provided by office-based specialists. Senior doctors can treat privately insured patients on an FFS basis. Since 2004, hospitals can also provide certain highly specialized services on an outpatient basis.

The 16 state governments determine hospital capacity, while ambulatory care capacity is subject to delegated decision-making according to rules set by the Federal Joint Committee. Inpatient care is paid per admission through a system of diagnosis-related groups (DRGs), made obligatory in 2004, currently based on 1,148 DRG categories. The system is revised annually to account for new technologies, changes in treatment patterns, and associated costs.



**Mental health care:** During the process of dehospitalization in the 1990s, the number of hospitals providing care only for patients with psychiatric and/or neurological illness fell while the number of office-based psychiatrists, neurologists, and psychotherapists working in the ambulatory care sector (all funded by both SHI and VHI, and paid FFS) increased. Acute psychiatric inpatient care was largely shifted to psychiatric wards in general (acute) hospitals. To further promote outpatient care for psychiatric patients (particularly in rural areas with a low density of psychiatrists in ambulatory care), hospitals can be authorized to offer outpatient treatment. Since 2000, ambulatory psychiatrists have been made coordinators of a new set of SHI-financed benefits called sociotherapeutic care (which requires referral by a GP) to encourage the chronically mentally ill to use necessary care and to avoid unnecessary hospitalizations.

**Long-term care:** Long-term care insurance is mandatory and usually provided by the same insurer as health insurance, and therefore constitutes a similar public–private insurance mix. The contribution rate of 1.95 percent of gross salary is shared between employers and employees; people without children pay an additional 0.25 percent. Everybody with a physical or mental illness or disability (who has contributed for at least two years) can apply for benefits. Eligible beneficiaries are stratified into three groups of care needs dependent on illness or disability severity. As stated above, beneficiaries can choose between in-kind benefits and cash payments (around a quarter of long-term care insurance expenditure goes to these cash payments). Both home care and institutional care are provided almost exclusively by private not-for-profit and for-profit providers. Long-term care insurance covers approximately 50 percent of institutionalized care, and hospices and ambulatory palliative care are fully covered.

**What are the key entities for health system governance?**

Within the legal framework, the Federal Joint Committee has wide-ranging regulatory power to determine the services to be covered by sickness funds and to set quality measures for providers (see below). To the extent possible, their coverage decisions are based on evidence from health technology assessments and comparative-effectiveness reviews. The Federal Joint Committee is supported by the Institute for Quality and Efficiency (IQWiG), a foundation legally charged with evaluating the cost-effectiveness of drugs with added therapeutic benefits, and the Institute for Applied Quality Improvement and Research in Health Care (the AQUA Institute). Since 2008, the Federal Joint Committee has had 13 voting members: five from the Federal Association of Sickness Funds, two each from the Federal Association of Statutory Health Insurance Physicians and the German Hospital Federation, one from the Federal Association of SHI Dentists, and three who are unaffiliated. Five patient representatives have an advisory role but no vote in the committee.

The Federal Association of Sickness Funds works with the Federal Association of Statutory Health Insurance Physicians and the German Hospital Federation to develop the ambulatory care fee schedule and the DRG catalogue, respectively, which are then adopted by bilateral joint committees. To extend competition beyond these jointly regulated issues, some purchasing powers have been handed over to the sickness funds, e.g., to contract providers selectively within an integrated care contract or to negotiate rebates with pharmaceutical companies.

**What is being done to ensure quality of care?**

Quality of care is addressed through a range of measures broadly defined by law, and in more detail by the Federal Joint Committee. Since January 2010, the AQUA Institute has been charged with developing quality assurance across ambulatory and inpatient care. Although there are several approaches and associations to ensure quality of care and patient safety, a national safety agency does not yet exist. Structural quality is assured by the requirement that providers have a quality management system, by the stipulation that all physicians continue their medical education, and by health technology assessments for drugs and procedures. All new diagnostic and therapeutic procedures applied in ambulatory care must be positively evaluated in terms of benefits and efficiency before they can be reimbursed by sickness funds. Hospital accreditation is voluntary. Volume thresholds have been

introduced for a number of complex procedures (e.g., transplantations), requiring a minimum number of such procedures for hospitals to be reimbursed.

Process and (partly) outcome quality is addressed through the mandatory quality reporting system for about 2,000 acute-care hospitals. Under this system, more than 150 indicators are measured for 30 diagnoses and procedures covering about one-sixth of all inpatients. Since 2007, all hospitals have been required to publish results on 27 selected indicators defined by the Federal Office for Quality Assurance, enabling a comparison of hospitals.

Many institutions and health service providers include complaint management systems as part of their quality management programs, although they are not obligatory. At the state level, professional providers' organizations are urged to establish complaint systems and arbitration boards for the extrajudicial resolution of medical malpractice claims.

Since 1998, the Robert Koch Institute, an agency subordinate to the Federal Ministry of Health and responsible for the control of infectious diseases and health reporting, has conducted national patient surveys and published epidemiological, public health, and health care data. Disease registries for specific diseases, such as certain cancers, are usually organized regionally. In August 2012, as part of the National Cancer Plan, the federal government introduced a draft bill that proposes the implementation of a nationwide standardized cancer registry in 2018 to improve the quality of cancer care; every hospital will be obliged to document the incidence, treatment, and course of the disease.

#### **What is being done to improve care coordination?**

Many efforts to improve care coordination are being implemented. Since the introduction of multispeciality clinics in ambulatory care in 2004, their number had grown from 70 clinics and 251 working physicians to 1,654 clinics and 8,610 working physicians (6.2% of ambulatory care physicians) by 2010. SHI funds also offer integrated-care contracts; GPs receive an average flat rate of approximately €100 (US\$128) per year for each patient enrolled in such a contract.

Legislation in 2002 introduced SHI Disease Management Programs (DMPs) for chronic illnesses to improve the provision of care for chronically ill patients and to improve care coordination between providers in the ambulatory sector. DMPs for diabetes types 1 and 2, breast cancer, coronary heart disease, asthma, and chronic obstructive pulmonary disease are modeled on evidence-based treatment recommendations, with mandatory documentation and quality assurance. Physicians receive an extra payment for their efforts in documentation. Nonbinding clinical guidelines are produced by the Physicians' Agency for Quality in Medicine and by professional societies. In January 2012, 10,618 registered regional DMPs had enrolled almost 6 million patients (about 8% of all SHI-insured). Participating in a DMP is voluntary for patients and can be done through GPs as well as specialists. Sickness funds are free to give patients incentives to enroll, such as exemptions from copayments for pharmaceuticals. Until 2009, participation in DMPs was a separate category in the risk adjustment scheme, giving sickness funds a strong incentive to implement them. Since the risk adjustment scheme was strengthened in 2009, sickness funds receive only a per-capita administration compensation of €168 (US\$215) per year for each insured enrolled in a DMP.

#### **What is being done to reduce disparities?**

Strategies to reduce health disparities are mainly delegated to public health services, and the levels at which they are carried out differ from state to state. Health disparities are implicitly mentioned in the national health targets. In 2001, the Federal Center for Health Education initiated a network to promote the health of the socially deprived, a nationwide cooperation of 53 health-related institutions, e.g., sickness funds and their associations. The law § 20 SGB V makes primary prevention mandatory for sickness funds; detailed regulations are delegated to the Federal Association of Sickness Funds, which has developed guidelines regarding need, target groups, and access, as well as content and methods. Sickness funds support 22,000 health-related programs according to law § 20 SGB V, e.g., in nurseries and schools.

**What is the status of electronic health records?**

About 90 percent of physicians in private practice use electronic health records (EHRs) to help with billing, documentation, tracking of laboratory data, and quality assurance. In some regions about 60 percent of physicians use online services to transmit billing information and documentation from DMPs. A unique patient identifier does not exist, as data safety concerns represent a significant obstacle. Nevertheless, many hospitals have implemented EHRs, to varying degrees. The greatest problem with implementing a systemwide EHR is the incompatibility of the different programs within and between hospitals, and between hospitals and ambulatory care.

A national strategy to create an electronic medical chip card was implemented in October 2011 and is expected to be completed by the end of 2012.

**How are costs contained?**

A central element of the 2007 health reform legislation aimed to enhance competition in health care services with the introduction of various elective insurance schemes (such as DMPs or family physician care models, sick pay for the self-employed, and optional deductible schemes). Enrolling in an elective insurance scheme is voluntarily and the contract lasts for at least three years. Sickness funds are obliged by law to report regularly on the results of these insurance schemes, especially regarding efficiency and savings.

All drugs, both patented and generic, have been subject to reference prices since 2004, unless they can demonstrate added medical benefit. Since 2011, drug companies have been required to produce a scientific dossier demonstrating a drug's added medical benefit, to be evaluated by the Federal Joint Committee and IQWiG within a three-month period. Since 2008, IQWiG has been legally charged with evaluating the cost-effectiveness of drugs with added therapeutic benefits, leading to either inclusion in the reference group in case of no added benefit, or price negotiations between the manufacturer and the Federal Association of Sickness Funds. In addition, rebates by sickness funds to pharmaceutical manufacturers have been negotiated as incentives to lower prices below the reference price.

Recently, reliance on overall budgets for ambulatory physicians and hospitals and collective regional prescription caps for physicians has been replaced by emphasis on quality and efficiency. Physicians are financially liable if they exceed regular volumes for their patient mix above the prescription cap, which complements reference prices for pharmaceuticals.

**What major innovations and reforms have been introduced?**

During what is known as the 2011 health reform, four acts were introduced in 2010–2012. In 2010, the SHI Financing Act was enacted into law; although conversion to a new model of financing for SHI has not yet happened, this act is a step toward per-capita flat-rate financing of SHI. It legislated 1) the setting of a uniform contribution rate by law, rather than by the federal government; 2) the income-independent supplementary contribution, which individual funds can impose if necessary, and which is no longer limited to 1 percent of the income of a member; and 3) the introduction of social adjustment, paid for out of taxes that are paid into the health care fund as a federal subsidy, to protect members with lower incomes from excessive financial burdens. The 2011 health care reform also prescribed extensive measures for the pharmaceutical sector. The SHI Reform Act of 2010 and the Pharmaceuticals Market Reform Act of 2011 both provide structural changes and anticipated savings over a defined period of time. The SHI Reform Act has obliged pharmaceutical manufacturers to give a discount of 16 percent (previously 6%) on all drugs that are not subject to a reference price; prices have been frozen at the August 2009 level until the end of 2013.

The final major piece of legislation for health care reform was passed in December 2011: the SHI Care Structure Act consists of a number of measures with the common objective of improving provision of services nationwide. Structural changes particularly relate to ambulatory SHI care and are intended to counteract the problem of under- and oversupply.

*The author would like to acknowledge Reinhard Busse and Stephanie Stock as contributing authors to earlier versions of this profile.*

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## **The French Health Care System, 2012.** Isabelle Durand-Zaleski, Université Paris-Est Créteil

### **What is the role of government?**

In 2009, the Hospital, Patients, Health, Territories Reform Act reformed the regional organization of health care delivery by creating Regional Health Agencies, which merge the governance of hospital and community care, public health, population health monitoring, and health care financing. National health budgets (see below) allocate funding to the Regional Health Agencies, which use a range of tools and incentives to determine population needs and contract with providers. Recurrent earmarked funds from the national government are also available to promote the coordination of care, 24-hour access, and multiprofessional and multidisciplinary practices.

### **Who is covered?**

Coverage is universal. All residents are entitled to coverage from noncompeting statutory health insurance (SHI) funds, which are statutory occupation-based entities. Entitlement comes through employment (for salaried or self-employed persons and their families), as a benefit (for people and their families who have become unemployed), and through being a student or retired person. Since the introduction of universal medical coverage (CMU) in 2000, the state has covered the health care costs of residents not eligible for SHI (0.4% of the population). The state covers illegal residents who have applied for residency. Visitors from within the EU are covered, but non-EU visitors are covered for emergency care only. Complementary private health insurance (PHI), covering user charges and/or excluded services (e.g., psychologists, dieticians), covers 95 percent of the population, and is obtained through employers or means-tested vouchers (CMU-C). The statutory health insurance funds now also can provide PHI, competing with private (not-for-profit) companies to cover CMU-C beneficiaries (CMU 2012).

### **What is covered?**

**Services:** SHI covers hospital care; rehabilitation or physiotherapy; ambulatory care provided by GPs, specialists, dentists, and midwives; diagnostic services; prescription drugs; medical appliances; some prescribed prostheses; and prescribed transportation. It also partially covers long-term and mental health care and provides limited coverage of outpatient vision and dental care. Immunization is covered

for individuals over 65 years of age, persons suffering from chronic diseases, pregnant women, and newborns; HPV immunization is covered for adolescent girls; and mammography and colorectal cancer screenings are free for individuals over the age of 50. Other preventive services, including immunizations, are paid for directly by patients (or PHI).

Covered outpatient services are defined in three national positive lists of reimbursable SHI health care procedures, drugs, and devices. Since 2004, SHI has been responsible for defining the benefits package and for setting price and cost-sharing levels in coordination with the Ministry of Health (MoH). Drugs and medical devices are added to the list by the MoH, while procedures are added by SHI, following guidance from the National Authority for Health (HAS). For each item on the positive list, SHI specifies both the reimbursement rate and the official tariff. A separate pharmaceutical list covers inpatient care and expensive and innovative drugs and devices. Otherwise, given the DRG reimbursement scheme, there is an implicit understanding of the range of services that can be delivered to hospitalized patients.

**Cost-sharing:** Coinsurance rates are applied to all health services and drugs in the SHI benefits package, and vary according to the type of care (inpatient care, 20%; doctor visits, 30%; dental care, 30%); the effectiveness of prescription drugs; and adherence to the recently introduced gatekeeping system (30% for visits to the gatekeeping GP, up to 50% for visits to other GPs). In addition to coinsurance, which can be fully reimbursed by PHI (except refusal of generics or noncompliance with gatekeeping), the following nonreimbursable copayments apply, up to an annual ceiling of €50: €18 (US\$64: \$23) for each inpatient hospital day (€13.50 [US\$17.20] in psychiatric wards), €1.00 (US\$1.30) per doctor visit, €0.50 (US\$0.70) per prescription drug, €2.00 (US\$2.60) per ambulance transport, and €18.00 (US\$23) for hospital treatment above €120.00 (US\$153). These copayments have not changed since their introduction in 2008. Doctors and dentists can extra-bill—that is, charge higher prices than SHI will pay—and the extra-billed amounts may or may not be covered by PHI.

**Safety net:** Exemptions from coinsurance apply to: individuals with any of 32 chronic illnesses (8.6 million people), with the exemption limited to treatments required for their conditions as listed by HAS; individuals who benefit from either universal medical coverage (CMU, 2 million) or the means-tested vouchers for PHI (CMU-C, 4 million); and individuals receiving invalidity and work-injury benefits. Hospital coinsurance applies only to the first 31 days in hospital, and some surgical interventions are exempt. Children and people with low incomes are exempt from paying nonreimbursable copayments. Since 2000, people with low incomes are entitled to free or subsidized PHI (CMU-C) and free eye and dental care, and cannot be extra-billed by doctors.

#### **How is the health system financed?**

**Publicly financed health care:** Public expenditure accounted for 77 percent of total expenditure on health in 2010 (OECD 2012). SHI is mostly financed by employer and employee payroll taxes (43%); a national earmarked income tax (33%); revenue from taxes levied on tobacco and alcohol (8%); state subsidies (2%); and transfers from other branches of social security (8%). Funds are pooled at the national level, and allocation of funds to providers is determined by the national budgets for 1) public and not-for-profit hospitals, 2) for-profit hospitals, 3) out-of-hospital care, and 4) geriatric care. Within each budget, a regional allocation is made and distributed by the Regional Health Agency. Coverage for those not eligible for SHI or PHI is financed mainly by the state through an earmarked tax on tobacco and alcohol and a 5.9 percent tax on PHI insurer profits.

SHI funds are statutory entities and membership is based on occupation, so there can be no competition between them. Levels of both contribution and benefits vary between funds. The three major funds cover more than 90 percent of the population: 1) salaried employees, 2) rural workers, and 3) self-employed persons. The funds are managed by a board of representatives, with equal representation from employers and employees (trade unions). Every year parliament sets a (soft) ceiling for the rate of expenditure growth in the social health insurance scheme for the following year. Reimbursement for

drugs and devices by SHI and PHI is based on a reference price set by the government's national pricing committee.

**Privately financed health care:** In 2010, out-of-pocket spending accounted for 7.3 percent of total health expenditures and was mainly spent on dental and vision services (OECD 2012). PHI accounted for 13.7 percent of total health expenditure. It is provided mainly by not-for-profit, employment-based mutual associations (*mutuelles*), though also by SHI funds. To enhance access to PHI, a special fund created in 2000 provides vouchers for PHI for low-income individuals and their dependents (CMU-C). PHI originally covered cost-sharing only for SHI-covered services, but a few PHI providers were recently allowed to extend coverage to well-being services that are not covered by SHI. Insurers increasingly offer tailor-made PHI contracts that allow people to choose the rate of coverage for each type of care.

#### **How are health services organized and financed?**

**Physicians:** Solo practice for both GPs and specialists is still the norm. Most physicians are self-employed (59%), with GPs (68%) more likely to be so than specialists (51%). GPs or specialists who are not working in public or not-for-profit facilities are self-employed and paid on a fee-for-service (FFS) basis. As of 2011, the cost per visit (€23 [US\$29]) is identical for specialists and for GPs; depending on the extent of their medical training, physicians may charge above this level. In addition, as of 2009, physicians may opt for the opportunity to receive additional payment through a pay-per-performance system (CAPI, see below). The 2004 health financing reform law introduced a voluntary gatekeeping system for adults (those age 16 and over): although registration with a primary care doctor is not a legal obligation, there are strong financial incentives for patients to have a gatekeeping physician, including higher copayments for visits and prescriptions without a referral from the gatekeeper. More than 85 percent of the population has registered with a GP. Patients are free to choose among GPs and specialists.

**After-hours care:** After-hours care is delivered by the emergency departments of public hospitals; private hospitals that have signed an agreement with the Regional Health Agency and receive financial compensation; self-employed physicians who work for emergency services; and, more recently, *maisons médicales de garde*, public facilities open after hours, financed by SHI funds and staffed by health professionals on a voluntary basis. Information on facilities that provide after-hours care is made available to GPs by Regional Health Agencies, and there are also telephone advice lines organized by disease and by provider. For example, the SHI has an advice line for diabetic patients (Sophia), and the *mutuelle* MGEN has a line that provides information on risk factors.

**Hospitals:** Two-thirds of hospital beds are in government-owned or not-for-profit hospitals and are funded by SHI (90%), PHI (7%), or direct patient payment (3%). In addition, all university hospitals are public, and the remaining hospitals are private for-profit clinics. They are individually owned or, increasingly, owned by large corporations (e.g., Générale de Santé). The funding mechanism for private hospitals is the same as that for public hospitals, but the respective share of SHI, PHI, and out-of-pocket costs differs. Since 2008, all hospitals and clinics are reimbursed via the DRG-like prospective payment system, which applies to all inpatient and outpatient admissions. Public and not-for-profit hospitals benefit from additional non-activity-based grants that compensate research and teaching (up to an additional 13% of the budget) and the provision of emergency services, organ harvesting, and transplantation (on average, an additional 10%–11% of a hospital's budget). Doctors' fees are billed in addition to the DRG in private clinics, but in public and not-for-profit hospitals DRG tariffs cover physicians' salaries. Since 1968, hospital physicians have been permitted to see private patients in public hospitals. The 2009 Hospital, Patients, Health, Territories Reform Act restructured the governance of public and not-for-profit hospitals by expanding the role of the hospital director in defining a hospital's strategies and in making decisions regarding operations.

**Mental health care:** The SHI package covers hospitalization, clinic visits, medication, and community care, but does not cover outpatient psychologist visits, psychoanalysis, or psychoeducation. Mental health care provided by GPs and psychiatrists in private practice is partially covered by SHI; individuals

presenting a long-term psychiatric condition are fully covered. Care provided in public and private psychiatric hospitals for adults and children is financed by SHI; patient copayment is 20 percent of a daily tariff that varies among hospitals. Social care and support are provided by state and local governments. Sixty-seven percent of mental health patients are in outpatient facilities; they are either in medical-psychological centers, day clinics, or home care. Twenty-five percent are full-time inpatients, and 9 percent are part-time inpatients. Expenditures for mental health (dementia excluded) represent roughly 8 percent of total health expenditures; hospital care represents two-thirds and community care one-third of mental health spending. Over 90 percent of inpatient expenditure is provided by SHI- and state-funded public or not-for-profit institutions. Public mental health institutions are paid through a capitated budget determined retrospectively. Private institutions charge a per-diem rate in addition to standard fees.

**Long-term care:** There are currently four sources of funding for long-term health and social care for frail older people in France: 1) The National Solidarity Fund for Autonomy (CNSA), which receives resources from both SHI and Solidarity Day (named for an unpaid working day introduced in 2004) and finances long-term care in nursing homes and community services for older people, as well as a share of the long-term care allowances up to a total amount of nearly €15 billion (US\$19 billion) per year; 2) local authorities, which provide over €2 billion (US\$2.6 billion) per year for long-term, means-tested care allowances; 3) households, for which private out-of-pocket payment for care in a nursing home currently averages €1,500 (US\$1,913) per month per individual; and 4) PHI contracts, which may cover expenses for medical care not fully covered by SHI, as well as a contractual part of housing expenditures.

**What are the key entities for health system governance?**

The National Authority for Health (HAS) was set up by the government in 2004 to streamline a number of activities designed to improve the quality of patient care and to guarantee equity in the health system. HAS assesses drugs and medical devices, publishes guidelines and requirements for patient safety, accredits organizations, and certifies doctors. HAS assessments are used to determine coverage rates and, indirectly, market prices. Existing technologies are reassessed every five years and, since the 2008 Social Security Finance Act, reassessments have included economic evaluation. The Commission for Economic Evaluation and Public Health has been set up within HAS to advise the HTA process.

The National Union of Health Insurance Funds and the National Union of Complementary Health Insurers were created in 2004, incorporating all SHI funds and private health insurers, respectively. This new governance enables direct negotiations between the government and representatives of SHI, PHI, and professionals' unions.

**What is being done to ensure quality of care?**

Mandatory accreditation systems supervised by HAS monitor the quality of care in hospitals and clinics, as well as ambulatory care. Hospitals must be accredited every four years by a team of experts. The accreditation criteria and reports are publicly available on the HAS Web site ([www.has-sante.fr](http://www.has-sante.fr)). CompaqH, a national program that publishes performance indicators, also reports selected results. Quality assurance and risk management in hospitals are monitored nationally, under the authority of the MoH, by the web portal PLATINES, which publishes online technical information, data on hospital activity, and data on control of hospital-acquired infections. Currently, financial rewards or penalties are not linked to public reporting, although the issue remains contested.

Every fifth year, physicians are required by law to undergo an external assessment of their practice in the form of an audit. For hospital physicians, the practice audit can be performed as part of the accreditation process, but for office-based physicians, certification and revalidation are organized by an independent body approved by HAS (usually a medical society representing a particular specialty). Dentists and midwives will soon have to undergo a similar process. In addition, HAS also publishes guidelines on care and defines best-care standards.

Disease registries exist but are considered to include too few patients to ensure sufficient quality of care. The 2004 Public Health Act underlined the need for larger national cohorts, and some, such as that for Alzheimer's disease, are currently being recruited. The 2010 presidential loan is also expected to finance such cohorts (e.g., a cohort of patients with mental health disorders).

Office-based physicians can receive incentive payments through pay-for-performance programs (CAPIs) for achieving targets in caring for asthma, diabetes, hypertension, and immunization, and in screening for breast cancer (see below).

#### **What is being done to improve care coordination?**

The 2002 Patients' Rights and Quality of Care Act combined diverse provider network initiatives under the concept of "health networks," which are defined by a form of managed care that aims to strengthen the coordination, continuity, and the interdisciplinary nature of health care provision with particular focus on selected population groups, disorders, and activities. Physicians are additionally compensated for coordinating care for chronic patients (€40 [US\$51] per patient). Physicians in solo practice do not employ nurses because, as a rule, nurses do not work in doctors' practices but are self-employed and paid by FFS. Self-employed nurses provide care to patients at home. Physicians in group practice usually do not share a common patient list but aim to ensure continuity of care and mutualize extensive capital investments. About 40 percent of self-employed physicians are involved in such practices.

Provider networks operate disease management programs to improve coordination between providers; to provide services that are currently not part of the SHI benefits package (e.g., dietary advice); to improve access to specialized services; and to experiment with new models of care delivery (e.g., nurses performing tasks formerly reserved for doctors). Provider networks are disease- and region-specific, meaning that aside from performing required periodic performance assessments, networks are free to choose the type of services they want to provide and the professionals involved. Enrollment of both providers and patients is voluntary. The incentive for patients is that networks may offer services that are not usually covered by SHI (e.g., foot care or dietary advice for diabetic patients). The incentive for physicians is that preventive services and patient education can be paid for by SHI. Some PHI plans are developing their own networks, but price discrimination based on enrollment in these networks is not permitted.

#### **What is being done to reduce disparities?**

The 2004 Public Health Act made reducing health inequalities a national priority, and set targets for reducing inequities. A strategy was then established and implemented by the directorate of statistics within the MoH and by the National Institute for Prevention and Health Education. At the regional level, Regional Health Agencies have been given a specific mandate to reduce health inequities, and public service contracts with financial incentives are offered to medical students working in underserved areas, on condition that they agree not to practice extra-billing. The 2009 Hospital, Patients, Health, Territories Reform Act attempted to improve access to care in deprived areas by creating disincentives for physicians who practice in oversupplied areas. Opposition from physicians' unions led to the withdrawal of the measure, but nurses' unions did agree to a similar arrangement. The 2011 SHI Finance Act increased the yearly income threshold for beneficiaries of the state-sponsored CMU-C by 6 percent in 2010 and 4 percent in 2011 (currently €661 [US\$843]), and has also set targets to improve access for beneficiaries of the CMU-C (who were sometimes denied care by office-based physicians who wished to extra-bill).

#### **What is the status of electronic health records?**

In 2008, the General Inspectorate for Social Affairs published a report that expanded on earlier projects and presented six principles for the success of electronic health record (EHR) technology: 1) to be useful for professionals; 2,3) to be modular and implemented incrementally, based on emerging requirements; 4) to be deployed according to an agreed-upon time frame; 5) to strike a balance between informational requirements and the protection of patients' privacy; and 6) to have clear governance. The report



recommends the creation of a high-level committee, chaired by the minister of health and comprising members of parliament and representatives of all stakeholders, to govern the project, and also recommends the creation of a government agency to take charge of health information technology (HIT). It estimates the total cost of developing pilot projects to be €900 million (US\$1.15 billion). In order to improve the interoperability of existing systems and to monitor the creation of a unique patient identifier, the Agency for Health Information Systems (ASIP Santé), a dedicated information systems agency, was created in 2009. In 2011, ASIP Santé launched the EHR project in four regions. The project is currently extended across the entire country and a total of 166,296 patients (0.25% of the population) have been included.

Apart from the EHR project, there are two coexisting HIT systems: one for hospital admissions (the PMSI), used by hospitals to bill SHI, and one for patient reimbursement claims for outpatient and hospital care. The National Health Insurance Inter-Plan Information System (SNIIR-AM) was created in 2004 to connect the two into one comprehensive system, the SHI interfund system, and the unique identifier that allows linkage of PMSI and SNIIR-AM is being pilot-tested. Currently, the PMSI system comprises information on medical diagnoses and procedures performed during an admission, while the SNIIR-AM includes claims data only, with demographic information but no medical information, although some claims can be directly connected to a medical condition.

#### **How are costs contained?**

Cost control is a key issue, as the health insurance scheme has faced large deficits over the past 20 years. The economic downturn constitutes a further threat to the state budget in general (the public deficit for 2011 is 5.2% of GDP [INSEE 2012]) and to the health insurance scheme in particular as the revenue base shrinks. More recently, however, the health insurance scheme's deficit has fallen, from an annual €10 billion to €12 billion (US\$13 billion to \$15 billion) in 2003 to €8.6 billion (US\$11 billion) in 2011. This drop may be partly attributable to the following changes that have taken place in the past three years: a reduction in the number of acute-care hospital beds; limits on the number of drugs reimbursed; the removal of 600 drugs from public reimbursement in the past few years; an increase in generic prescribing and use of over-the-counter drugs; a requirement to deliver a generic drug unless specified otherwise on the prescription; the introduction of a voluntary gatekeeping system in primary care; and a basic benefit package for the management of chronic conditions. Since 2008, reimbursement by PHI of some copayments has been discontinued for prescription drugs, doctor visits, and ambulance transport. As of 2011, the drug reimbursement rate has been curtailed, newly diagnosed hypertension has been excluded from the list of fully covered chronic diseases, and reimbursement of transportation for chronically ill patients has been made contingent on whether it is medically justified. However, following the economic downturn, the deficit is expected to have increased to €14.7 billion (US\$18.7 billion) in 2012 because of the reduction in expected revenues.

#### **What major innovations and reforms have been introduced?**

There have been major innovations in the governance of public and not-for-profit hospitals and in the creation of Regional Health Agencies that merge sickness funds and state administrations at the regional level. These innovations involve more than simply creating administrative economies of scale: in 2000, a single department was created to take over responsibility for health care and public health policies, managed care, and social services, which previously had been overseen by seven departments.

In April 2009, SHI launched a series of individual contracts with office-based physicians (CAPIs) that introduced a pay-per-performance mechanism, in addition to the traditional FFS and the flat €40 (US\$51) capitation for chronic patients, providing up to €5,000 (US\$6,375) per year for the achievement of targets in caring for asthma, diabetes, hypertension, and immunization, and in screening for breast cancer. Although the contracts were initially opposed by the physicians' unions, the national physicians' regulation authority, and the union of the pharmaceutical industry, roughly 16,000 physicians have signed them, and the average additional payment is €3,100 (US\$3,953) (Ameli 2012). In 2012, the CAPIs

dropped their individual-based characteristic and became part of the contractual agreement signed between the SHI and all GPs.

The reform of long-term care financing is a major challenge for the future. The French president announced in 2008 that a new fund would be created. However, discussions surrounding the resources for this new fund are continuing.

In September 2012, a scheme was established by the SHI to encourage the use of generic drugs rather than brand-name drugs. This scheme makes the delivery of generic drugs mandatory (unless otherwise specified by the physician) in order to be eligible for third-party payment. In other words, only patients who agree to a generic instead of brand-name drug will not pay anything at the pharmacy, while those who request a brand-name drug will have to pay and wait for reimbursement. Although it is early to assess the effectiveness of the scheme, informal reports from the manufacturers indicate a steep decrease in the sales of brand-name drugs.

*The author would like to acknowledge Karine Chevreul as a contributing author to earlier versions of this profile.*

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## **The Dutch Health Care System, 2012.** Gert Westert, Radboud University Nijmegen Medical Centre

### **What is the role of government?**

The national government monitors access, quality, and costs, and provides most preventive care. The 2006 reforms introduced a prominent role for health insurers. Under the Health Insurance Act (*Zorgverzekeringswet*, or ZVW), statutory coverage is provided by private insurers and regulated under law. Health insurers are given the task of increasing the efficiency of health care through prudent purchasing of health services on behalf of their enrollees.

### **Who is covered?**

Since 2006, all residents (and nonresidents who pay Dutch income tax) are mandated to purchase health insurance coverage. Insurers are required to accept all applicants, and enrollees have the right to change insurer each year. Those with conscientious objections to insurance and active members of the armed forces are exempt from the mandate. In 2010, roughly 135,000 persons (1% of the Dutch population)

were uninsured and 283,000 (2% of the population) defaulted or failed to pay their premium for at least six months and were subsequently uninsured. The number of defaulters has increased slightly over the years; in 2009, additional policy measures were taken to enforce insurance premium payment. Asylum seekers are covered by the government, and several mechanisms, including a government fund implemented in 2008, are in place to reimburse the health care costs of illegal immigrants unable to pay for care; annual expenditures were €14.4 million (US\$18.4 million) in 2010. Most people also purchase complementary private health insurance (PHI) for services not covered by the statutory benefits package, such as adult dental care; PHI providers are allowed to screen their applicants based on risk factors.

### **What is covered?**

**Services:** Health insurers are legally required to provide a standard benefits package covering the following: medical care including care provided by general practitioners (GPs), hospitals, specialists, and midwives; dental care through age 18 (coverage after age 18 is confined to specialist dental care and dentures); medical aids and devices; prescription drugs; maternity care; ambulance and patient transport services; paramedical care (limited physical/remedial therapy, speech therapy, occupational therapy, and dietary advice); ambulatory mental health care (five sessions with a primary care psychologist); and outpatient and inpatient mental care up to a year. Insurers may decide how and by whom this care is delivered, giving the insured a choice of policies based on quality and costs. A limited number of effective health improvement programs (e.g., smoking cessation) are also covered.

The government defines the statutory benefits package based on the advice of the Health Care Insurance Board (CVZ). Some treatments are only partially covered or are excluded (e.g.):

- Ambulatory counseling by a psychologist is limited to five sessions in a year.
- For physiotherapy, since January 2012, the first 20 sessions in a year are no longer covered, except for people with specific chronic conditions.
- Some elective procedures are excluded, e.g., cosmetic plastic surgery without a medical indication.
- For in vitro fertilization, only the first three attempts are included.
- Sleep medication and antacids were excluded in 2011 and 2012, respectively.

Long-term disability protection is organized separately from health care insurance. Everyone who is residing legally in the Netherlands, as well as nonresidents who are liable for Dutch payroll tax, is compulsorily insured for long-term care under the Exceptional Medical Expenses Act (AWBZ), a statutory health insurance scheme for those whose chronic conditions require continuous care and have considerable financial consequences (Schäfer et al., 2010). Patients can choose to receive a personal care budget and purchase care themselves. Between 1998 and July 2009, the number of personal budget recipients for AWBZ care rose from 10,000 to almost 160,000.

**Cost-sharing:** In addition to income-based contributions and community-rated premiums (see below), every insured person over age 18 must pay a deductible of €220 (US\$282) (as of 2012) for any health care costs in a given year (with some services, such as GP visits, excluded from this general rule). In 2013, the deductible will be increased to €350 (US\$448).

**Safety net:** GP care and children's health care are exempt from cost-sharing. The government also pays for children up to the age of 18 to be covered and provides subsidies for community-rated premiums (the subsidies are known as "health care allowances") for low-income families if the average community-rated premium exceeds 5 percent of their household income—approximately 5 million people.

### **How is the health system financed?**

**Publicly funded health care:** The statutory health insurance system under the ZVW is financed through a nationally defined, income-related contribution and through community-rated premiums set by each

insurer (everyone with the same insurer pays the same premium, regardless of age or health status). The income-related contribution is set at 6.9 percent of up to €32,369 (US\$41,423) of annual taxable income (as of 2010). Employers must reimburse their employees for this contribution, and employees must pay tax on this reimbursement. For those who do not have an employer and do not receive unemployment benefits, the income-related contribution is 4.8 percent. The contributions of self-employed people are individually assessed by the Tax Department. Contributions are collected centrally and distributed among insurers based on a sophisticated risk-adjusted capitation formula that considers age, gender, labor force status, region, and health risk (based on past drug and hospital utilization). In 2011, the average annual community-rated premium for adults was €1,256 (US\$1,607). In 2011, total spending on health care and social care was €90 billion (US\$115 billion), a 4 percent increase over 2010. The insurance market is dominated by the five largest insurer conglomerates, which account for more than 80 percent of all enrollees.

**Privately funded health care:** In addition to purchasing statutory health insurance, most of the population purchases a mixture of complementary and supplementary PHI from the same health insurers who provide statutory coverage. The premiums and products of these types of PHI coverage are not regulated. Complementary and supplementary PHI accounts for roughly 3 percent to 5 percent of total annual health spending. People with these types of PHI do not receive faster access to any type of care, nor do they have increased choice of specialist or hospital.

#### **How are health care services organized and financed?**

**Primary care:** The GP is the central figure in primary care; other primary care providers include dentists and midwives. The gatekeeping principle, one of the main features of the Dutch system, stipulates that hospital care and specialist care (except emergency care) are accessible only upon referral from a GP; only 4 percent of appointments with a GP result in a referral to secondary care. All citizens are registered with a GP of their choice, usually in their own neighborhood. On average, patients contact their GP five times per year; a full-time working GP has a practice list of approximately 2,300 patients. Patients can switch GPs without formal restriction. In 2011, there were 8,884 practicing GPs: 51 percent worked in group practices of three to seven, 29 percent worked in two-person practices, and 20 percent worked solo. Most GPs are independent entrepreneurs or work in a partnership; only a small number are employed in a practice that is owned by another GP.

Since the 2006 reform, GP remuneration combines elements of the old payment systems for SHI (capitation fee per registered patient) and PHI (fee-for-service). As a result, the system consists of several components:

- Capitation fee per registered patient;
- Consultation fee for GPs, including phone consultation;
- Consultation fee for practice nurses (if practice includes any), including phone consultation;
- Contribution (fee-for-service) for activities that either increase efficiency (e.g., task delegation) or substitute GP care for secondary care; and
- Compensation (mostly hourly rates) for providing after-hours care.

In addition, there are bundled payments for a few chronic diseases (diabetes and chronic obstructive pulmonary disease), and efforts are under way to implement them for heart failure and depression (described below). Many GPs employ nurses on salary and the reimbursement for the nurse is received by the GP, so any productivity gains that result from substituting a nurse for a GP's work accrue to the GP. Additional budgets can be negotiated with the insurer for extra services, practice nurses, additional staff, complex location, etc. There are ongoing experiments with pay-per-performance to improve quality in primary and hospital care. The Dutch Health Care Authority (NZa) determines provider fees.

**Outpatient specialist care:** Almost all specialists are hospital-based and either in group practice (65%–70%) or on salary (most but not all in university clinics). There is a nascent trend for specialists to work outside hospitals—for example, in the growing numbers of ambulatory surgery centers—but this shift is rather marginal, and most ambulatory surgery centers are tied to hospitals. These specialists are paid fee-for-service.

**After-hours care:** After-hours primary care is organized at the municipal level in GP posts—centralized services typically run by a nearby hospital that provide GP care between 5:00 p.m. and 8:00 a.m. GPs decide whether or not patients need to be referred to the hospital. The GP post sends the information regarding a patient's visit to his or her GP. Emergency care is provided by GPs, emergency departments, and trauma centers. Depending on the urgency of the situation, patients or their representatives can contact their GP or a GP post (for after-hours care), call an ambulance, or go directly to the emergency department at the nearest hospital (Schäfer et al., 2010). All hospitals have an emergency department, and also a GP post.

**Hospitals:** In 2010, the Netherlands had 141 hospital sites and 52 outpatient specialty clinics divided among 93 organizations, which included eight university hospitals. Practically all are private, nonprofit organizations. There were also more than 150 independent private and nonprofit treatment centers whose services were limited to same-day admissions for nonacute, elective care (e.g., eye clinics, orthopedic surgery centers).

Hospital budgets were previously developed using a formula that paid a fixed amount per bed, patient volume, number of licensed specialists, and other factors; additional funds were provided for capital investment. Since 2006, budgets have been determined through negotiations over price and volume between insurers and hospitals; capital has been funded through a prospective payment mechanism. Currently, payment of approximately 70 percent of hospital care is freely negotiable and takes place through the case-based Diagnosis Treatment Combinations (DTC) system: each hospital negotiates with each insurer for a DTC rate. These DTCs cover both outpatient and inpatient hospital costs as well as specialist costs, thereby strengthening the integration of specialist care in the hospital organization. Hospital specialists practice directly or indirectly under contracts negotiated with private health insurers. Two-thirds of hospital-based specialists are self-employed or work in partnership with other physicians; the remaining third are salaried. In 2012, the number of DTCs was reduced from 30,000 to 3,600.

**Mental health care:** Mental health care is provided in both primary and secondary care. Primary health care professionals in mental health care include GPs, psychologists, and psychotherapists. When more specialized care is required, the GP refers the patient to a psychologist, an independent psychotherapist, or a specialized mental health care institution. In 2006, around 772,000 people were treated in specialized mental health care organizations. Around 75 percent of them received ambulatory treatment; 4 percent received part-time inpatient care (i.e., one or more daily periods of care per week in an institution); 14 percent were hospitalized in a closed institution; and approximately 6 percent lived in a sheltered housing facility. Prior to 2008, the majority of mental health care was financed under the AWBZ; in 2008 the financing structure was fundamentally reformed. The first 365 days of mental health treatment and up to five primary care psychologist sessions became coverable under basic health insurance, financed under the ZVW.

**Long-term care:** Long-term care, financed by the AWBZ, makes up 38 percent of the total health care budget and is provided both in institutions (residential care) and in communities (home care). Health insurers are formally responsible for implementing the AWBZ, but this task is delegated to regional care offices (Zorgkantoren). The Center for Needs Assessment (CIZ) has been commissioned by the government to carry out assessment for eligibility under the AWBZ. Patients, their relatives, or their health care providers can file a request with the CIZ. The CIZ then sends its decision to a care office (Zorgkantoor).

Home care is provided by home care organizations, residential homes, and nursing homes. In 2010, there were 500 of these providers. Currently, the Netherlands has 324 nursing homes, 960 residential homes, and 210 combined institutions.

Most palliative care is integrated into the regular health system and is delivered by GPs, home care providers, nursing homes, specialists, and voluntary workers. Health care providers, palliative units, and hospices currently participate in regional networks in order to promote integration and coordination of care. The number of hospices and palliative units is growing throughout the country, but under 5 percent of the population currently dies in a hospice.

**What are the key entities for health system governance?**

A number of arm's-length agencies are responsible for setting operational priorities. At the national level, the Health Council advises the government on evidence-based medicine, health care, public health, and environmental protection; the Health Care Insurance Board (CVZ) advises the government on the components of the basic health insurance package; and the Medicines Evaluation Board (CBG) oversees the efficacy, safety, and quality of medicinal products. Health technology assessments (HTAs) are carried out by the Health Council and the CVZ. The Dutch Health Care Authority (NZa) has primary responsibility for ensuring that the health insurance market, the health care purchasing market, and the health care delivery markets function appropriately, while the Dutch Competition Authority (NMa) enforces fair competition among both insurers and providers, subject to the Dutch Competition Act.

**What is being done to ensure quality of care?**

The Dutch Health Care Performance Report 2010 provided indisputable evidence that the quality and price of Dutch health services vary substantially among providers, and that more needs to be done to address the variation in quality (Westert et al., 2010). At the health system level, quality of care is ensured through legislation governing professional performance, quality in health care institutions, patient rights, and health technologies. The Dutch Health Care Inspectorate (IGZ) is responsible for monitoring quality and safety. Most quality assurance is carried out by health care providers, sometimes in close cooperation with patient and consumer organizations and insurers. Mechanisms to ensure quality of care provided by individual professionals include reregistration/revalidation of specialists based on compulsory continuous medical education; regular on-site peer assessments organized by professional bodies; and profession-owned clinical guidelines, indicators, and peer review. The main methods used to ensure quality in institutions include accreditation and certification; compulsory and voluntary performance assessment based on indicators; and national quality improvement programs based on the breakthrough method *sneller beter* ("faster, better"). Patient experiences are also systematically assessed and, since 2007, a national center has been working with validated measurement instruments comparable to the approach of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) in the United States. The center also generates publicly available information for consumer choice on such topics as waiting lists, patient satisfaction, and a few quality indicators.

The Ministry of Health recently issued a directive to the Dutch parliament stating that, from 2013, a central body (the National Institute for Health Care Quality) needs to be established to further accelerate the process of quality improvement and to encourage evidence-based practice.

**What is being done to improve care coordination?**

As mentioned above, bundled payments for patients with select chronic conditions (e.g., diabetes) are being offered. In 2007, the Dutch minister of health approved the introduction of a bundled-payment approach for integrated chronic care, initially on an experimental basis with a focus on diabetes. In 2010, the bundled-payment concept was approved for nationwide implementation for diabetes, chronic obstructive pulmonary disease (COPD), and vascular risk management. Under this system, insurers pay a single fee to a principal contracting entity—the "care group"—to cover a full range of chronic disease (diabetes, COPD, or vascular disease) care services for a fixed period. A care group is a newly created actor in the health care system, consisting of a legal entity formed by multiple health care providers, who

are often exclusively general practitioners (GPs). The care group assumes both clinical and financial responsibility for all assigned patients in the diabetes care program. For the various components of diabetes care, the care group either delivers services itself or subcontracts with other care providers. The bundled-payment approach supersedes traditional health care purchasing for the condition and divides the market into two segments—one in which health insurance companies contract care from care groups and one in which care groups contract services from individual providers, be they GPs, specialists, dietitians, or laboratories. The price for the bundle of services is freely negotiated by insurers and care groups, and the fees for the subcontracted care providers are similarly freely negotiated by the care group and providers (Struijs, 2011).

**What is being done to reduce disparities?**

Smoking is still a leading cause of death, followed by obesity. For many determinants, lower socioeconomic groups do worse on all fronts. However, the current government does not have a specific policy to overcome health disparities, as the cornerstone of present policy is an emphasis on people's personal responsibility for healthy lifestyles.

**What is the status of electronic health records?**

Dutch authorities are working to establish a central health information technology network to enable information exchange across sites of care. All Dutch patients have a unique identification number (BSN). Virtually all GPs have a degree of electronic information capacity—for example, they use an electronic health record (EHR), and can order prescriptions and receive lab results electronically. Hospitals do not show the same degree of uptake, with only 10 percent to 20 percent of hospital specialists using EHRs. EHRs for the most part are not nationally standardized or interoperable between domains of care, reflecting their historic development as regional initiatives. The National IT Institute for Healthcare, operating under the Ministry of Health, is tasked with bringing together all initiatives to coordinate their efforts and promote the development and adoption of national standards.

**How are costs controlled?**

One of the most significant themes in the public debate surrounding the most recent elections (September 2012) was on how to bend the cost curve. Recent figures from Statistics Netherlands indicate that health expenditures have risen substantially—the most recent annual expenditure growth was approximately 3.6 percent—not least as a result of increases in doctors' incomes and volume of services delivered.

When the 2006 reforms were first introduced, the government aimed to take a back seat and allow market forces to operate. The main approach to controlling costs in the Dutch health system rests on regulating competition between insurers and improving efficiency of care with the use of performance indicators. In addition, provider payment reforms, including a general shift from a budget-oriented reimbursement system to a performance- and outcome-driven approach, have been implemented; costs are increasingly expected to be controlled by the new DTC system, in which hospitals must compete for the prices of specific services; and various local and national programs aim to improve health care logistics.

The government has recently set a ceiling for the annual growth of hospital care volume at 2.5 percent. These and costs rising elsewhere in the system (AWBZ), combined with the economic crisis, may force the government to intervene further.

**What major innovations and reforms have been introduced?**

The biggest reform of the past decade involved the 2006 introduction of a universal compulsory insurance scheme executed by private insurers. Previously, people with earnings above approximately €30,000 (US\$38,392) per year and their dependents (around 35% of the population) had been excluded from statutory coverage provided by public sickness funds and could purchase coverage from private health insurers; the government had regulated this form of substitutive private health insurance to ensure that older persons and people in poor health had adequate access to health care and that the

publicly financed health insurance scheme was properly compensated for covering a disproportionate number of high-risk individuals. However, growing dissatisfaction with the dual system of public and private coverage eventually led to the 2006 reform (substitutive private health insurance was also abolished in 2006), creating a level playing field. The underlying logic is that consumers who have the right to exercise choice induce competition among insurers, and insurers will therefore push health care providers to increase the quality and efficiency of their services. However, further research will be required to determine whether this policy has led to optimal performance for all actors involved.

Additionally, there is an ongoing review of the coverage of both the statutory health insurance scheme and the AWBZ scheme for long-term care. Progress has been made on producing indicator information, although there is a continuing focus on improving transparency.

*The author would like to acknowledge Niek Klazinga as a contributing author to earlier versions of this profile.*

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**The English Health Care System, 2012.** Contributing author: Anthony Harrison, The King's Fund, London

## What is the role of government?

Responsibility for health legislation and general policy rests with Parliament, the Secretary of State for Health, and the Department of Health. The National Health Service (NHS) provides care to all residents, including hospital and physician services and prescription drugs. Under the terms of the NHS Health and Social Care Act 2012, which mandates a major restructuring of the health system, day-to-day responsibility for running the NHS will be handed over to a new governmental organization, the NHS Commissioning Board. The Board will be responsible for managing the NHS budget, overseeing Clinical Commissioning Groups (CCGs, new bodies described below) and ensuring that high-level objectives set for the NHS by the Secretary of State are met. It will commission general practice, dentistry, pharmacy, and optometry, and cancer care and some specialized services for small client groups. All other NHS services will be commissioned by local CCGs, in which general practitioners (GPs) and other clinicians will play a central role. Budgets for public health will be handed over to local authorities, who will establish Health and Wellbeing Boards to improve coordination of local services with particular reference to the need to reduce health disparities. Some national public health functions, including overall responsibility for screening and vaccination programs, will remain with the Department of Health.



**Who is covered?**

Coverage is universal. All those “ordinarily resident” in England are automatically entitled to health care that is largely free at the point of use through the NHS. Only treatment in an emergency department and for certain infectious diseases is free to people not ordinarily resident, such as visitors or illegal immigrants (Department of Health 2010a). Most private hospital care—largely for elective conditions—is financed through supplementary private voluntary health insurance.

**What is covered?**

**Services:** The precise scope of the NHS is not defined in statute or regulation. In practice, it provides or pays for: preventive services, including screening and immunization and vaccination programs; inpatient and outpatient care; physician services; inpatient and outpatient drugs; dental care; some eye care; mental health care, including some care for those with learning disabilities; palliative care; some long-term care; and rehabilitation.

**Cost-sharing:** There are only a few cost-sharing arrangements for publicly covered services. Outpatient prescription drugs are subject to a copayment (currently £7.65 (US\$12.23) per prescription in England); drugs prescribed in NHS hospitals are free. NHS dentistry services are subject to copayments of up to a maximum of £209 (US\$334) per course of treatment. These charges are set nationally by the Department of Health.

**Safety net:** The following people are exempt from prescription drug copayments: children under the age of 16 years and those in full-time education ages 16–18; people age 60 or older; people with low income; pregnant women and those who have had a baby in the past 12 months; and people with cancer and certain long-term conditions and disabilities. Patients who need a large number of prescription drugs on a regular basis can buy prepayment certificates which limit their cost to £2 (US\$3.20) a week. Just under 6 percent of prescriptions actually incur the full charge at the point of dispensing; the remainder are exempt from charges (NHS Information Centre 2012a). Young people, students, and International Profiles of Health Care Systems, 2012

those with low incomes also receive financial support for eyeglasses and dental copayments. Transportation costs to and from provider sites are also covered for people with low income.

**How is the health system organized and financed?**

**Publicly financed health care:** In 2010, England spent about 9.6 percent of its GDP on health care. Public expenditure, mainly on the NHS, accounted for about 82 percent of this in 2009 (OECD 2012). Around 76 percent of NHS funding comes from general taxation and 18 percent from national insurance (a payroll tax). The NHS also receives income from copayments, those using NHS services as private patients, and some other minor sources.

**Privately financed health care:** Most private expenditure is for over-the-counter drugs and other medical products (accounting for just under half of private spending), and private hospital care, including both insured and uninsured costs. Most private hospital care, largely for elective conditions, is financed through voluntary health insurance. About 11 percent of the U.K. population has voluntary insurance, the majority as work-related benefits (Office of Health Economics 2012). In addition, just over a million people are covered through self-insuring schemes run by employers. Private providers must be registered with the Care Quality Commission and with Monitor, but their charges to private patients are not regulated by the government, and there is no public subsidy for either voluntary insurance or provision of private care.

**How are health services organized and financed?**

**Primary care:** Primary care is delivered mainly through GPs. There were 39,780 GPs in 8,316 practices in 2011, with an average of 6,651 patients per practice and 1,562 patients per GP. The number of solo practices—currently 1,746—is a third lower than 10 years ago, while there are now nearly 3,500 practices with 5 or more GPs (NHS Information Centre 2012). GPs are normally the first point of contact, and people are required to register with a local GP. The government plans to introduce a “right” to

choice of GP in the near future. In some areas walk-in centers offer primary care services, for which registration is not required. Most GPs are private contractors operating under a national contract and are paid using a mixture of capitation, contract payments for specific services, and performance-related bonuses (described below). Although still a minority (around 20%), the number of GPs employed in practices as locums (e.g., standing in when GPs are unavailable because of illness, training courses, etc.) or on a salaried basis is increasing. Some private providers of GP services set their own fee-for-service rates. GPs act as gatekeepers to specialist care.

**Outpatient specialist care:** Specialists are almost all salaried employees of NHS hospitals. Patients are able to choose which hospital to visit, and the government has introduced the right to choose a particular specialist within a specific hospital (not yet fully implemented). Most outpatient specialist consultations are carried out in hospitals, although consultation may take place in GP practices. Some GPs, called GPs with specialist interests, also offer specialist consultations. Primary care dental services are delivered through contracts with dentists or dental practices for an agreed level of dental services per year within the framework of a nationally determined contract. Most dentists also provide private care. Eye services outside hospitals are provided almost entirely by the private sector.

**After-hours care:** GPs are no longer required to make after-hours care available to their patients, although a minority still do so. Instead local commissioners contract for these services with a range of providers, including GP cooperatives and private companies, both of which usually pay GPs on a per-session basis. Serious emergencies are handled by hospital emergency departments. In some areas, minor injury units and walk-in centers staffed by nurses deal with less serious conditions. Telephone advice is available on a 24-hour basis through NHS Direct, but a new service, NHS111, is being introduced to take over some of its functions. Details of the care provided by these services are usually sent to the patient's GP.

**Hospitals:** Publicly owned hospitals are organized either as NHS trusts, which are directly accountable to the Department of Health, or as Foundation Trusts. Foundation Trusts enjoy greater freedom from central control, have easier access to capital funding, and are able to accumulate surpluses or run (temporary) deficits. The government wants all hospitals (as well as mental health and ambulance services) to become Foundation Trusts in the near future. Both types of hospitals contract with local commissioners to provide services to local populations and are reimbursed for most of these services at the same nationally determined diagnosis-related group (DRG) rates. Public funds have always been used to purchase some hospital care from the private sector, e.g., for mental health patients, but the level has grown in recent years. From 2003, some routine elective surgery and diagnostic services have been procured for NHS patients from freestanding treatment centers owned and staffed by private sector providers. However, the private sector contribution remains low, at around 2 percent of all NHS elective operations. Specialist doctors are employed by NHS hospitals on a salaried basis, but may supplement their salary by treating private patients within private hospitals. Over 50 percent of NHS specialists also work in the private sector (Office of Fair Trading 2011).

**Mental health care:** Mental health care is an integral part of the NHS. Less serious illnesses are usually dealt with by GPs, but those requiring more advanced treatment, including inpatient care, are treated by mental health or hospital trusts. Many services, including rapid response teams, are provided by community-based staff belonging to mental health trusts. About a quarter of mental health care hospital-based services are provided by the private sector (for-profit and not-for-profit).

**Long-term care:** The NHS pays for some long-term care (e.g., for those with continuing medical or skilled nursing needs), but in recent years its role has been substantially reduced. Most long-term care is referred to as adult social care, and is provided by local authorities and the private sector. State-funded residential care is means-tested and is available free only to those with less than £23,250 (US\$37,160) in assets. The level of charges for state-funded social care provided at home depends on a local council's interpretation of the national framework for eligibility, and therefore varies from area to area. In 2009,

the private sector provided 70 percent of residential care places in the U.K. (including England, Northern Ireland, Scotland, and Wales), with the local authority providing 12 percent and the voluntary sector 18 percent (Laing and Buisson 2010). End-of-life palliative care is provided by the NHS in hospices (usually run by charitable organizations), at home (including care homes), and in hospitals. Separate government funding is available to people with disabilities according to national eligibility criteria, and is not means-tested.

#### **What are the key entities for health system governance?**

The Department of Health and the Secretary of State for Health are ultimately responsible for the management of the health system as a whole, but the NHS Commissioning Board will shortly take over some of the functions of the Department of Health, including overall budgetary control and, along with Monitor (described below), responsibility for setting DRG rates for provision of NHS services. The National Institute for Health and Clinical Excellence (NICE) sets guidelines for the NHS on clinically effective treatments and appraises new health technologies for their efficacy and cost-effectiveness; all drugs or interventions that NICE evaluates as clinically effective and cost-efficient are available in the NHS. The Care Quality Commission ensures basic standards of safety and quality through a provider registration system and monitoring of the care standards actually achieved (see below). Monitor is responsible for authorizing NHS trusts to become Foundation Trusts and monitoring their financial performance, with powers to intervene if performance deteriorates significantly. The 2012 Act extends its role to being economic regulator of public and private providers. It will also investigate potential breaches of the NHS competition code. All of these bodies are independent of the Department of Health and accountable directly to Parliament. The 2012 Act provides for the establishment of a new national body, Healthwatch England, to promote patient interests, and for establishing local Healthwatches in each locality. From 2013, these local Healthwatches will support people who make complaints about services and will report quality concerns to Healthwatch England, which can then recommend that the Care Quality Commission take action.

#### **What is being done to ensure quality of care?**

An explicit policy toward quality of care was articulated under the Labour government in 1998 (Department of Health 1998). Although the details have changed since then, it comprises three main elements: standard setting, monitoring, and enforcement. Since the policy's inception, the Department of Health has developed a set of National Service Frameworks intended to improve particular areas of care (e.g., coronary heart disease, cancer, mental health, diabetes). Improvement strategies have also been developed for a range of other services including stroke, end-of-life care, and trauma care. Those strategies set national standards and identify key interventions for these care groups. In 2004, the DoH also issued a set of generic standards (i.e., not linked to a particular disease or treatment mode).

More recently, NICE has been charged with developing 150 quality standards for the main pathways of care by 2015. NICE also sets guidelines for the NHS on clinically effective treatments and appraises new health technologies for their efficacy and cost-effectiveness. All drugs or interventions that NICE assesses as clinically effective and cost-effective are available in the NHS. A Web site, NHS Evidence, has been established to provide professionals and patients with up-to-date clinical guidelines for a wide range of conditions.

In 2009, the Care Quality Commission took over responsibility for the regulation of all health and adult social care in England, whether provided by the NHS, local authorities, the private sector, or the voluntary sector. All health and social care providers must be registered by the Care Quality Commission. The Commission monitors provider and commissioner performance using nationally set quality standards, and investigates individual providers where concerns have been raised (e.g., by patients). It can close down poorly performing services.

All doctors practicing in the U.K. are required by law to have a license to practice from the General Medical Council. Similar requirements apply to all professions working in the health sector. A process of revalidation every five years is being introduced for doctors.

The Quality and Outcomes Framework was introduced as part of the new GP contract in 2004 and provides GP practices with financial incentives to improve quality. GP practices are awarded points (the total of which determines part of their remuneration) for keeping a disease register of patients with certain diseases or conditions, managing and treating patients with those conditions, and improving the health of affected patients by, for example, helping them to control their blood pressure or cholesterol levels. GPs can also earn points for good practice organization and good patient experience of care (as measured by patient surveys). These incentives make up on average a quarter of a GP's income. For hospitals, a small portion of revenue is linked to the achievement of a limited number of quality goals through a scheme known as CQUIN (Commissioning for Quality and Innovation). In addition DRG rates for some procedures are linked to best practice.

Since 2010, acute care and mental health care providers have had to produce annual "Quality Accounts," publicly reporting on the quality of services they provide in terms of safety, effectiveness, and patient experience. The primary aim of the reporting is to provide patients with information about provider performance. In the future, Quality Accounts will be extended to other care settings such as general practice.

#### **What is being done to improve care coordination?**

GPs increasingly work in multipartner practices employing nurses and other clinical staff who carry out much of the routine monitoring of patients with long-term conditions. Practices provide most of the features of a medical home: they hold treatment records for patients registered with them and direct patients to specialist services in hospitals or elsewhere according to their needs. GPs are not paid a specific amount for care coordination; such activity is carried out as part of their overall contract for personal medical services. Accordingly, they refer patients to other community-based professionals such as dietitians and community nurses. The Quality and Outcomes Framework offers a financial incentive for GPs to provide many elements of the care required for long-term conditions such as diabetes and heart disease.

The NHS Health and Social Care Act 2012 introduced new duties to promote integrated care. The NHS Commissioning Board, Monitor, and clinical commissioning groups are all charged by the Act with a duty to promote integration. In addition, the Act provides for the establishment of Health and Wellbeing Boards within local authorities to promote integration between health and other services.

#### **What is being done to reduce health disparities?**

In 2001, the then Labour government aimed to bring about by 2010 a 10 percent reduction in differences in infant mortality rates between socioeconomic groups and in life expectancy between those living in deprived areas and the general population. Additional resources were made available to areas of poor health to support this policy. The Health and Social Care Act 2012 places duties on the Secretary of State, the NHS Commissioning Board, and CCGs to "have regard" to the need to reduce health disparities. The government's white paper *Healthy Lives, Healthy People* (Department of Health 2012) announced that a new organization, Public Health England, would be established to support local efforts to reduce disparities. As noted above, finance will be allocated directly to local authorities to pay for public health programs.

#### **What is the status of electronic health records?**

Every patient registered with the NHS receives an NHS number, which acts as a unique patient identifier. Most GP patient records are computerized. Some practices use electronic systems to allow patient to make appointments and e-mail their GP but there is no requirement to do so. However, hospital and general practice records are not integrated into a single system.

The previous (Labour) government attempted to introduce a patient record covering all service providers, but had to abandon it because of cost and other factors. The current government is introducing the Summary Care Record, which will store a limited range of data (current medication, adverse reactions, allergies) for all patients except those who choose not to have one. Electronic transfers are widely used for prescriptions from GP practices to pharmacies and for the storage and distribution of digital images (scans, X-rays, etc.). The Choose and Book system, allowing patients to choose where they want to be treated and to book appointments online, is now operational across the country. These developments had been centrally led by the Department of Health. However, the national program is being dismantled, and future developments will be left to localities.

Interest and investment in telecare and telehealth have grown steadily over the past five years, but neither approach is mainstream. Such technology has recently been tested in a large randomized control trial, the results of which are being analyzed.

#### **How are costs controlled?**

Budgets for the NHS are set at the national level, usually on a three-year cycle. To control health care use and costs, the government sets a capped overall budget for local purchasers. These are expected to achieve financial balance each year. The new commissioning organisations, CCGs, will be allocated funds by the NHS Commissioning Board which will closely monitor their financial performance.

The current economic situation has resulted in a largely static NHS budget, but demand continues to rise. The NHS has therefore been set a target of £20 billion (US\$32 billion) in savings to be achieved over four financial years up to 2014–15. A number of initiatives, including the following, are in place to help the NHS meet this target.

- Pay for NHS staff has been frozen for all but the lowest-paid workers from 2011 to 2013. A cap of 1 percent per annum has been set for the following two years.
- A DRG-like activity-based funding system known as Payment by Results (PbR) has been introduced for acute hospital services. The aim is to extend it across all health care services. The DRG rate is based on the average cost of providing each procedure or treatment across the NHS as a whole. However, it also specifies an assumed annual improvement in efficiency. The current rates have not increased in line with cost inflation.
- The Department of Health's Quality, Innovation, Productivity, and Prevention program supports NHS organizations in improving quality of care while making efficiency savings, by offering technical and other advice on how improvements can be made.
- The government has proposed cuts of 45 percent to management costs, mainly through the abolition of Strategic Health Authorities and Primary Care Trusts, replacing the latter with CCGs.
- NHS Shared Business Services—a joint venture between the Department of Health and a private company—provides shared functions such as finance, payroll, and e-procurement for an estimated 100 NHS organizations to reduce the costs of back-office services.
- Successive government negotiations with the pharmaceutical industry as part of the Pharmaceutical Price Regulation Scheme have reduced the cost of prescription drugs. Prescribers have been encouraged to prescribe generic equivalents where available; 83 percent of prescriptions are now written for generic drugs, although only 69 percent are dispensed as such (NHS Information Centre 2011b). The Department of Health is developing a new value-based approach to the pricing of branded medicines to replace the PPRS in 2013. The intention is for drugs to be available to the NHS at a price reflecting their value although how this will be determined remains to be seen.
- Initiatives have been taken to cut the costs of purchasing medical supplies, including national and regional contracts designed to achieve savings through bulk purchases.

### **What major innovations and reforms have been introduced?**

The NHS Health and Social Care Act 2012 sets out a large-scale program for reform to be implemented by the end of 2014 (Department of Health 2010b). The broad aim of the reform is to decentralize the way the NHS is run. The NHS Commissioning Board and Monitor will be free from the day-to-day control of the Secretary of State, while the new local purchasing organizations, CCGs, are intended to give clinicians a greater say in how services are designed and delivered.

In areas such as promoting competition in providing NHS services and encouraging new entrants to the market, the new government has continued with existing policies. Most of the policies being pursued to improve care quality and control costs also represent a continuation of existing policies. However, as noted above, in one key respect the government has modified the commitment to competition by placing a new duty on CCGs, the NHS Commissioning Board, and Monitor to promote service integration. The move was prompted by the need to improve care coordination for the growing numbers of people with long-term conditions.

*The author would like to acknowledge Sarah Gregory, Claire Mundle and Seán Boyle as contributing authors to earlier versions of this profile.*

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## **The Swiss Health Care System, 2012.** Paul Camenzind, SwissHealthObservatory

### **What is the role of government?**

Duties and responsibilities in the health system are divided between three governmental levels: federal, cantonal, and communal. The system can be considered highly decentralized, as the cantons are given a critical role. The 26 cantons are responsible for licensing providers, hospital planning, and subsidizing a number of institutions and organizations. Cantons are like states, in that they are sovereign in all matters that are not specifically designated as the responsibility of the Swiss Confederation by the federal constitution. Each canton and demicanton has its own constitution articulating a comprehensive body of legislation.

**Who is covered?**

Coverage is universal, with residents mandated under the 1996 Federal Health Insurance Law to purchase statutory health insurance (SHI) from competing insurers. There are virtually no uninsured residents. Every individual intending to reside in Switzerland is required, within three months of arrival, to take out an insurance policy, which is then applied retroactively to the arrival date. Since only those with valid residence of more than three months can take out SHI policies, the problem of undocumented immigrants remains unresolved. SHI typically applies to the individual. It is not sponsored by employers, and dependents must purchase separate policies. Many residents also purchase complementary and supplementary voluntary health insurance (VHI) for coverage of services not covered under the basic package, for free choice of hospital doctor, or for improved accommodation (e.g., an individual or twin room instead of a shared room) when hospitalized.

**What is covered?**

**Services:** The Federal Department of Home Affairs decides whether or not to include a service in the SHI benefits package by evaluating whether the service is effective, appropriate, and cost-effective. It is supported in this task by the Federal Office of Public Health and by Swissmedic, the Swiss agency for the authorization and supervision of therapeutic products, among other authorities.

SHI covers most general practitioner (GP) and specialist services, as well as an extensive list of pharmaceuticals, medical devices, physiotherapy (if prescribed by a physician), and some preventive measures, including the costs of selected vaccinations, selected general health examinations, and early detection of disease among certain risk groups and for certain diseases (e.g., one mammogram a year if a woman has a family history of breast cancer). Hospital services are covered by SHI, but highly subsidized by the cantons. Care for mental illnesses is covered if provided by certified physicians. The services of nonmedical professionals (e.g., psychotherapy by psychologists) are covered only if prescribed by a qualified specialist and provided to patients in the specialists' practices. Otherwise, those services must be covered by VHI or paid for out-of-pocket by patients. SHI covers only "medically necessary" services in long-term care (see below). Dental care is largely excluded from the SHI benefits package, as is optometry for adults (unless necessitated by a primary disease). From mid-2012, however, optometry for children has been covered, along with some complementary medicine.

**Cost-sharing:** Insurers are required to offer a minimum annual deductible of CHF300 (US\$248) for adults in SHI, though enrollees may opt for a higher deductible and a lower premium. Enrollees pay 10 percent coinsurance above deductibles for all services (except for a 20% charge for brand-name drugs with a generic alternative unless specifically prescribed) and a CHF15 (US\$12) copayment per inpatient day. Providers are not allowed to charge higher prices than SHI will reimburse.

**Safety net:** Out-of-pocket spending on covered services (i.e., 10 percent coinsurance) is capped at CHF700 (US\$580) for adults, and at CHF350 (US\$290) for minors under 19 years of age, in a given year. Adults must make an out-of-pocket copayment of CHF15 (US\$13) per hospital day. Maternity care and a few preventive services are exempt from deductibles, coinsurance, and copayments. Minors are exempt from deductibles and from copayments for inpatient care. The Confederation, or federal government, and the cantons provide income-based subsidies to individuals or households to help cover SHI premiums; in addition to variation based on income thresholds, the process varies by canton. Overall, around 30 percent of residents benefit from individual premium subsidies. Municipalities or cantons cover the health insurance expenses of social-assistance beneficiaries and recipients of supplementary old age and disability benefits.

**How is the health system financed?**

**Publicly financed health care:** There are three streams of funding for publicly financed health care: mandatory SHI (see below); direct financing by government for health care providers (tax-financed budgets spent by the Confederation, cantons, and municipalities; the largest portion of this spending is given as cantonal subsidies to hospitals providing inpatient care); and social insurance contributions from

health-related coverage of accident insurance, old-age insurance, disability insurance, and military insurance.

Mandatory SHI, regulated by law and supervised by the Federal Office of Public Health, is purchased on an individual basis from a number of competing nonprofit insurers. Cantonal average annual premiums in 2012 for adults (for ages 26 and above, with a deductible of CHF300 [US\$248]) range from CHF3,510 (US\$2,907) (Appenzell Innerhoden) to CHF6,005 (US\$4,973) (Basel-Stadt). Costs are redistributed among insurers by a central fund operated by the Common Institution under the Federal Health Insurance Law, in accordance with a risk equalization scheme adjusted for canton, age, and gender. From 2012, risk equalization also takes into account hospital or nursing home stays of more than three days in the previous year (see below).

Insurers offer premiums for defined regions, and the basis for variation in those premiums is limited to age category (children up to age 18, young adults ages 19 to 25, and adults over 25), level of deductible, and alternative insurance plan (so-called managed care plans). In 2010, 46.9 percent of residents opted for basic coverage with a managed care insurer: either a health maintenance organization, an independent practice association, or a fee-for-service plan with gatekeeping provisions. Within a given region, the premium variation between insurers can be significant—as much as 70 percent in the city of Zurich, for example. This variation may be in large part because of risk selection, rather than efficiency differences. All premiums for the subsequent year are controlled and authorized by the Federal Office of Public Health, which rejects only those premiums that do not cover past, current, and estimated future costs for the insured persons in a given premium region. In such cases the insurer has to propose a new premium that satisfies the Federal Office of Public Health's criteria.

Cantons partially finance public acute care hospitals, with the remainder financed by contributions from insurers. Private hospitals also receive public subsidies if the cantonal governments have need of their services to guarantee a sufficient supply of acute care services within that canton. The other part of the cantonal governments' direct subsidization goes to outpatient care, to medical homes, and to public health programs.

All expenditures by government are financed by general taxation. In 2009, direct spending by government accounted for 19.4 percent of the total health expenditure (CHF61 billion [US\$51 billion]), and income-based SHI subsidies for 5.8 percent. Including SHI premiums (29.3% of total health expenditure) and those of other social insurance schemes (5.8%), publicly financed health care accounted for 60.2 percent of all health care spending.

**Privately financed health care:** Private expenditure accounted for 39.8 percent of total health expenditure in 2009. VHI is regulated by the Swiss Financial Market Supervisory Authority; health insurers offering voluntary coverage can vary benefit packages and premiums and refuse enrollment to applicants based on medical history. Service tariffs are usually negotiated directly between insurers and service providers. Unlike statutory health insurers, voluntary insurers are normally for-profit; often an insurer will have a nonprofit branch offering SHI and a for-profit branch offering VHI. It is illegal for voluntary insurers to base voluntary insurance enrollment decisions on health information obtained via basic health coverage, but this rule is not easily enforced. VHI accounted for 8.8 percent of total health expenditure in 2009. There is no available information on the number of persons covered.

In 2009, out-of-pocket payments accounted for three-quarters of all private expenditure on health (30% of total health expenditure). Cost-sharing in SHI and VHI accounted for 5.6 percent of total health expenditure. Most out-of-pocket payments were spent on dentistry and long-term care. More than 90 percent of all expenditure on dental treatment is accounted for by households.

#### **How is the delivery system organized and financed?**

**Physicians:** Residents are not required to register with a GP, and generally have free choice among self-employed GPs, unless enrolled in certain managed care plans. In 2011, 22 percent of doctors in the



outpatient sector were classified as GPs. Outpatient care tends to be physician-centered, with nurses playing a relatively small role. Solo practice is the norm.

Residents have free access (without referral) to self-employed specialists unless enrolled in a gatekeeping managed care plan. Specialist practices tend to be concentrated in urban areas and in the proximity of acute-care hospitals. Specialists can hold joint appointments in public hospitals and private practice. Apart from some managed care plans, in which physician groups are paid on a capitation basis, ambulatory physicians (including GPs) are paid according to a national fee-for-service scale based on points (TARMED). TARMED offers incentives for less resource-intensive forms of care. The point values can vary among cantons and service groups (physicians, hospitals) and are negotiated annually between the health insurers' association, *santésuisse*, and the cantonal medical associations or hospitals, or decided by the cantonal government if the other parties cannot agree.

**After-hours care:** The cantons guarantee the reliability of care provision and are responsible for after-hours care. They delegate those services to the cantonal doctors' associations, which organize and run appropriate care networks in collaboration with their affiliated doctors' facilities. The networks can also include public and private ambulance and rescue services, hospital emergency services, and, increasingly common in recent years, walk-in clinics. There is no regular exchange of information between these services and GPs' offices (as people are also not required to register with a GP). TARMED includes an additional payment to physicians for after-hours care, but the payment is heavily criticized by physicians as insufficient to render such services attractive.

**Hospitals:** About 70 percent of acute inpatient care is provided by public or publicly subsidized private hospitals. Hospitals receive around half of their funding from insurers. The corresponding base rates (i.e., the amount that is paid in the DRG system for a hospital case with cost-weight 1.0) are negotiated between hospitals and health insurers and must be approved by the cantonal government. The remaining costs of public and subsidized hospitals are covered by the cantons, which provided 44.5 percent of inpatient funding in 2009. Cantons are also responsible for hospital planning. The policy of planning and funding hospitals at the cantonal rather than the central level is one of the main reasons why the Swiss system is fragmented along cantonal lines. However, since 2009, cantons have been legally bound to coordinate their planning with other cantons. The introduction of a national diagnosis-related group (DRG) inpatient payment system in 2012 (to replace per-diem payment) will also redress cantonal fragmentation. The precise remuneration scheme depends on the insurance contracts; as a consequence, fee-for-service remuneration is still possible for patients with VHI for inpatient services not covered under SHI. Hospital-based physicians are normally paid a salary, and public-hospital physicians can receive extra payments for seeing privately insured patients.

**Mental health care:** Psychiatric practices are generally private, and psychiatric clinics and hospital departments are a mix of public, private with state subsidies, and fully private. There is also a wide range of sociopsychiatric services and day-care institutions that are mainly state-run and -funded. The provision of psychiatric health care is not systematically integrated into primary care in Switzerland as in other countries. Outpatient psychiatric prices are calculated using the TARMED tariff system, while inpatient care prices are usually calculated as a daily rate.

**Long-term care:** Since 2011, SHI has paid a fixed contribution to cover direct care-related (i.e., medically necessary) long-term care costs; the patient pays at most 20 percent of noncovered care-related costs, and the remaining care-related costs are financed by the canton or municipality. Long-term inpatient care (in nursing homes and institutions for disabled and chronically ill persons) cost a total of CHF10.5 billion (US\$8.7 billion) in 2009, representing 17.2 percent of total health expenditure. Two-thirds of these costs (64.3%) are paid for by private households (out-of-pocket and cost-sharing), 15.3 percent by SHI (nursing care), and the rest by government subsidies (19.8%) and disability insurance. A third of the 1,500 long-term care institutions in Switzerland are state-funded, a third privately funded but with public subsidies, and a third funded exclusively by private means. For long-term outpatient care (called *Spitex*),

SHI also covers the cost of home nursing care, which made up roughly a third of Spitex's total expenditure of CHF1.3 billion (US\$1.1 billion) in 2009. The other two-thirds, devoted mainly to support and household services, is paid for by customers and via state subsidies.

**What are the key entities for health system governance?**

Mandatory statutory health insurance (SHI) is regulated by law and supervised by the Federal Office of Public Health. The Federal Department of Home Affairs defines the SHI benefits package; it is supported in this task by the Federal Office of Public Health and various expert authorities, in particular by Swissmedic. The Swiss Health Observatory (Obsan) was created 10 years ago to improve the transfer of health information to political authorities, and different strategies have been developed to do so. Since Swiss health care is largely decentralized, the key entities for health system governance exist mainly at the cantonal level.

**What is being done to ensure quality of care?**

Professional self-regulation has been the traditional approach to quality improvement. Providers must be licensed in order to practice medicine, and are required to meet educational and regulatory standards. However, only the Swiss Medical Association requires regular further education of its member physicians in order for them to maintain medical specialist titles; revalidation by state authorities (i.e., cantons) is not currently required. An analysis of the degree to which evidence-based medicine is taught in postgraduate training in different clinical fields in Switzerland shows that it is not yet an important part of the medical curriculum. Many local quality initiatives have been undertaken, often at the provider level, including the development of clinical pathways and consensus guidelines, although these are not standardized or used systematically nationwide. However, providers have very little financial incentive to improve the quality of outpatient care. In recent years, the government has been considering the implementation of a framework for systematic quality measurement, public reporting, and minimum national standards. At the end of 2009, the Swiss Federal Council, the supreme governing and executive authority of the country, approved the Quality Strategy of the Swiss Health System. The report establishes in detail different areas of quality control in which the Confederation will play an active role in the future. The main focus is the implementation of a bill for quality management in the education of medical personnel to promote public health literacy. One of the first measures has been the publication of medical quality indicators for Swiss hospitals, on a voluntary basis.

**What is being done to improve care coordination?**

Care coordination is seen as underdeveloped, particularly in light of a projected lack of providers in the future and the need to improve efficiency to increase capacity. A task force led by the cantons and the Confederation has recently proposed new approaches to care. Some focus on fully integrated care for all patient groups, while others focus on specific patient populations (i.e., chronic patients) or propose specific interventions (i.e., disease prevention). However, only one element of these new approaches encourages collaboration between different types of health professional. As a result, the skills of nonmedical health professionals (pharmacists, physiotherapists, psychologists, etc.) are not fully applied in the treatment of people with chronic conditions.

**What is being done to reduce health disparities?**

There are several reasons why health disparities have not received much political and professional interest at the national level. First, health inequalities are not considered to be significant in comparison to other Organization for Economic Cooperation and Development (OECD) countries; second, it is still difficult to obtain detailed statistical information about the epidemiological situation and health outcomes of the Swiss population as a whole, and for its different regional and socioeconomic subgroups in particular; and third, health inequalities are seen more as the responsibility of regional authorities (cantons or communes, the lowest level of the state structure) than of the federal government, making them much less visible at the national level.

**What is the status of electronic health records?**

A national e-health service called eHealth Suisse (an administrative unit of the Federal Office of Public Health) was established in 2007. EHealth Suisse is coordinated and funded by the federal and cantonal governments and is divided into three fields of action. First, starting in 2015, everyone in Switzerland should be able to give providers electronic access to information relevant to their treatment. Second, health-related Web sites and online services will be required to undergo quality certification and a national health Web site will be constructed. Third, the necessary legal changes will be made to realize these measures. A formal statement of the Executive Federal Council is expected in November 2012.

A key element of eHealth Suisse is the SHI enrollee card, introduced in 2010, which encodes a personal identification number and allows all insured persons to record information about allergies, illnesses, and medication. GP eHealth is still at an early stage, and there are ongoing discussions about forthcoming incentives to be provided to physicians for adopting new technologies. Financial incentives and binding technical standards are seen to hold the most promise.

Hospitals are more advanced: some have merged their internal clinic systems in recent years and hold interdisciplinary patient files. However, the extent of this development varies greatly among hospitals and across cantons, in spite of efforts by eHealth Suisse to convince providers of the benefits of EHRs for medical practice. An interoperable national patient record is not a priority for eHealth Suisse, since the principles of decentralization, privacy, and data protection are regarded as very important in Swiss health care.

#### **How are costs controlled?**

Switzerland's health costs are among the highest in the world (only the U.S. and Norway spent more). The introduction of regulated competition among nonprofit health insurers and among service providers in 1996 aimed to contain costs as well as to guarantee high-quality, comprehensive health care, and to establish greater solidarity among the insured. While scientific analyses and public perception have been particularly critical of competition's ability to cut or control health care costs, the other objectives are generally regarded as having been successfully achieved.

The failure of regulated competition to contain costs is largely ascribed to inadequate risk equalization, the dual funding of hospitals by cantons and insurers, and pressure on insurers to contract with all certified providers. In 2012, the risk equalization formula has been improved, and should now bolster insurers' incentives to improve efficiency. In the future it may be changed from a retrospective to a fully prospective system, further strengthening those incentives. Greater use of managed care plans employing gatekeeping and capitation-based physician payment may also help to reduce expenditure in the future.

All new pharmaceuticals are evaluated before a coverage decision is made, pending which both effectiveness (by Swissmedic) and cost (by the Federal Office of Public Health) are considered. Efforts are also being made to reassess more frequently the price of older drugs. Generic drugs must be sold for at least 50 percent less than the original brand; however, they made up only 9.8 percent of all drugs sold in the Swiss market in 2011. Patients pay a higher rate of coinsurance for brand-name drugs that have a generic equivalent (20% instead of 10%). Pharmacists are paid a flat amount for filling prescriptions, so have no financial incentive to dispense the more expensive drugs.

#### **What major innovations and reforms have been introduced?**

Since 2000, two reform packages have been debated in parliament. The first was mainly concerned with reform of risk equalization, health care prices, monitoring of insurers, SHI enrollee cards, selective contracting, premium reduction, and cost-sharing. The second involved reform of hospital funding and managed care. A "necessity clause" introduced in 2002 and regulating the establishment of new outpatient service providers was in place for GPs through 2009 and for specialist physicians and pharmacists until 2011. Discussions about reintroducing the necessity clause for specialists have not ceased since then.

In June 2008, the federal parliament reformed long-term care financing. Instead of covering the costs of basic care (i.e., activities of daily living) and nursing care for patients in nursing homes and those needing home care, SHI pays a flat contribution fixed by the Federal Council. The patient contributes up to 20 percent of the highest amount paid by SHI, and the cantons and communes regulate the financing of the remaining costs. The changes were implemented in 2011.

In addition to converting hospital payment to the DRG system in 2012, the federal parliament plans to refine the risk equalization formula. However, the parliament's proposal that was part of the proposed law to promote managed care was rejected in a June 2012 referendum. In addition to legal changes, the Federal Council has also decided to increase the degree to which the insured can opt for a higher deduction in order to reduce their premium. The hope is that more people will choose higher deductibles, and that this will more strongly disincentivize unnecessary care.

In the primary care sector, the Federal Council launched an initiative, the *Masterplan Hausarztmedizin und medizinische Grundversorgung*, which focuses on finding reasonable and quick solutions for the most urgent problems in primary care through concrete measures in the areas of training, further education, research, new care models, after-hours care, and tariffs. Along with the *Masterplan*, the Federal Council would also like to encourage the withdrawal of a popular initiative ("*Ja zur Hausarztmedizin*," or "Yes to general practice"), which began in June 2012 and will end in spring 2013. For the Federal Council, the initiative is too focused on promoting only primary care physicians as the center of care, rather than promoting other primary health care specialties as well, like professional home care.

*The author would like to acknowledge David Squires as a contributing author to earlier versions of this profile.*

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**"A.      Policy topics**

1. *The current **policy concept** of social health protection is not reflected in the legislation. There is therefore a need to update the legislation in this regard with particular reference to the following issues:*
  - a. **No equal access.** Those with mandatory and private health insurance have easier access to more services without a risk of impoverishment than people enrolled in Community Health Funds (CHF) and other informal sector health insurance schemes or people with no insurance at all. A common basic health services benefits package (BBP) is not universally implemented, although such a package has been proposed<sup>102</sup>. As regards the budget-funded benefits, priority-setting is left to the Councils and there is no guarantee that all the money intended for health services is indeed spent on them. Benefits provided as a part of health insurance scheme<sup>103</sup> reach only a part of the population.
  - b. **No equity** in payment into the health system. Voluntary private and community insurance schemes charge a variety of different flat fees, mandatory social health insurance charges, wage dependent, and percentage-based contributions, the latter being at different levels. Out of pocket payments (OOP) are an important component of health-care **funding**, but they do not contribute to equity in financing the system.
  - c. **No universal coverage.** Despite tremendous efforts by the GOT and ministries, most people in the informal sector continue to be excluded from coverage owing to low enrolment in the insurance schemes targeting such populations.
2. **Fragmentation.** As with the health finance system in general and health insurance in particular, the legislation covering these areas is fragmented. There is no unified or even harmonized system of regulation covering the different forms of health insurance that uses comparable governance regulations or the same body/organ for regulation and oversight.
  - a. The National Social Security Fund (NSSF) and its Social Health Insurance Benefits (SHIB) program report to the Ministry of Labour (MOL), while conforming to the NSSF Act and its regulations and schedules.
  - b. The National Health Insurance Fund<sup>104</sup> (NHIF) reports to the Ministry of Health and Social Welfare (MOHSW) and is regulated by the NHIF Act and subsidiary legislation as well as the SSRA Act with respect to "non-technical" health matters.
  - c. Both the NSSF and NHIF are subject to oversight by the Social Security Regulatory Authority (SSRA) established under the SSRA Act<sup>105</sup>, which in turn reports to the MOL.
  - d. Private health insurers are regulated/governed by the Tanzania Insurance Regulatory Authority<sup>106</sup> (TIRA), established by the Insurance Act and reporting to the Ministry of Finance (MOF). This Act does not, however, provide for any health insurance-specific regulations.

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<sup>101</sup> Bultman, Jan et al: Tanzania Health Insurance Regulatory Framework. review on request of the Ministry of Health and Social Welfare and the Social Security Regulatory Authority. GIZ/P4H. Dar es Salaam, March 2012

<sup>102</sup> Ministry of Health. National Package of Essential Health Interventions in Tanzania, January 2000

<sup>103</sup> Benefits package is in this review defined not only in terms of medical interventions but also in terms of copayments and other conditions for access to services.

<sup>104</sup> Established under the National Health Insurance Fund Act, 1999 [Cap. 395 R.E. 2002].

<sup>105</sup> Established under the National Social Security Fund Act, 1997[Cap. 50 R.E. 2002].

<sup>106</sup> The Social Security (Regulatory Authority ) Act, 2008, No. 8 of 2008

- e. CHF, through their respective Councils, report to the Prime Minister's Office Regional Administration and Local Government (PMO-RALG) and are regulated by the CHF Act<sup>107</sup>. MOHSW, PMO-RALG and NHIF attempt to improve efficiency in operations by giving HIF responsibility for the CHF administration<sup>108</sup>, keeping the option of further regulatory and practical steps open.
  - f. Health maintenance organizations (HMOs) and medical benefits management organizations (MBMO's) are not subject to oversight by anybody in the health sector.
  - g. MOHSW vertical disease programs exist next to health insurance-financed services of mainstream health care provided by the five tiers of the health services system. Furthermore, a devolved political system, which is not yet fully implemented, has mandates in health financing next to the MOHSW vertical programs and insurance-paid benefits. Although the benefits regulations of NHIF and NSSF-SHIB exclude MOHSW-financed services (next to other explicitly mentioned medical interventions and diseases), demarcation problems exist, burdening providers. This was noted during the focus group discussion with hospital representatives and arises when, for example, a hospital treats a patient for cancer (budget financed) and the patient has other diseases at the same time.
  - h. The regulatory framework in Tanzania has not been designed to regulate common functions across organizations; rather, it is designed to regulate the bodies/agencies themselves.
3. Explicit policies regarding **competition in health insurance** do not exist. At the moment, NHIF has a monopoly in the formal public sector, while in the formal private sector, private health insurers, NSSF, and (as of 2010) the NHIF compete for members. In the informal sector, some micro schemes compete with CHFs. The lack of a specific policy and regulatory framework on competition makes it difficult to deal with the possible adverse side effects of competition and hence may not advance the GOT's SHP objectives. Topics to address in regulation include risk selection and risk rating by insurers. The absence of such regulations could possibly lead to reduced access to health insurance and thus to reduced health care. As a direct consequence there would be a reduction in access equality and an increase in inequity in financing.

Competition in health finance also requires dedicated regulation and oversight. Should the GOT desire to prevent risk selection and use competition to advance efficiency and client orientation, it may want to establish a risk equalization schedule. To do this, considerable efforts are required to create a suitable HMIS infrastructure, to enforce the provision of reliable data and to have oversight mechanisms in place that enforce compliance. The current regulations would obviously have to be amended to allow for such instruments.

The SSRA Act is in line with the implicit GOT policy regarding the stimulation of competition among insurers as there are only formal criteria to register or deregister insurers. However, the SSRA cannot prevent insurers from risk rating individual contributions, from excluding certain services to the insured based on pre-existing diseases and from refusing coverage. In other words this Act is not explicitly intended to promote equity in financing, equal access to insurance and to health services and to prevent or reduce impoverishment; although, it can "facilitate extension of social security coverage.. " (s 5 (k)). So, SSRA may want to consider establishing rules governing

<sup>107</sup> Established under the Insurance Act, 1996 (repealed and replaced by Act No. 10 of 2009) [Cap. 394 R.E. 2002].

<sup>108</sup> Under a tripartite Memorandum of Understanding among these three institutions due to expire at the end of this year unless renewed. It is one of the documents reviewed for and appended to this report.

competition in the health sector which would mitigate or prevent the negative aspects of competition.

## **B. Regulators**

4. **SSRA** is a rather new but potentially very useful regulatory authority for social security related insurance schemes.
  - a. However, it does not cover all health insurance schemes, such as private schemes, HMO's and MBMO's.
  - b. The SSRA Act is not specifically oriented toward health insurance. But since it is a framework law, regulations based on this Act can provide for health insurance specifics.
  - c. SSRA has no mandate regarding cost containment and promoting quality assurance in health-care services delivery. Although SSRA does not directly deal with health-care providers, it could support the focus of NSSF-SHIB and NHIF in these areas and play a coordinating, regulatory and supervisory role, thus making sure that members get value for money.
5. **TIRA** is focused on insurance in general and as such covers private health insurance. However, there are some grey areas between what is covered in this Act and in the SSRA Act and between the mandates of TIRA and SSRA - as regards HMOs, for example. Furthermore, the TIRA Act does not allow for establishing requirements for private health insurance as regards benefit packages, etc. Is therefore recommended that the TIRA Act explicitly refer to private health insurance as a second (voluntary) tier supplementing the first tier of social health insurance which is regulated under the SSRA Act. The reverse should be done in the SSRA Act. Given the established expertise of TIRA in technical insurance matters and financial management, it would be advisable for there to be coordination and cooperation between TIRA and SSRA. Such coordination could be based on a memorandum of understanding (MOU) or on amendments of the two Acts.

## **C. Insurers**

6. Although **NSSF** is mandatory for formal private sector workers<sup>109</sup>, enrolment in its SHIB program is not. Funding for the SHIB program comes from the general NSSF contribution (which, however, is not disaggregated to indicate what portion, if any, in percentage or proportion, counts towards the SHIB program).
7. The **NHIF Act** does not allow for flexible contribution rate setting to enable adjustments according to need. NSSF, on the other hand, does not charge health insurance-specific contributions.
8. The NHIF Act (Section 36 (2)) does not allow for the maximizing of financial reserves. It is therefore recommended that the GOT consider operationalization to protect NHIF members from being either overcharged or having unnecessarily limited benefits.
9. Beside the fact that **benefits**<sup>110</sup> are dissimilar in social health insurance (SHI), contracts with services providers and payment schedules also differ. A fee for services (FFS) contract is

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<sup>109</sup> And, as an alternative choice among other social security schemes that have no SHIB programs, it could be said to be mandatory for public sector workers not covered under any other scheme

<sup>110</sup> Benefit package understood as the entitlement to health services of which the services can be described by either using a system of positive and/of negative lists, indicate the provider from whom the services need to be

implemented by NHIF and a capitation fee is paid by NSSF to every registered provider for services. This burdens providers with having to run different administration systems. It may also create bias/double standards in the treatment of patients, because of the possibility of maximizing profit by “under providing” for those members who are covered by the capitation scheme and “over providing” for those under fee for service.

10. Criteria and a generally accepted method for **determining fee amounts** are lacking, raising questions among providers that have no negotiating power in the system as well as among health insurers that are required to justify their payment levels. A dedicated forum with participation of all relevant stakeholders backed by supportive expertise might be worth considering. The ongoing service costing study may provide a good starting point.
11. NHIF and NSSF operate their own **accreditation systems** with different standards. The recent MOHSW Tanzania Quality improvement Framework in Health Care 2011-2016 (October 2011) makes no reference to the existence of SHI or to the possibility of using SHI legislation and SHI contracts as a tool for implementing the MOHSW quality assurance and quality improvement policies.
12. NSSF and NHIF have their own **conflict resolution mechanisms**. A generic health insurance ombudsman could serve both SHI and private health insurance in an advisory role, regardless of the differences in BPs. SSRA could also opt for such an ombudsman function provided that SSRA could also deal with private insurance, CHFs and other community-based schemes. There is a possibility that this would generate a considerable workload and capacity requirements, especially if the insured became aware of such a possibility. A dedicated patients' rights Act could serve as a legislative vehicle to support such a development.
13. Health insurance regulation can be a great tool for guaranteeing access to health services, which makes it a valuable health policy instrument. The NSSF and NHIF Acts provide for this through the benefits-in-kind system and the contracts with providers. The **Insurance Act** does not, its focus being mainly on general protection of consumers of insurance against fraud and insurer insolvency and on regulating the insurance market. Private health insurance is insurance to cover financial losses in case of financial damage. Health policy considerations do not play a role in this private sector.
14. None of the health insurance schemes takes account of the need to **cross-subsidize** other schemes, aiming at more equity overall in financing the health sector.
15. NHIF and NSSF make creative use of their reserve funds by **providing loans** to health-care providers (called advance payments for which an administration fee is paid). The funds could actively use this facility to ensure the equitable distribution of health technologies. However, a national health facilities planning system, which could guide investments and loan policies, does not exist. MOHSW requirements for standard equipment, related to the type and level of facility, can provide guidance. NHIF and NSSF are not involved in any of the **investment decisions** of MOHSW but do have to pay (part of) the operating costs. Although this may not be perceived as an urgent problem because of the need for providers to comply with MOHSW standards and because of the more than sufficient reserves of NHIF and NSSF, this situation may change and the current regulation does not provide for this. This is not just a matter of financial considerations, quality of care is also important. Planning and concentrating **high tech and high risk interventions** improves the chances of achieving better health outcomes and greater efficiency. Legislation in this area could therefore be considered.

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received, the location where the services will be offered and the conditions for access, such as existing medical need, referral, co-payment, pre-authorization, etc.



**D. Governance**

16. *Generic regulation provides for conflict-of-interest avoidance rules and the declaration of assets/wealth for high level officials and public servants. This promotes **good governance**. However, other critical positions of responsibility should also be identified in health insurance and regulatory bodies, where the risk of inappropriate use of funds exists, and subsequent legislative action may need to be taken.*
17. *The system of financial **auditing** of public insurance is straightforward and guided and overseen by the National Audit Office (NAO). Although NAO has started "value for money" auditing in the health sector, it has not yet done so in SHI. There is no legal obligation to do this. Coordination with SSRA in this regard would need to be developed and most of the activities could be left to SSRA, under the oversight of NAO. "*

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