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15 essentials for African countries to achieve sustainable healthcare financing systems

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Why this paper?

The author of this paper has 31 years' experience across all forms of insurance, including health insurance, in many countries. His last 10 years have been specifically focused on health system financing in developing countries in the Middle East and Africa. The author's work has included working for a "Big 4" advisory firm, a GCC government and currently working for a multinational human data science company as its domain lead in health system financing and regulation providing advisory and consulting services to that company's government clients.

The reason for this paper comes from the author's desire and passion to see the achievement of Universal Health Coverage in line with UN Strategic Development Goal 3.8 specifically in sub-Saharan African countries. The only way to achieve this is through a solid, sustainable healthcare financing system.

Governments have historically relied upon advice from many donor-funded consultants who may do a great job within a specific area of health system *strengthening* but who do not generally provide the "Big Picture" when it comes to health system *financing*. A strong healthcare system is nothing without an underlying, sustainable financing structure.

The author's experience shows that understanding within governments about the concepts, models, challenges, development and implementation of healthcare financing systems could be improved. So, the purpose of this paper is to provide answers to some of the frequently asked questions but more importantly to describe the essential elements to help African nations achieve a sustainable healthcare financing system.

1) Adopt integrated policy making

Whether designing a new health financing system or revising an existing one, a number of key policy decisions must first be made. These fall under the broad headings of:

- Who amongst the population is to be covered?
- What healthcare services should the scheme provide?
- What financing model is most suitable: national health insurance, social health insurance, private health insurance or a hybrid?
- Who will contribute the necessary finance and how?
- How and by whom will the system be governed?
- What are the timeframes for scheme implementation?
- Who will be responsible for ensuring there is capacity to deliver services?
- To what extent will the government commit to investing in technology to support the system?

It is under these headings where governments, to a lesser or greater degree, consistently fail to appreciate that a lack of a set of clear, coordinated policies will result in a system which will not work or will work inefficiently with system "leakage" in terms of errors, fraud, waste, abuse and poor quality service delivery or no delivery. The rest of this article will expand on these and other essential elements to achieve sustainable health financing systems in sub-Saharan Africa (SSA) countries.



2) Decide who should be covered and how

Who should be covered would appear to be obvious since all countries are committed to providing Universal Health Coverage (UHC) under UN SDG 3.8 by 2030. But “provision of coverage” is not the same as “delivery of care”. Too often we see governments declare that “all citizens will be covered” yet little thought is given to how “coverage” translates into “delivery of care” and the sustainable financing system to be employed to ensure that delivery.

United Nations Sustainable Development Goal: SDG 3.8
Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all

Several countries have separate systems for certain “key” workers such as those in the armed services, the civil service and other government related entities. How will these schemes be integrated, if at all?

In addition, several countries have workers (and often their dependents) who are not citizens. These can range from highly paid professionals working for multinational corporations (who will probably be taken care of under their employer’s international private health insurance scheme) to low paid foreign workers with either no cover or who are reliant on whatever free services are available at government facilities. How will they be catered for? Then there is the growing number of refugees in some countries.

It is therefore essential to understand that Universal Health Coverage means just that – universal. However, UN SDG 3.8 does not dictate how that coverage is to be financed. The obligation of a government is to arrange a program of UHC which provides *access* for all to healthcare and medicines in an affordable way. Government policy should therefore focus not on *who* is to be covered but *how*? This will clearly need to be linked to the question of who is to pay (see below).

3) Develop a reasonable and affordable essential benefits package

Some governments attempt to provide the broadest of health care benefit packages without due consideration to cost and capacity to deliver. This is a particular problem in rural and poor suburban areas of SSA. Already there are calls in some countries for a review and streamlining of benefits packages. Another issue is the focus on in-patient (IP) benefits rather than out-patient (OP) benefits. This results in underfunding for primary care with a higher than necessary demand for IP because illnesses are not discovered early enough or, better still, prevented. The high prevalence of cancer and later stage cancers in sub-Saharan Africa is an example of the result of underfunding primary healthcare delivery although much work has been accomplished over recent years in lifestyle education and earlier detection by way of national cancer programs in some SSA countries.

4) Find out what it will cost to provide benefits

A regular shortcoming in policy making is that governments pay too little attention to understanding the costs of the benefits to be provided. The costs are determined by several factors just a few of which are listed here:

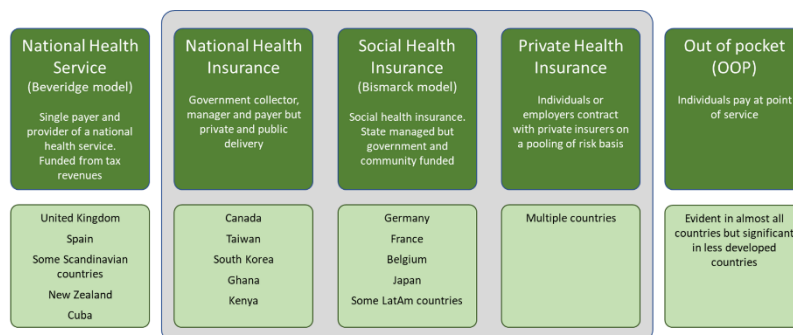
- Size of population
- Probability of an illness arising (including morbidity and lifestyle factors)
- Rates of accident and violence
- Additional costs for service delivery in rural areas
- Costs of operating healthcare facilities (utilities, rent, debt repayments, salaries, equipment)
- Cost of medicines and consumables
- Scheme management and operating costs including supporting technologies

No government should design a health financing system without a thorough investigation of the above and other factors. This will involve lengthy research, data collection and analysis and actuarial studies.



5) Choose the right financing model that suits your country

A surprising lack of knowledge exists within governments about the different types of health system financing models. There are broadly 5 models (see illustration) but this article will focus on the distinction between the broad headings of “national” health insurance (NHI), “social” health insurance (SHI) and “private” health insurance (PHI). National health insurance comes in many forms but typically it is a system where funds from various sources are collected by government authorities and deployed to finance healthcare provision at no or low-cost at point of delivery. Sources of funds can be direct government expenditure, tax revenues, national (or social) health insurance scheme contributions, employer contributions and individual contributions. The system relies upon an efficient allocation of sufficient funds to where they are needed and sufficient capacity to deliver services.



Note that these are high level models. Each country mentioned has adopted hybrid systems to meet its demographic and healthcare infrastructure needs.

Social health insurance originated in various industrial areas in Germany under the rule of Otto von Bismarck. It is a scheme where workers from a particular trade or industry would belong to a scheme funded by employer and employee contributions where the funds are pooled to provide healthcare services when required. Over time these schemes typically became managed by government (including some government funding) although retaining their community based roots.

Private health insurance involves a contract between an individual (or her employer) and an insurance company in which the insured pays a premium to an insurance company which then pools those premiums in a fund that is used to pay claims as and when they arise. Service delivery takes place at hospitals and clinics that are part of the insurance company’s “network of providers” which can include both private and government facilities. Insurers need to price their premiums carefully taking account of the expected *probability* of a claim and its *severity* (costs incurred) to ensure that there will always be sufficient funds in the pool to meet claims, operating expenses and a return for shareholders (although in a few countries in Europe profits are not allowed). The system typically benefits only those who can afford to pay premiums which in SSA excludes many although some microinsurance schemes have succeeded in extending benefits to some who would otherwise not be able to afford PHI.

The efficient management of private health insurance operations requires great skill, judgement and technological capability. Not all insurance companies have these qualities so governments need to make a qualified assessment of each insurer which wants to be part of the system. This assessment should also extend to third party administrators (TPAs) who are independent companies that process claims on behalf of insurance companies.

NHI, SHI and PHI each have their own advantages and disadvantages yet several governments such as those of Ghana, Kenya, Senegal and Lagos State in Nigeria have tended towards NHI, sometimes attempting to replicate the models of systems in former colonial occupying powers’ own countries. Even so, PHI does exist, to a small extent, alongside SHI serving more affluent citizens or employees of multinational corporations based in the country or, through microinsurance, serving those whose means to fund premiums are limited.

But the choice of model should not be an “either or” policy decision. This is a mistake that many governments make leading them down the road of NHI alone in the mistaken belief that they can provide the widest range of benefits at no or low cost at point of delivery to the entire population.

12 reasons why most countries developed hybrid systems

1. State financial restraints
2. Socio-political imperatives
3. Government structures (federal, state, national)
4. Some individuals can afford to pay for services
5. Rising cost of healthcare
6. Differences in healthcare infrastructure and ownership
7. Accessibility to healthcare facilities within and between countries
8. Commercial imperatives...the opportunity to make money
9. Availability of qualified clinical staff
10. Availability and application of technology
11. Demographic composition (including foreign nationals)
12. Changing demographics including refugee crises



This is all fine. Unfortunately, no government is able to finance such a venture by itself. Increasingly, hybrid models have been developed to account for many factors specific to individual countries (see box above).

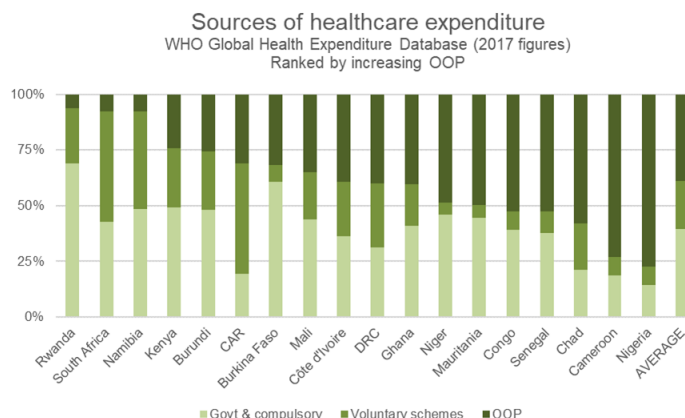
6) Determine who will contribute the necessary finance and how

So, if a hybrid model involving both NHI and PHI is needed, how will it be funded and by whom? For NHI it is a question of the extent to which governments are willing to provide central funds from tax or other revenues (such as revenues from oil and other natural resources which it owns and sells) and the extent to which they are willing to impose a requirement on the direct economy (formal workers, informal workers, family households, employers) in the form of subscriptions, usage fees, registration fees and the like. This is where politics enters the discussion although it should not be the primary driver of who should pay. The primary driver should be the *capacity* to pay.

Donor aid has also been a long-time contributor to health financing. However, we are seeing a reduction in the levels of such aid and, to be frank, this is a good thing for the future, a future in which African countries should both want and be able to be self-sufficient and have control over their own healthcare financing systems.

Regarding financing of PHI this is less problematic. Basically, those who desire to have healthcare benefits and can afford to do so will pay the required insurance premium to the insurer who then pools all premiums received and pays claims as and when they arise. The only question here is if the individual is employed in the formal sector should the employer contribute? In several Arabian Gulf countries employers are required to pay premiums on behalf of their workers but this is in an environment where employers generally pay low or no corporation tax and whose (often foreign) workers would otherwise seek free treatment at government facilities or go without treatment.

The chart at right shows a breakdown of sources of healthcare expenditure for 18 SSA countries split between government and compulsory schemes, voluntary schemes and out of pocket (OOP) expenditure. It is OOP that we need to drive down.



7) Adopt a collaborative approach to scheme governance

Moving on from policy decisions on finance, the system of scheme governance is often the result of “turf battles” between ministries of economy, finance, health and other regulatory bodies including those bodies regulating insurance companies. We see everywhere NHI schemes that are constrained in their work because of which ministry they are controlled by. Schemes of whatever nature (NHI, SHI, PHI or hybrid) need to be governed by a body independent of any particular ministry. That body should have representation from all stakeholders in the health insurance ecosystem giving it credibility for all involved in the funding, management and delivery of health services. This is rare but would go a long way to solve many of the problems of current healthcare financing systems.

Jurisdictional fragmentation (several states or regions within a single country having their own systems) is another challenge which requires a collaborative approach. Nigeria is a clear example.

Operational governance is another area of failure where the day to day management of schemes is hindered by lack of human resources, lack of technology and lack of finance.

Regulatory governance of the market is another area which policy makers often neglect, particularly in the PHI market where there are often no clear lines between insurer, administrator, health management organisation



or even insurance broker. The question of insurable risk and who is accepting this risk is also often unclear. This is particularly problematic where insurers allow TPAs to manage claims on a “capitation” model basis. Typically, a TPA will offer to manage the claims of a particular scheme within a fixed overall total value of claims. This effectively places a cap on the insurer’s risk but leaves a problem for the TPA: if total claims are approaching the annual limit agreed with the insurer does the TPA cover the shortfall or start rejecting claims? This has dangerous consequences for patients to the extent that some countries are now banning capitation schemes.

A lack of a coordinated policy in these areas of governance leads inevitably to fraud, abuse, financial leakage and reduced quality of service.

8) Adopt realistic timeframes for development and implementation

Another policy decision which is often badly determined is the timeframe for development and implementation of the system. I have worked (or am working) with three Arabian Gulf governments in the past 7 years to help develop health financing systems for populations between 4mn and 33mn. Systems typically require at least one year to assess, determine and agree the available options in order to make policy decisions, a further one or two years to develop the system (including the technology support) and three years to implement. We are therefore looking at five or six years from start to finish. Unfortunately, the typical election cycle in several SSA countries is four years. Politics again!

The corollary of election cycles and the impact on health system financing development and implementation is that the five or six years required could be adversely impacted or interrupted by a change of government part way through the development or, worse still, during the implementation stage. This prospect does not provide comfort for foreign investors looking to help finance healthcare facility development or international reinsurers who support the local insurance market.

Another often ignored aspect which is critical in larger SSA countries is how the implementation will be managed from a geographical perspective. Where do we start? In cities, in rural areas? Should there be a pilot? Or do we attempt a nationwide implementation all at once? It is interesting to note that Egypt with a population of around 100mn has embarked on an implementation plan spanning 15 years and beginning with a pilot in one governorate, Port Said.

9) Design efficient and effective communication and enrolment programs

Enrolment is problematic in SSA countries. This is largely due to poor communication, a lack of easy enrolment methods (such as internet or mobile phone) and enrolment fees. Governments must make firm policy commitments to facilitating enrolment in schemes at no cost. Communications should cover the whole spectrum from physical (posters in health centres and other government buildings) to electronic (social media channels particularly). These policy matters have often been neglected but the results of this neglect are low enrolment in national schemes (two examples being Senegal and Ghana).

10) Coordinate scheme implementation with healthcare capacity plans

Governments promise “universal health coverage” but as described above this is not the same as “universal healthcare delivery”. Policy makers often neglect to consider what capacity is needed, how much is needed, how quickly it will be needed (as more of the population begin to utilize their benefits) and where it will be needed (rural locations being a particular challenge in Africa). A health financing system cannot be built in isolation from capacity planning. Questions of both the financing of and investment in healthcare facilities must be part of the policy making process. A solid policy and a sound health financing system are also known to encourage foreign direct investment in healthcare facilities. Quite simply, investors will invest if they are confident that their facilities will receive payment for their services.



11) Develop a strong supply chain policy

Another neglected area of policy is that of the supply chain, particularly in relation to pharmaceuticals, devices and consumables. Should individual healthcare providers be subject to individual negotiations with manufacturers and distributors, many of which have huge negotiating power or should the government implement a centralized procurement system to obtain the best prices on behalf of providers?

Supply chain policy should also cover investment in local manufacture of pharmaceuticals, devices and consumables which would strengthen supply and provide greater cost control.

These seem simple decisions to be made but the actual policy decisions that we often see in these areas are the result of “undue influence” by some parties. This must be rejected. It demonstrates that it is not just the *policy* that is important but the *policy making process* itself

12) Focus on maternal, newborn and child health

All governments recognize the particular importance of maternal, newborn and child health. However, in relation to health system financing design, this is often an area that is neglected in terms of a specific policy on benefits to be provided (such as priority for complicated pregnancies leading to emergencies and caesarean sections, policy on vaccinations and how these should be financed and policy on pre- and post-natal care in rural areas).

13) Employ robust data collection and data analytics methodologies

Both the design of health financing systems and the measurement of their outcomes rely upon the collection of, access to and security of data. On some occasions, governments have designed schemes and implemented them in the absence of sufficient data needed to measure the effectiveness, outcomes and success of the scheme. Schemes have also been launched without the facility even to collect data, not only on health outcomes or quality but even to know with certainty the numbers of people enrolling in schemes, be they social or private health insurance schemes. Technology is critical in this and so many other areas of effective health system financing.

Data collection policies must address what data is to be collected, how it is to be collected and how it will be used and secured. There must also be policies that address how health outcomes data will be shared such as the quality outcomes and service levels of healthcare providers as well as the performance of health insurance companies and TPAs in terms of customer service and combatting fraud and abuse in the system.

14) Ensure and secure the appropriate allocation of funds

Obtaining funds is difficult enough. Squandering them is relatively easy. There are numerous examples where funds earmarked for healthcare have suddenly been reallocated to other areas of government expenditure or, worse still, have been “misappropriated” or simply “disappeared”. This has been particularly true of donor funds and not just in Africa.

Policy must therefore be strong enough to ensure that all funds allocated to the healthcare financing system are secured and their allocation diligently logged and tracked. In the absence of such a policy the financiers of the scheme, be they donors, employers or individuals, will be reluctant to pay money into the system resulting in underfunding and poor enrolment numbers.

15) Keep politics out

We have seen throughout the first half of 2020 the damage that has been done in a small number of countries hosting large populations to the approach to containing the Covid-19 pandemic brought about by the politicization of the country’s response. I urge all leaders of African nations who seek the goal of a sustainable and general healthcare financing system to put politics aside and focus on achieving a workable system including all of the points in this article. Everyone deserves access to healthcare regardless of who they may vote for and unhindered by changes in government. --- Robin Ali