Oxford Policy Management

Providing for Health (P4H): Feasibility and appropriateness of National Health Insurance (NHI) in Malawi

Presentation of Phase 1 findings

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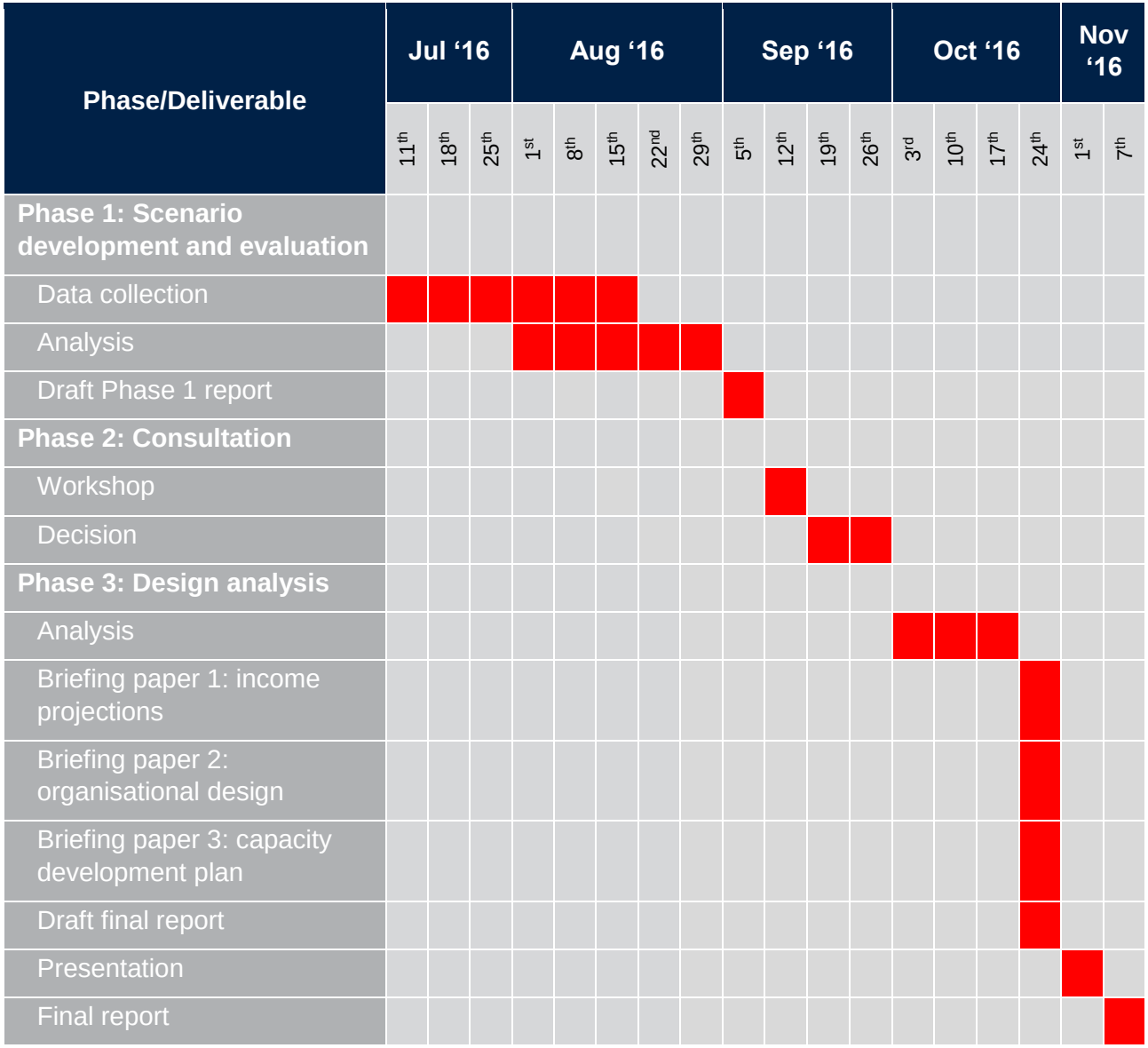
Context: overview of the work

- Government wide-performance review
- Concept paper “P4H”
- TOR for this work ~ four scenarios
- Work phases
  - Phase 1: Assess the four scenarios to inform a decision by MOH as to the preferred one based on further stakeholder discussions and data collection.
  - **Phase 2**: Present and discuss the findings of the Phase 1 report at a stakeholder workshop in Malawi. Following the workshop, the MOH will indicate to the consulting team the preferred NHI scenario to be the subject of a more detailed analysis in Phase 3.
  - Phase 3: Detail the reform scenario selected by MOH in Phase 2. Content will be organised in separate briefing papers: income projections (paper 1); organisational design, business processes, administrative costs (paper 2) and capacity development needs (paper 3).



Note: to be updated following the Stakeholders' Forum.

Context: the team

- Tomas Lievens (Oxford Policy Management) – Team Leader, health financing expert;
- Denis Garand – Actuarial specialist;
- Andrew Kardan (Oxford Policy Management) – Social protection expert;
- Alexandra Murray-Zmijevski – Macroeconomics expert;
- Adrian Gheorghe (Oxford Policy Management) – Health economist;
- Deliwe Malema – Public health expert, national consultant.

Context: scenarios

- **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.

Analytical approach

- Institutional and policy analysis

- Assess four NHI scenarios
  - Cost-benefit analysis
  - Benchmarking analysis ~ system-level health financing objectives

- Rapid appraisals informing the CB and benchmarking analysis:
  - Malawi Revenue Authority
  - Unified Beneficiary Registry and poverty targeting mechanisms

- Modelling of NHI structure

Synthesis of stakeholders' views

Expectations from NHI:

- Main objective is raising revenue, but also improving equity
  - Also potential platform for far-reaching reforms
- Reaching out to the informal sector is key both for premium collection and limit free-riding
- Agreement that the poor should be at the centre of NHI
- Mixed views on design elements e.g. universal vs phased approach to enrolment

Synthesis of stakeholders' views

Concerns related to introducing NHI:

- Ensuring good governance will be paramount
- Market for health insurance does not appear to be sufficiently mature
  - People would still prefer to keep paying out-of-pocket when needed
- Decentralization: local budgets (community, primary and secondary care) vs national budget (tertiary care)
- Low density of service providers in rural areas, therefore little potential for provider choice
- In the premium-based scenarios, user-fees for non-contributors may be necessary to enforce NHI and stimulate enrolment

The assessment – benchmarking framework

	MOH	Full 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

1. Revenue mobilisation

Modelling methods and key assumptions:

- Population projections using DHS 2015-2016
- Health expenditure: projections from current levels, accounting for population age structure and inflation
- Revenues: informed by NHA 2012-2015; insurance coverage and premium levels; authors' projections and other sources (SSDI, WB)
- Cost of NHI: staffing structure of purchasing agency and of national insurance agency with district offices

1. Revenue mobilisation

Modelling findings :

- Gap between health expenditure and revenues expected to increase over next five years; none of the analysed scenarios can fully close this gap
- Market for health insurance does not appear to be sufficiently mature
  - People would prefer to keep paying out-of-pocket when needed
- Decentralization: local budgets (community, primary and secondary care) vs national budget (tertiary care)
- Low density of service providers in rural areas, therefore little potential for provider choice
- **Scenarios 2 and 3 have the potential to raise additional funding for the Health Sector. However, this funding would come largely from the formal sector already taxed**

1. Revenue mobilisation: projected health expenditure

Health expenditure of Malawi	Projected expenditure						
	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022
Scenario 1 – MoH							
Total health expenditure (million)	**380,471**	**454,273**	**517,512**	**574,656**	**634,615**	**698,104**	**766,142**
Per capita health expenditure	21,581	25,194	28,078	30,515	32,997	35,558	38,243
Scenario 2 – Full NHI and user fees							
Total health expenditure (million)	**380,471**	**454,273**	**510,433**	**550,268**	**592,652**	**639,110**	**691,842**
Per capita health expenditure	21,581	25,194	27,694	29,220	30,816	32,553	34,535
Change from Scenario 1 per capita	0	0	-384	-1,295	-2,182	-3,005	-3,709
Scenario 3 – Tertiary care							
Total health expenditure (million)	**357,200**	**426,488**	**507,005**	**573,984**	**640,256**	**709,727**	**781,185**
Per capita health expenditure	20,261	23,653	27,508	30,480	33,291	36,150	38,994
Change from Scenario 1 per capita	0	0	-570	-36	293	592	751
Scenario 4 – Purchasing agency							
Total health expenditure (million)	**380,471**	**454,273**	**516,263**	**560,906**	**610,630**	**662,256**	**721,657**
Per capita health expenditure	21,581	25,194	28,010	29,785	31,750	33,732	36,023
Change from Scenario 1 per capita	0	0	-68	-730	-1,247	-1,826	-2,221

1. Revenue mobilisation: projected funding gap

Sources of revenue	Projected revenue						
	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022
Government	106,775	127,487	145,234	161,271	178,097	195,915	215,009
Rest of World	161,420	163,035	164,665	166,312	167,975	169,654	171,351
Corporation	11,333	13,237	14,759	16,048	17,361	18,716	20,137
Households	39,922	46,630	51,991	56,530	61,154	65,928	70,935
NPISH	11,890	13,888	15,485	16,837	18,214	19,636	21,127
Total	**331,340**	**364,277**	**392,135**	**416,997**	**442,802**	**469,848**	**498,559**
Shortfall from Scenario 1	**-49,131**	**-89,997**	**-125,378**	**-157,659**	**-191,813**	**-228,255**	**-267,583**

1. Revenue mobilisation: potential revenues (MWK million)

Potential options for raising contributions	Projected revenue				
	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022
Scenario 2 (full NHI)					
Informal non-poor paying premiums, % total population	0.0%	0.5%	0.5%	0.7%	1.0%
Informal non-poor paying user fees, % total population	20.0%	19.5%	19.5%	19.3%	19.0%
User fees from informal non-poor	3,332	3,320	3,428	3,463	3,479
Premiums from informal non-poor	0	282	288	412	601
Total revenue from informal non-poor	**3,332**	**3,602**	**3,716**	**3,876**	**4,080**
NHIS individual premium collection (inside or outside MRA)	0	71	72	103	150
Net revenue of NHI premium collection					=601-150
Total revenue from formal sector					
Public and private Employer/Employee contribution at 3% each (100% NHIS membership*) **– shifted from tax**	41,024	47,327	53,115	59,365	63,442
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**

1. Revenue mobilisation: projected costs of full NHI (MWK million)

Component	scenario	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022
NHI agency	2,3	5,147.4	6,852.8	7,259.9	8,147.1	8,570.8
Purchasing agency		59.3	105.1	172.4	274.2	292.6
MRA NHIS department (formal sector and informal businesses)		176.9	181.7	189.9	205.2	220.7
NHIS individual premium collection (inside or outside MRA)		0	71	72	103	150
Additional health resources for processing		87.4	311.2	323.6	489.9	400.9
Total		5,471	7,522	8,018	9,219	9,635

Potential options for raising contributions
Scenario 2 (full NHI)
Informal non-poor paying premiums, % total population
Informal non-poor paying user fees, % total population
User fees from informal non-poor
Premiums from informal non-poor
Total revenue from informal non-poor
Hypothetical scenarios
Public and private Employer/Employee contribution at 3% each (100% NHIS membership*)
Informal non-poor contributions at 3% of income (100% NHIS membership*)
Health fund (MAREP, storage levy and MV insurance – medium scenario**)

2. Technical efficiency

- Key areas of inefficiency in the health sector are known from previous analyses: medicines, service delivery, human resources
- MoH reforms ongoing to address some of these areas e.g. decentralization, provider autonomy, reviewing the essential health package
- Purchasing-provider split can improve efficiency through: the contractual relationship between purchasers and providers that can balance financial risks between the two; improving health treatment protocols; and improving financial management.
- There is some evidence from the international experience of efficiency gains associated with transition from passive to active purchasing (e.g. Thailand, Turkey)
- **Scenarios 2, 3 and 4 have comparable potential to improve efficiency through the separate purchasing component, as outlined above**

3. Equity

- Several dimensions of equity:
  - Non-Malawians vs Malawians
  - Informal sector vs formal sector
  - Poor vs non-poor

- National ID roll-out essential for non-Malawians/Malawians; currently proof-of-concept

- Current targeting mechanisms that distinguish between the poor and non-poor present serious challenges for the purpose of NHIS
  - Covering 18 out of 28 districts
  - 60% of poorest households are not correctly identified as poor
  - 44% of the better-off are wrongly identified as poor

- **Scenarios 2, 3 and 4 have comparable potential to improve efficiency through the separate purchasing component, as outlined above**

3. Equity

- Since MRA does not have capabilities to track informal sector individuals, **service-access fees** may become necessary

- Concurrent introduction of user-fees and an NHIS as an exemption mechanism from these fees will, at the current performance of poverty targeting mechanisms, likely limit access to (some of) the poor

- 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

- **NHIS combined with service access fees (Scenarios 2 and 3) cannot be recommended from an equity perspective. A purchasing agency (Scenario 4) may affect equity positively as a purchaser-provider split is expected to increase service quality**

4. Financial risk protection

- Full insurance scenarios (2 and 3) could protect to an extent against catastrophic and impoverishing health expenditures

- A purchasing-provider split alone (Scenario 4) would not directly affect financial risk protection

- Important caveats:
  - Service-access fees
  - NHI only coupled with other measures
  - Unclear benefits of Scenarios 2 and 3 vs. Scenario 1 (MoH)

5. Policy coordination and resource allocation

- **Separation of service purchasing from service provision (scenarios 2, 3 and 4) will lead to substantial additional complexity in the health sector governance and regulatory arrangements**

- Increased stewardship and coordination requirements on MoH

- Ensuring coherence in purchasing arrangements is likely to be an important challenge
  - Malawi: Service Level Agreements
  - E.g. Nigeria NHIS: sub-optimal regulation, no audit systems, late payments

6. Health outcomes

- Malawi's disease profile is complex, however disease burden is comparable with that of neighbouring countries
- Overall performance of the Malawian health system is moderate compared with that of other African countries
- Improving health outcomes across the board would be best served by a balanced benefit package that emphasizes prevention and primary care delivery
- **Introducing a purchasing-provider split under scenarios 2 to 4 creates the premise for better quality, leading to better outcomes; scenario 3 (tertiary care) is probably the least aligned with the epi profile**

Summary (I)

- Strong and consistent stakeholder commitment towards the idea of NHI
- Good governance will be key, esp. in light of previous public sector and health sector reforms
- Neither options can fully close the funding gap
- Agreement that the poor should be able to benefit, however current identification and targeting mechanisms are not commensurate with the requirements of a NHIS
- Targeting the informal sector for revenue collection faces serious challenges given Malawi Revenue Authority's current and expected capacity
- National ID a pre-requisite for poor/non-poor, contributory/enrolment status

Summary (II)

Key issues:

- Introduce a purchaser-provider split in a move away from input-based financing? Success will largely depend on accompanying reforms and raises the risk of difficult coordination.

- Introduce “service access fees”, as without fees there would be very limited incentives to enrol in a NHIS? Serious equity, health outcomes and financial risk protection risks. Revenue generated through NHIS and fees from the non-poor informal sector is likely to be small.

Recommendations

Scenario 4 – establishment of a purchasing agency

Relative to the other scenarios:

- Scenario 1 (MoH): unclear whether current reforms can transform how resources are allocated and managed.
- Scenario 2 (full NHI): high costs of collecting insurance premiums, service fees likely, major imperfections in existing mechanisms of identifying the poor, detrimental effects on equity and financial risk protection, limited revenue generation effect from NHIS contributions and fees.
- Scenario 3 (tertiary care) does not fully address Malawi's disease profile, most costly through delinking inpatient from outpatient care, decreases allocative efficiency.

- Raising and managing insurance revenue through levies on informal sector businesses can be added to Scenario 4 in the short to medium term.
- Earmarking some form of tax revenue for health deserves consideration.

Suggested areas for discussion (I)

- The balance between NHI revenue generation objective and broader health system objectives + projected funding gap
- Transition towards active purchasing: implications for current systems
- Coordination with ongoing public sector reforms beyond health sector
- Assumptions in the calculations

Suggested areas for discussion (II)

Further analyses/considerations conditional on the preferred scenario:

- Scenario 1 (MoH) e.g. role of PBF scale-up, programme-based budgeting
- Scenario 2 (full NHI) e.g. financial sustainability given revised EHP, insurance premiums and service access fees levels
- Scenario 3 (tertiary care) e.g. impact on health seeking behaviour and service delivery (self-)reconfiguration
- Scenario 4 (purchasing agency) e.g. choice of provider payment mechanisms and criteria, classification of providers for reimbursement purposes, audit systems and procedures (quality of care, performance, financial)

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Thank you