Recap Day 1: Health Sector Reforms - Focus National Health Insurance

2nd Health Sector Reform Stakeholder Forum – Focus: National Health Insurance

13-14 Oct 2016

Sunbird Capital Hotel, Lilongwe Malawi

Supported by giz

Under the umbrella of P4H Social Health Protection Network

Public-Private Partnership with CHAM

Implementation of a new MoU and clearing outstanding debt

SLA impact

- SLAs increase access to contracted services

Facility	Indicator	Annual Average without SLA	Annual Average with SLA
Mzambazi HC	ANC first trimester	4	35
	ANC total visits	1400	2100
	Live births	22	33
Koche HC	SBA deliveries	67	115
Malamulo HC	SBA deliveries	49	132
Pirimiti HC	SBA deliveries	62	154
	ANC total visits	442	633

Implementation status of revised MoU

CHAM facilities included under new MoU	
Total under all models of cooperation	175
eligible for SLA	121
Currently active SLA	54

- Catchment area of CHAM facilities: 2,679,860 people
  Substantial progress on outstanding debt:
- 77% of MWK 217 mio. paid for period Jun 2015 – Feb 2016
- No payments yet on MWK 296 mio. for period before Jun 2015; but goodwill between actors
- Guidelines, contract template and performance indicators reviewed
- Uptake of SLAs at district level still challenging

Decentralization

Increasing local acountability and management autonomy

Decentralization to Districts

- Turn Advisory Committees' at health facilities into elected Governance Boards with some level of statutory authority
- Enhance community participation and engagement through empowerment
- Decentralise approved health budget to Facility Boards by ring-fencing funding to each facility
- Decentralize Human Resources to facility boards
- Implement performance based contracts with Facility Boards (esp. preventive and promotive aspects of health)
- Align with local government governance structures from the village to the District Council level
- Pilot in 3 districts/ 11 facilities ongoing (DFID/Options support)

Decentralization to Central Hospitals

- Similar approach to decentralization to district level:
  - Institute Board as oversight mechanism
  - Increased authority over HR management
  - Strengthen performance management through contracts
- Cabinet paper presented by Minister early August, good idea and well received
- MOH has drafted a paper on operational modalities:
  - HR & Financial management
  - Relationship with MOH, CMST, etc.
  - Criteria for appointing Boards of Trustees
  - Financial implications of the Boards

Health Fund

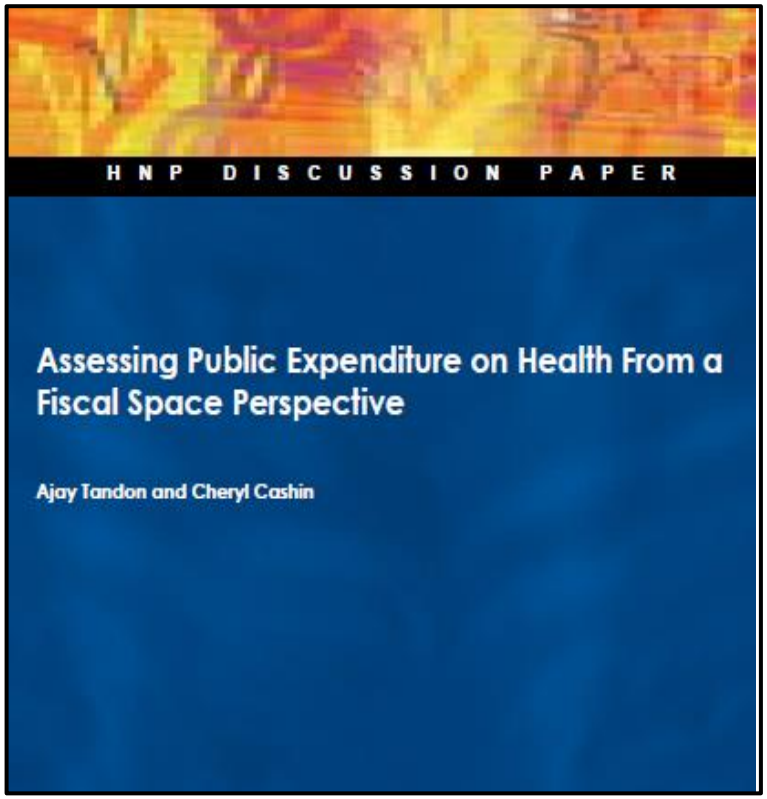
Fiscal Space Analysis and Prospects for Introducing Earmarked Taxes for Health

Research Paper by World Bank

FISCAL SPACE ANALYSIS

The prospects of creating 'fiscal space' for the health sector

PETER S HELLER
International Monetary Fund, Washington DC, USA



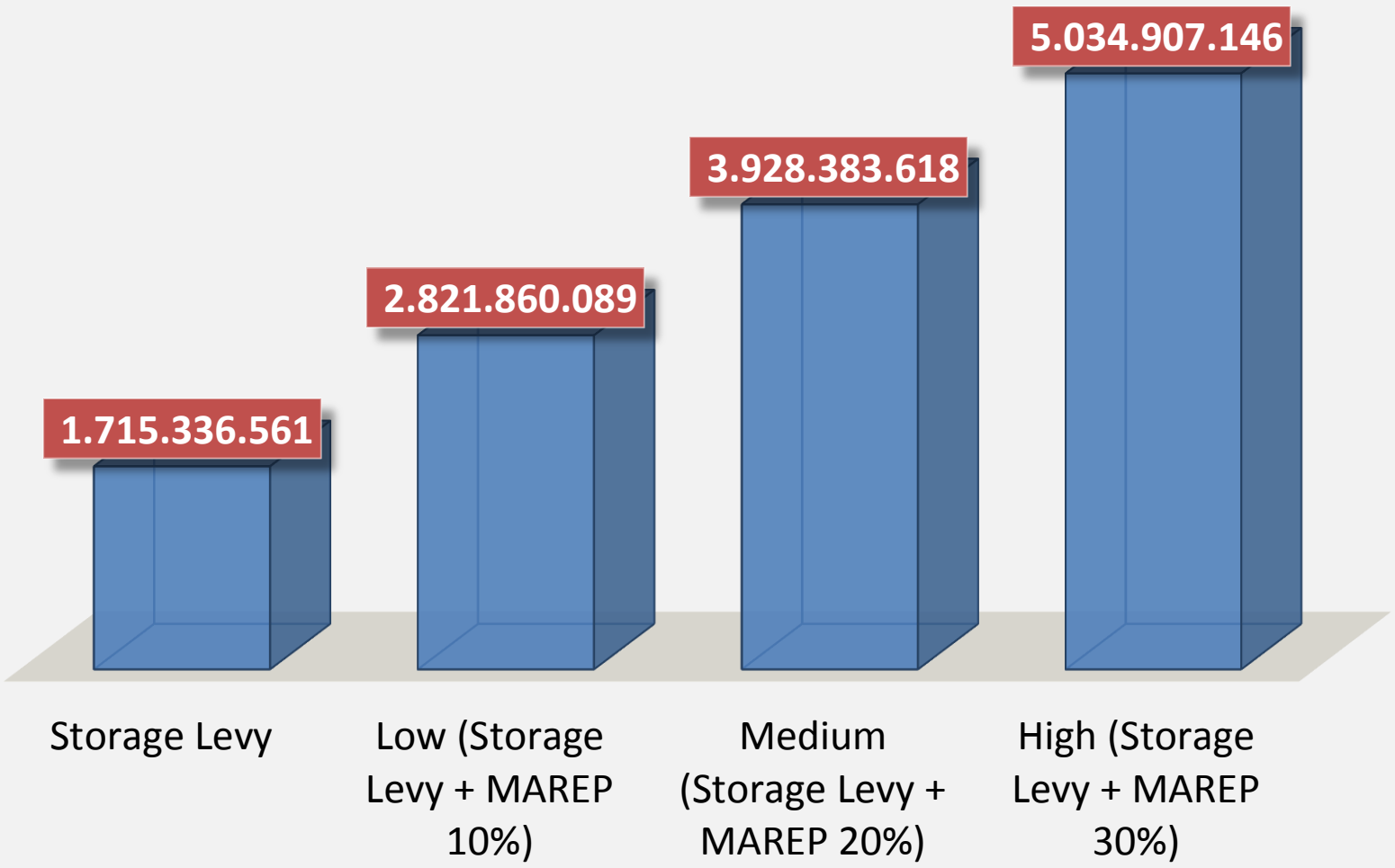
1. **Conducive macroeconomic conditions** including increased economic growth and overall government revenue with possibilities of increased government expenditure on health; **LIMITED**
2. **Re-prioritization** of health within the government budget; **LIMITED**
3. **Additional resources for the health sector** through earmarked taxes, health insurance, etc; **MODERATE**
4. **Increased health sector-specific foreign aid**; **LIMITED**
5. **Improved efficiency** in the government allocation and expenditure. **GOOD**

Feasibility of earmarked taxes

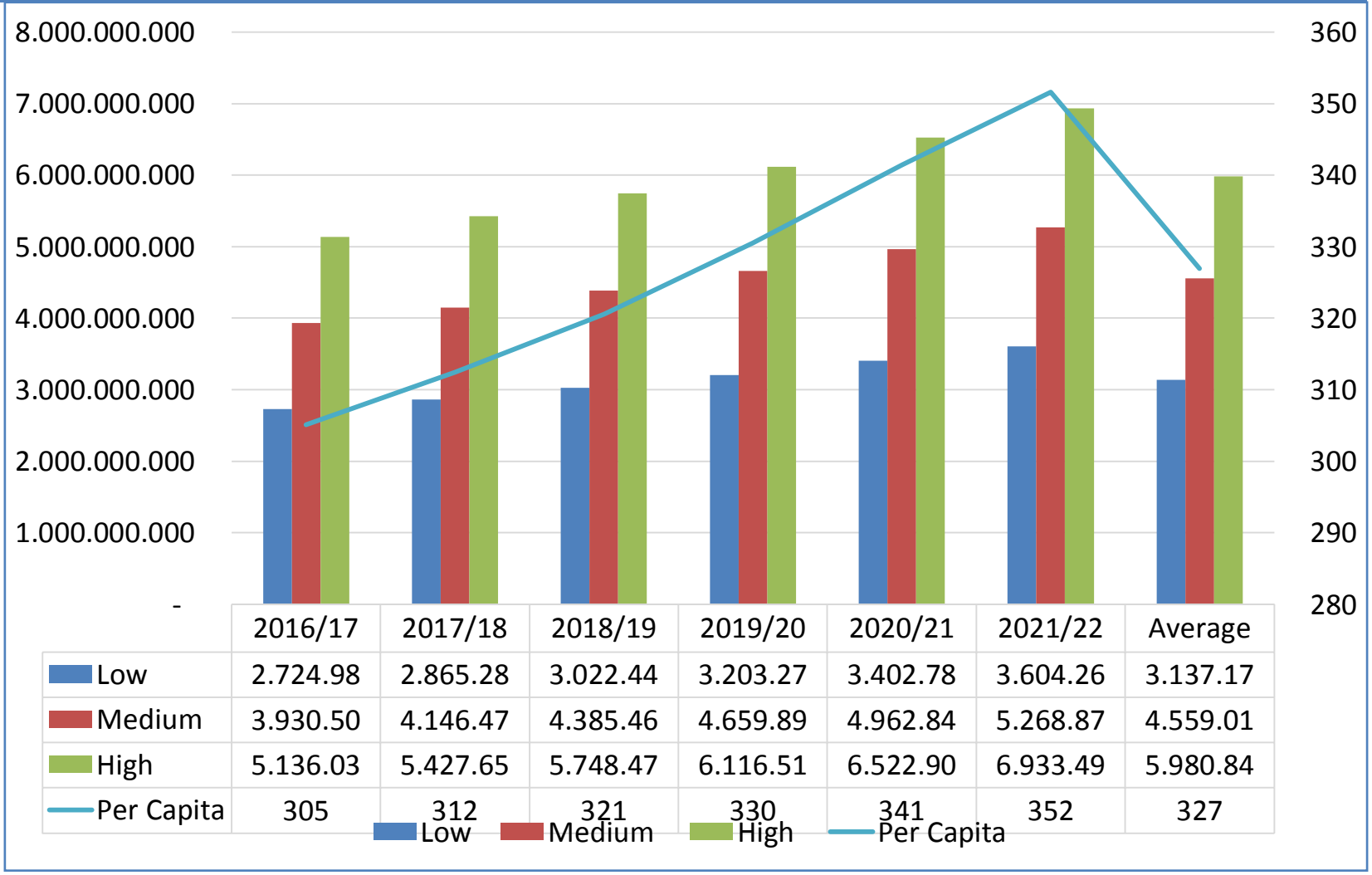
- Increased taxes or levies in the already existing areas can have an adverse effects on production, trade, and consumption
- Emphasis to be on improving the tax administration capacity at MRA which could lead to improved revenue collection
- Consensus was to identify and re-allocate revenue from existing taxes or levies without increasing tax rates
- Excluded areas: Mobile phone talktime; corporate businesses; VAT; moneys received from loans applied through parliament; and donations received from developing partners, foundations
- **Potential areas: Fuel & Motor vehicle insurance**
- Review the proposed establishment of a Third Party Motor Compensation Fund

Potential Revenue from MAREP and Storage Levy:

Annual Average 2016/17-2021/22



Fuel levies and tax on motor insurance premiums



	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	Average
Low	2.724.98	2.865.28	3.022.44	3.203.27	3.402.78	3.604.26	3.137.17
Medium	3.930.50	4.146.47	4.385.46	4.659.89	4.962.84	5.268.87	4.559.01
High	5.136.03	5.427.65	5.748.47	6.116.51	6.522.90	6.933.49	5.980.84
Per Capita	305	312	321	330	341	352	327

National Health Insurance

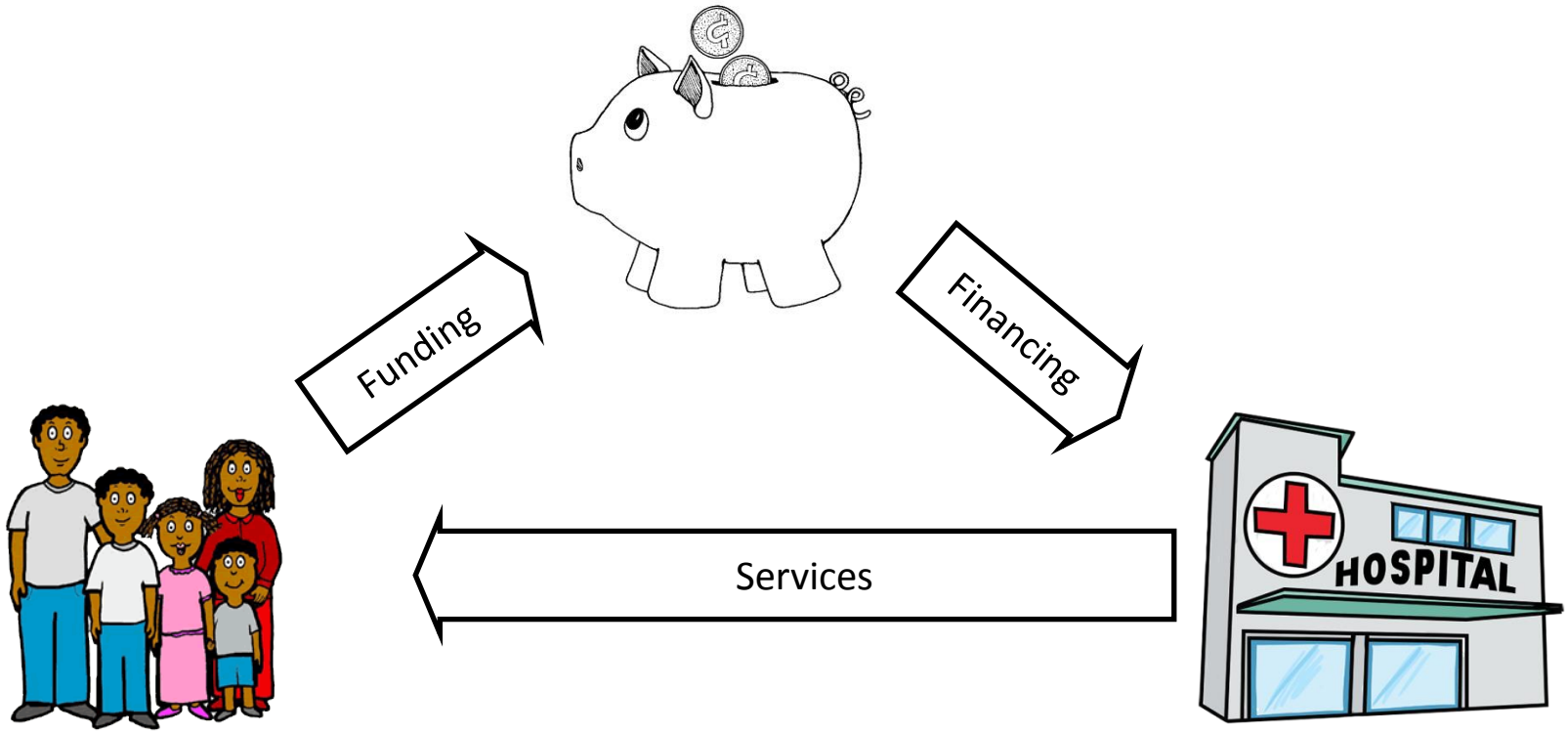
Assessment of feasiblity and appropriateness

Consultancy implemented by OPM

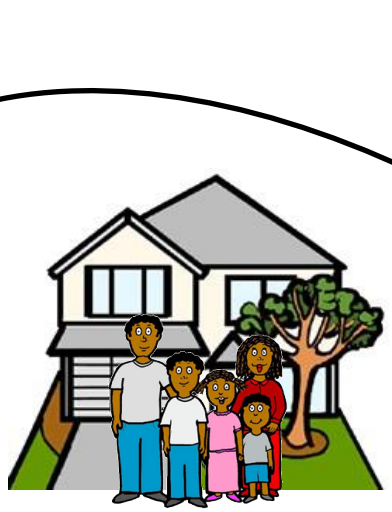
Background to the assessment

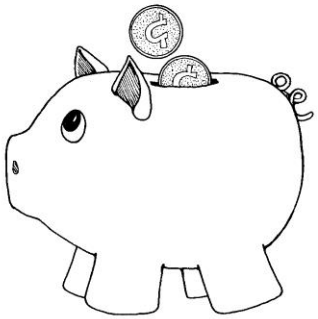
- DPP election manifesto: Health Insurance
- 2015 performance agreement between President & Minister of Health
- Previous work (USAID/SSDI) to be deepened
- Invitation to GIZ under P4H Network, contract to Oxford Policy Management
- Cost-benefit framework set by MOH – comparison of current system, NHI and 2 variations
- Benchmarking along health financing objectives agreed in inception phase

The health care funding/service cycle



The health care funding/service cycle



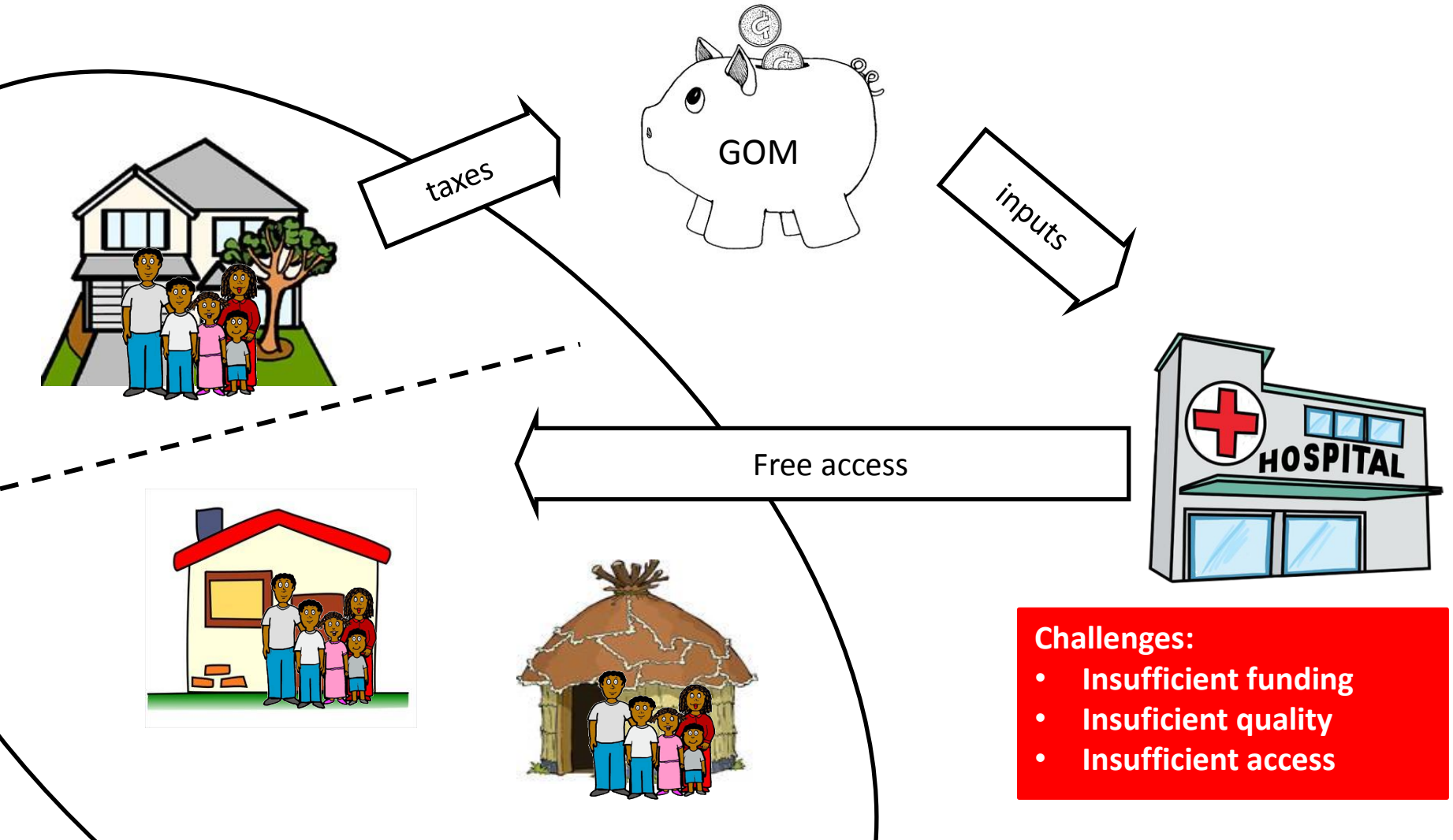


Funding

Financing

Services

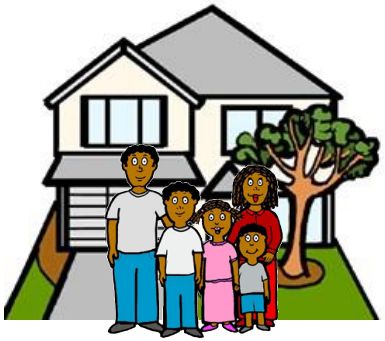
The current system – the base case

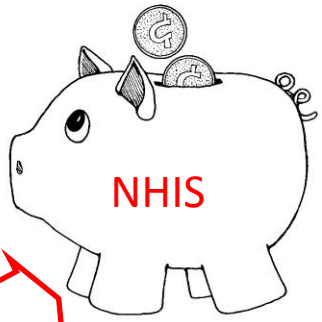


Challenges:

- **Insufficient funding**
- **Insuficient quality**
- **Insufficient access**

National Health Insurance - the central reform proposal





NHI premiums

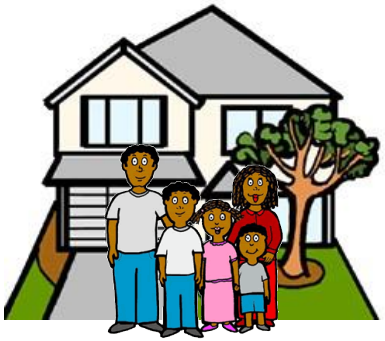
Service payment

Free access for NHI members

Expectation:

- **Raise revenue**
- **[improved quality]**
- **[more efficiency]**

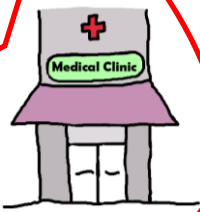
National Health Insurance - variation: tertiary care only



NHI premiums

Service payment

inputs



Free access for NHI members 3^{ary} care

Justification:
Primary and secondary care budgets already at districts

Alternative: Purchasing Agency

Why:
Observation in other countries that NHI premium collection a challenge

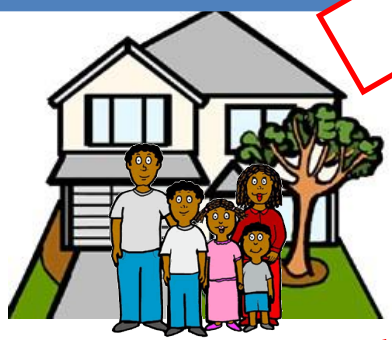
taxes

GOM

funds

Why:
Contracting of GOM-owned facilities

Service payment



Free access

Assessed reform scenarios - Summary

- **Scenario 1**: Maintain the status quo; ongoing reforms continue as planned;
- **Scenario 2**: Establish a premium based NHI: collecting mandatory direct contributions from the formal sector and the informal non-poor, while fully subsidizing the poor; reimbursing the entire Essential Health Package; pooling and purchasing at national level;
- **Scenario 3**: Establish a high-cost risk protection NHI: revenue collection as in Scenario 2; reimbursing only tertiary care; pooling and purchasing at national level;
- **Scenario 4**: Establish a Purchasing agency; separating service purchasing from service provision, either centrally or decentralized.

OPM's analytical approach

- Institutional and policy analysis
- Assess four NHI scenarios by benchmarking analysis
- Modelling of NHI structure
- Rapid appraisals informing the CB and benchmarking analysis:
  - Malawi Revenue Authority
  - Unified Beneficiary Registry and poverty targeting mechanisms

The benchmarking framework

	MOH	Full NHI	NHI tertiary care	Purchasing agency
Revenue mobilisation				
Technical efficiency				
Equity				
Financial risk protection				
Policy coordination and resource allocation process				
Health outcomes				

Populated with evidence from: a health system model, Malawi data and international experience

The benchmarking framework

	MOH	Full NHI	NHI tertiary care	Purchasing agency
Revenue mobilisation	NHI: Limited additional revenue from informal non-poor, high collection costs and low coverage; most income from fees			2, 3
Technical efficiency				
Equity				
Financial risk protection				
Policy coordination and resource allocation process				
Health outcomes				

Populated with evidence from: a health system model, Malawi data and international experience

Benchmark 1: Revenue Collection

- NHI net revenue effect = income – cost of revenue collection
- Assumptions:
  - no additional burden on formal sector, simply shifting tax to NHI contribution (no net gain)
  - Poor people fully subsidized by GOM (no net gain)
  - Service access fees as incentive to enrol
  - Coverage roll-out to follow path observe in other countries
- MRA rapid appraisal: no capacity to collect funding from informal setor households – extra costs for collection do arise
- But MRA appraisal also found: MRA may build capacity to raise revenue from informal sector business post 2018 based on non-traditional information sources

Benchmark 1: Revenue Collection (ctd)

Potential options for raising contributions	Projected revenue				
	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022
Incremental revenue for premium and fee for service for non-poor informal					
Informal non-poor paying premium, % target*** population	0.5%	5%	10%	15%	20%
User fees from informal non-poor	3,332	3,517	3,722	3,868	3,997
Premiums from informal non-poor	276	614	1,357	2,241	3,280
Cost of collecting Premium from informal non-poor	69	154	339	560	820
Total net revenue from informal non-poor	**3,540**	**3,978**	**4,740**	**5,549**	**6,457**
Incremental revenue with fiscal space analysis					
Health fund (MAREP, storage levy and MV insurance – medium scenario**)	4,147	4,386	4,660	4,963	5,269

Notes:

*** 100% NHIS membership has not yet been achieved in any low- or middle-income country. Scenario primarily for illustration purposes.**

****World Bank provisional calculations September 2016**

***** target population is the informal non-poor population which is 20% of the total Malawi population**

The benchmarking framework

	MOH	Full NHI	NHI tertiary care	Purchasing agency	
Revenue mobilisation	NHI: Limited additional revenue from informal non-poor, high collection costs and low coverage; most income from fees				2, 3
Technical efficiency	Paying for services instead of inputs has been observed in other countries to increase efficiency through incentives				2, 3, 4
Equity					
Financial risk protection					
Policy coordination and resource allocation process					
Health outcomes					

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The benchmarking framework

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Equity	Inequitable access effects of service fees, targeting mechanisms too weak to protect poor			1, 4
Financial risk protection				
Policy coordination and resource allocation process				
Health outcomes				

Populated with evidence from: a health system model, Malawi data and international experience

Benchmark 3: Equity

- Since MRA does not have capabilities to track informal sector individuals, service-access fees may be needed to give incentive to enrol into NHIS
- Poor performance of targeting mechanisms makes them unsuitable for use in access to care:
  - Used in only 18 / 28 districts
  - Assessing only 12.5%-50% ex-ante expected to be poor
  - Inaccuracies around cut-off points: 60% of households in poorest quintile not identified as such
- Unlikely that additional revenue at facilities from service-access fees and NHIS would improve service delivery sufficiently to make up for expected loss of access

The benchmarking framework

	MOH	Full NHI	NHI tertiary care	Purchasing agency
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Equity	Inequitable access effects of service fees, targeting mechanisms too weak to protect poor			1, 4
Financial risk protection	Unclear effects overall			n/a
Policy coordination and resource allocation process				
Health outcomes				

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Financial risk protection	Unclear effects overall			n/a
Policy coordination and resource allocation process	Splitting purchasing from provision increases complexity, new contractual relationships			1
Health outcomes				

Populated with evidence from: a health system model, Malawi data and international experience

The benchmarking framework

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Financial risk protection	Unclear effects overall			n/a
Policy coordination and resource allocation process	Splitting purchasing from provision increases complexity, new contractual relationships			1
Health outcomes	No favourite between current system, NHI and purchaser – but separating tertiary care sets wrong priorities			Not 3

Populated with evidence from: a health system model, Malawi data and international experience

Key messages

- **Opportunities to generate revenue from NHI** premiums from non-poor households in the informal sector **are limited**
- **Risks to unintentionally exclude poor households** from access to health care **are large**
- **Opportunities to gain efficiencies from paying for outputs** instead of inputs if coupled with more localized management
- Purchaser-provider split maximizes opportunities but has risks through increased complexity of institutional relations
- **Opportunities for additional general revenue in mid-term**:
  - **Health Fund** (fuel levies and 3rd party motor vehicles)
  - **Broadening of tax base** to informal sector businesses
- Health system modeling shows wide financing gap will remain