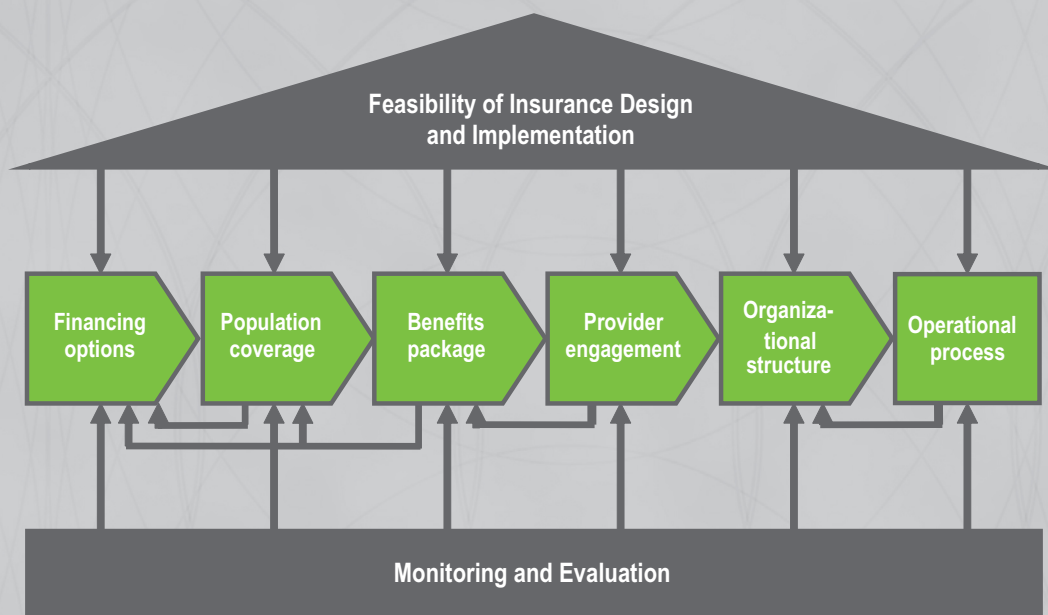


Health Insurance Handbook

How to Make It Work



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Hong Wang

Kimberly Switlick

Christine Ortiz

Beatriz Zurita

Catherine Connor

Investment Climate Advisory Services of the World Bank Group



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Washington DC 20433
Telephone: 202-473-1000
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1 2 3 4 14 13 12 11

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ISBN (electronic): 978-0-8213-8953-9

ISBN (print): 978-0-8213-8982-9

DOI: 10.1596/978-0-8213-8953-9

Library of Congress Cataloging-in-Publication Data

Health insurance handbook : how to make it work / Hong Wang ... [et al.].

p. ; cm. -- (World Bank working papers, ISSN 1726-5878 ; no. 219) (Investment climate in health series)

Rev. ed. of: Africa health insurance handbook / Hong Wang ... [et al.]. 2010.

Includes bibliographical references.

ISBN 978-0-8213-8982-9 -- ISBN 978-0-8213-8953-9

I. Wang, Hong, MD. II. World Bank. III. Africa health insurance handbook. IV. Series: World Bank working paper ; no. 219. 1726-5878 V. Series: Investment climate in health series.

[DNLM: 1. Insurance, Health--economics. 2. Insurance, Health--organization & administration. 3. Cost Control. 4. Cost Sharing. 5. Developing Countries. W 100]

368.38'2--dc23

2011048413

Investment Climate in Health Series

This subseries of the World Bank Working Papers is produced by the Investment Climate Department of the World Bank Group. It is a vehicle for publishing new material on the World Bank Group's work in the health sector, for disseminating high-quality analytical work, and for consolidating previous informal publications after peer review and standard quality control.

The subseries focuses on publications that expand knowledge of government policies and the operating environment and suggest ways of better engaging the private health sector in treating illnesses among the poor and other vulnerable populations. Best-practice examples of both global and regional relevance are presented through thematic reviews, analytical work, and case studies.

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Foreword

This volume deals with practical problems and solutions to expanding health insurance coverage for the 4 billion people in low- and middle-income countries who have no protection against financial hardship during illness.

Millions of the poor have already fallen back into poverty as a result of the recent global financial crisis. Millions more are at risk before full recovery. It is the poor and most vulnerable who are hit the hardest from the impoverishing effects of illness.

The Africa Region is the last frontier for health insurance. In many countries, it does not exist at all and, in others, it is in a nascent phase of development. The challenge of introducing health insurance starts with reaching a clear understanding of the problem countries are trying to address with this type of financing system and designing an affordable system that includes the poor. As seen in Nigeria, passing a law does not guarantee its successful introduction at the national level. And some countries, like Ghana, have pushed ahead with well-designed schemes that provide extensive coverage for the poor, but the devil is in the detail during implementation. Programs succeed and fail not to so much because of brilliant design but because of ability to implement them successfully and manage political and consumer expectations.

This handbook is not intended as an advocacy for or against health insurance. It provides the ABCs of “how” —not “why” —to introduce health insurance in low-income countries, with a particular focus on the Africa Region.

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Preface

This handbook provides a practitioner's guide for implementing health insurance in low-income countries. It builds on an expanding body of research on securing sustainable financing and financial protection supported and undertaken by the World Bank Group, the United States Agency for International Development (USAID), and others.

This recent research has shown that low-income populations are particularly vulnerable to the impoverishing effects of illness. But they are also often excluded from health insurance schemes and not well targeted by government-financed programs.

Success in improving access and financial protection through community and private voluntary health insurance has led many countries to attempt to make membership compulsory and to offer subsidized insurance through the public sector. Arguments in favor of this approach include the potential for achieving higher population coverage, broadening the risk pool by collecting at source from formally employed workers, and collective action in securing value for money in purchasing health care from providers.

But implementing insurance schemes is complicated and requires careful planning during the design phase as well as continued adjustments during implementation.

Countries face difficult trade-offs in terms of the depth and breadth of the benefits package, especially in severely resource-constrained environments. An attempt to rapidly expand population coverage in low-income countries may end up compromising the adequacy of the benefits package in terms of the range and effectiveness of services provided. This can undermine the policy objective of both access and financial protection for the poor if patients end up having to pay out-of-pocket for a significant range of services not covered under the publicly mandated benefits.

We hope that this handbook will help policy makers and implementers ask questions that will help them design better schemes and reduce the costs and risks during implementation.

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Acknowledgments

This report is reproduced, with minor stylistic and formatting changes, by permission of the Health Systems 20/20 project, funded by the United States Agency for International Development (USAID) and led by Abt Associates Inc. The original workshop publication, *Africa Health Insurance Handbook: How to Make It Work* (Wang et al. 2010), was also funded by USAID.

The authors would like to thank Chris Atim, François Diop, and Rena Eichler for their contributions to this handbook; and recognize Michael Adelhardt, Beverly Johnston, David Newman, Barbara O'Hanlon, Ligia Paina, and Alex Todd for their comments and suggestions on the first draft. Special thanks also to Laurel Hatt of Abt Associates Inc., who was critical in finalizing the handbook and the breakout exercises, and to Catherine Connor and Hong Wang, who edited the final draft.

The Health Systems 20/20 cooperative agreement, funded by USAID for the period 2006–12, helps USAID-supported countries address health system barriers to the use of life-saving priority health services. Health Systems 20/20 works to strengthen health systems through integrated approaches to improving financing, governance, and operations, and building sustainable capacity of local institutions.

The Health Systems 20/20 project is implemented for USAID by Abt Associates Inc., Bethesda, Md. in collaboration with: Aga Khan Foundation, BRAC University, Broad Branch Associates, Deloitte Consulting, LLP, Forum One Communications, RTI International, Training Resources Group, Tulane University School of Public Health and Tropical Medicine.

The ideas and opinions expressed here and in Wang et al. (2010) are the authors' and do not necessarily reflect those of USAID, the U.S. government, or Abt Associates Inc. For the original handbook, see www.healthsystems2020.org. Interested parties may use that document in part or in whole, provided that they maintain its integrity and do not represent its findings or present the work as their own.

Acronyms and Abbreviations

AMC	Assurances Maladies Communautaires [Community Health Insurance], Rwanda
ARS	Administrador de Regimen Subsidiado [Subsidized System Administrator], Colombia
CBHI	Community-based Health Insurance
DRG	Diagnosis-related group
ENAHU	Encuesta Nacional de Hogares [National Household Survey], Peru
EPS	Empresas Promotores de Salud [Health Promotion Enterprises], Colombia
EsSALUD	Health Social Security Agency, Peru
FESE	Ficha de Evaluación Socioeconómica [Socioeconomic Evaluation Sheet], Peru
FFS	Fee for Service
FP	Family Planning
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MIS	Management Information System
MMI	Medical Military Insurance, Rwanda
MOU	Memorandum of Understanding
NHIA	National Health Insurance Authority, Ghana
NHIF	National Hospital Insurance Fund, Kenya
NHIS	National Health Insurance Scheme, Ghana
NHS	National Health Service, United Kingdom
NSHIF	National Social Health Insurance Fund, Kenya
PBF	Performance-based Financing
RAMA	Rwandaise d'assurance maladie [Rwanda Medical Insurance]
RBF	Results-based Financing (aka Pay-for-Performance or P4P)
SBS	Seguro Básico de Salud [Basic Health Insurance Scheme], Bolivia
SIS	Seguro Integral de Salud [Health Insurance Program], Peru
SISBEN	Sistema de Identificación de Beneficiarios de Subsidios Sociales [National Targeting System], Colombia
SISFOH	Sistema de Focalización Hogares [National Household Targeting System], Peru
SNMN	Seguro Nacional de Maternidad y Niñez [National Maternal and Child Insurance], Bolivia
SUMI	Seguro Universal Materno Infantil [Universal Mother and Child Insurance Scheme], Bolivia
TPA	Third-Party Administrator

1. Introduction

Many countries that subscribe to the Millennium Development Goals (MDGs) have committed to ensuring access to basic health services for their citizens. Health insurance has been considered and promoted as the major financing mechanism to improve access to health services, as well as to provide financial risk protection.

In Africa, several countries have already spent scarce time, money, and effort on health insurance initiatives. Ethiopia, Ghana, Kenya, Nigeria, Rwanda, and Tanzania are just a few of them. However, many of these schemes, both public and private, cover only a small proportion of the population, with the poor less likely to be covered. In fact, unless carefully designed to be pro-poor, health insurance can widen inequity as higher income groups are more likely to be insured and use health care services, taking advantage of their insurance coverage.

Despite the many benefits that health insurance may offer, table 1.1 shows that the journey to implement insurance and achieve the benefits is challenging, long, and risky. Policy makers and technicians that support development and scale-up of health insurance must figure out how to increase their country's financing capacity, extend health insurance coverage to the hard-to-reach populations, expand benefits packages, and improve the performance of existing schemes.

Table 1.1. Potential Benefits and Risks in Health Insurance Development

Potential benefits	Potential risks
1. Protect households from impoverishment due to high out-of-pocket health spending.	Health system could emphasize expensive curative care over primary and preventive services, if insurance schemes do not view primary and preventive services as a way to minimize health insurance costs over the long term.
2. Increase access to and use of services where payment is normally required at the time of need.	Institutions and systems that are not ready to handle the burden of insurance implementation could find the process unworkable or highly inefficient and costly.
3. Influence provider and consumer behavior to improve quality, efficiency, and effectiveness.	Some provider payment methods do not have positive effects on quality, efficiency, and effectiveness, and their limitations may outweigh the cost of implementing them.
4. Harness private providers to address national health goals and objectives.	Low payment levels might not attract quality providers. Insurance agency could lack capacity to ensure quality of private providers Lack of cost controls could bankrupt the insurance fund. Failure to pay private providers on time could lead to frustration.
5. Generate additional and more stable resources for health.	Resources flowing through health insurance schemes could make governments feel free to reallocate general budget resources away from health, leaving the health sector with unchanged or fewer resources. Insurance funds without adequate oversight and accountability can become easy targets for corruption.
6. Expend resources for and access to priority health services for disadvantaged populations.	Benefits could favor the already better-off because they are easier to reach with insurance. Benefits to the poor could become false promises if insurance is not purposefully designed to target the poor and if financing is inadequate.
7. Assist in redistribution of resources for health to address socioeconomic and geographic inequities.	Countries may launch a broad, but expensive, benefits package that is financially unsustainable, and later be forced to limit coverage and thus dash expectations. Redistributive schemes may alienate higher-income groups who subsidize the redistribution of resources

Source: Authors.

Purpose of This Handbook

The purpose of this handbook is to provide policy makers and health insurance designers with practical, action-oriented support that will deepen their understanding of health insurance concepts, help them identify design and implementation challenges, and define realistic steps for the development and scaling up of equitable, efficient, and sustainable health insurance schemes. The handbook takes policy makers and health insurance designers through a step-by-step series of considerations and tasks that need to be achieved. The handbook's philosophy is to *not* be dogmatic, ideological, or prescriptive.

This handbook was prepared to be used in a six-day regional workshop. Clearly, health insurance design is an intensive political and technical process that takes much longer than six days. The expectation for the workshop is that by the end of the week, each team has a clear idea of next steps that they could take back home to engage other stakeholders and move toward scaling up and improving the performance of health insurance in their country.

Target Audience of This Handbook

This handbook is intended primarily to help developing countries strengthen and scale up existing health insurance schemes, as well as countries that are beginning to discuss health insurance. The handbook is written with middle- and low-income countries in mind and builds on numerous lessons learned and experiences from throughout the world. We envision that over time, this handbook will be honed and strengthened to address the evolving needs of such countries. We also envision the handbook's being adapted for different geographical contexts to make it more locally relevant.

Within countries, the handbook is intended for a variety of stakeholders who bring to the table the different perspectives needed for successful health insurance design and implementation. These may include Ministries of Health, Departments of Planning, Ministries of Finance, agencies that oversee/regulate health facilities and insurance companies, public health specialists, health care providers, civil society representatives, private sector entities, and health insurance agencies. The handbook provides a map to help the stakeholders collectively make decisions that serve the larger interest.

Structure of This Handbook

To facilitate the design process, this handbook breaks down the complex topic of health insurance into eight design elements. We do not intend to be comprehensive, but rather aim to present the key concepts, options for how to address each element, the pros and cons of different options (including the extent to which they are pro-poor), and lessons from other countries.

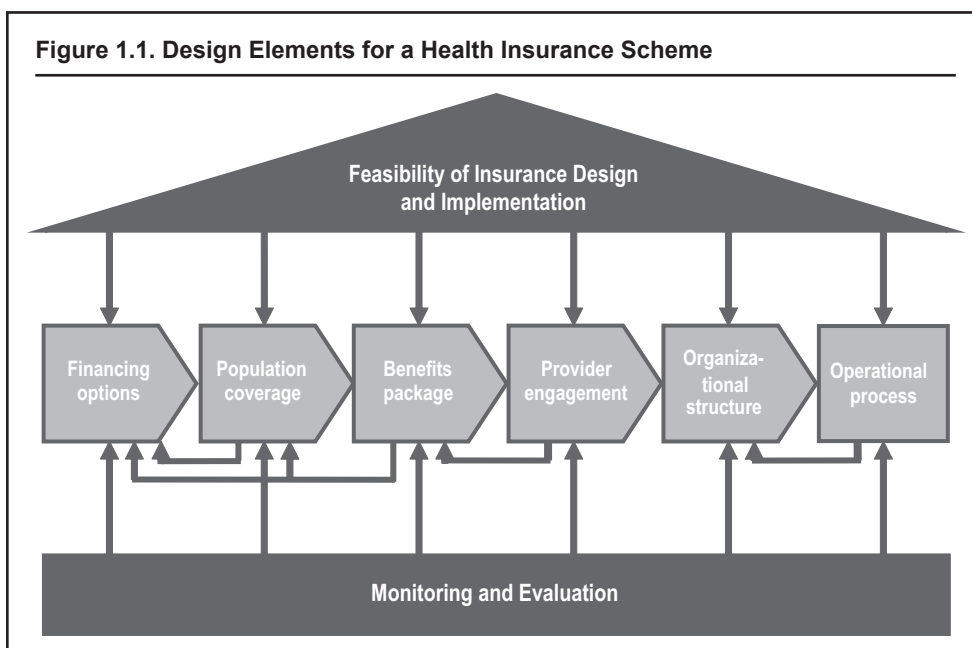
- Element 1: Feasibility of Health Insurance
- Element 2: Choice of Financing Mechanisms
- Element 3: Population Coverage
- Element 4: Benefits Package and Cost Containment
- Element 5: Engagement, Selection, and Payment of Health Care Providers

Insurance

- Element 6: Organizational Structure
- Element 7: Operationalizing Health Insurance
- Element 8: Monitoring and Evaluation of Health Insurance Schemes

Figure 1.1 shows the relationship among these elements. Overarching all is feasibility in the country's political, economic, and sociocultural environment. Monitoring and evaluation should form the foundation. Although the handbook presents these design elements sequentially to help policy makers and other stakeholders work on each element step-by-step, all the elements are intertwined. Stakeholders involved in the design process must be mindful of this interconnectedness, as every decision will affect multiple elements simultaneously.

For each design element, the handbook helps identify the political, economic, social, and institutional opportunities and barriers, and alternative approaches so policy makers and technicians can move health insurance forward on a rational, feasible path tailored to their country.



Source: Authors.

2. Design Element 1: Feasibility of Health Insurance

By the end of this session, you will be able to do the following:

- Identify major political, financial, and sociocultural prerequisites to set up or scale up health insurance in your country
- Assess gaps in and obstacles to health insurance development within the political, financial, and sociocultural context of your country
- Plan for how to lay the groundwork to address these gaps and obstacles, and prepare for health insurance development or scale-up, including the political process, financing strategies, and sociocultural issues.

Key Concepts

Gap analysis is an assessment used to compare actual conditions, performance, or capacity with potential or desired conditions, performance, and capacity. Gap analysis provides the foundation to estimate the investments of time, money, knowledge, and human resources required to achieve a particular outcome.

Political support is the backing and commitment (verbal, financial, or otherwise) by policy makers and leaders on a particular issue.

Political feasibility is defined as the extent to which officials and policy makers are willing to accept and pass into law or draft as a regulation a particular public policy. Health insurance is considered politically feasible when key stakeholders have come to consensus around the main design and implementation issues.

Political mapping is a technique to document and analyze the positions of and alliances among political actors and stakeholders within a specific policy arena.

Sociocultural factors are characteristics (cultural practices, ethnicity, community solidarity, socioeconomic status, etc.) that are determined by society and culture. Taking key sociocultural factors into consideration is critical to ensure the acceptability of health insurance by the general public. Such consideration will affect the political feasibility of design and implementation approaches.

Financial capacity is the ability of an organization or political entity to collect, spend and manage funds effectively and efficiently. Financial capacity is defined by the amount of funds available, and by the complex relationships among stakeholders that allow them to manage those funds effectively.

Provider capacity refers to the ability of health professionals, facilities, and organizations to meet the demand for services covered by health insurance. Provider capacity includes physical capacity (are there enough doctors, nurses, and hospital beds located where the insured population lives?); clinical capacity (are there enough providers who can deliver the covered services with adequate quality?); and management capacity (can the providers correctly identify who is insured, bill correctly, and be paid efficiently?).

Important Considerations

Important considerations are assessing feasibility; building political consensus; financial capacity; sociocultural factors and national solidarity; service availability, quality, and provider capacity.

Assessing Feasibility

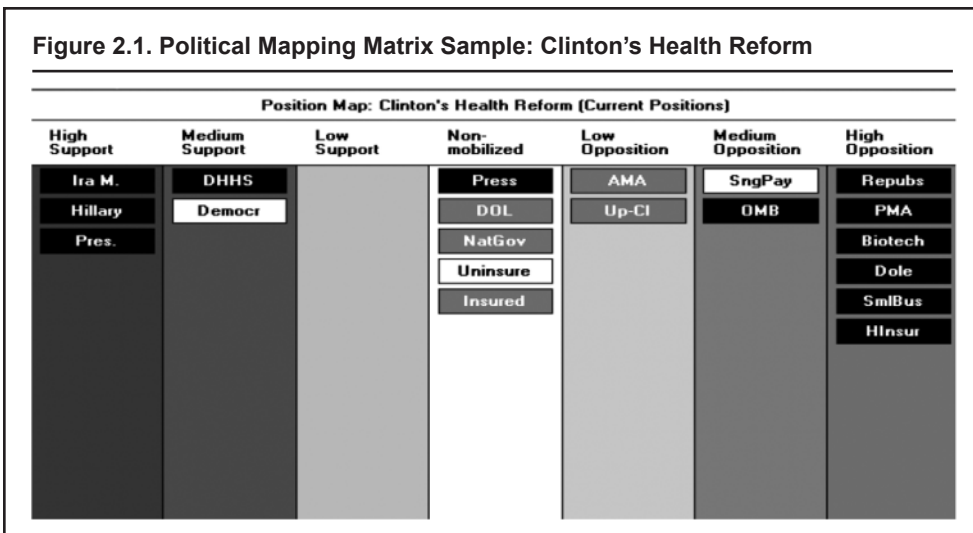
Designing and implementing national health insurance is as much a political process as a technical one. Stakeholder views and support will determine how a country will address all the next seven design elements and overall feasibility. The introduction of insurance in developing countries involves multiple government ministries, health care providers, consumers, employers, and donors. Policy makers and technical experts must work together to manage expectations, ensure decision making based on facts and technical analysis, and find common ground among competing interest groups. Policy makers must understand and be able to articulate the following:

- How will insurance contribute to overall national objectives?
- How will insurance combat poverty and contribute to great equity?
- Who are the major stakeholders and what are their positions on health insurance development or scale-up?
- What are potential political obstacles?
- What are possible mitigation strategies?
- How can a political coalition be built that will be able to push health insurance reforms and successfully keep them on the political agenda?

Building Political Consensus

Political mapping can help understand what level of political support exists for different aspects of health insurance design and implementation. It can help identify where support already exists, where it is lacking, and what strategies may be necessary to build consensus.

Political mapping can be done in different ways. Figure 2.1 shows an example of a political map matrix that looks at the Clinton health care reform initiative in the United States in the 1990s. The matrix places key stakeholders along the spectrum according to their support or opposition to the initiative. President Clinton strongly supported the plan; the Department of Health and Human Services also supported it, but less so. Most Republicans, small businesses, and others strongly opposed it.



Source: <http://info.worldbank.org/etools/docs/library/48236/04%20Presentation%203-Intro%20to%20PolicyMaker%209.21.pdf>.

Political mapping exercises like this can help identify the level of support, influential allies or opponents, and potential and opposing alliances (box 2.1). They can also help in the design of strategies to garner support, reduce obstacles, and seize opportunities. A core group of policy makers and technicians leading the process to introduce or expand health insurance needs the following to build political consensus:

- Strong political leadership or “champions” who can articulate a vision, engage technicians, motivate supporters, compromise with the opposition, develop consensus among competing interests, and move from plans and agreements to action
- A health insurance proposal that is consistent with the country’s other social and health policy objectives
- An understanding of possible trade-offs (for example, asking the wealthier population to finance the insurance program for everyone in the country may put strain on their support for the insurance program).
- Frequent consultation with different stakeholder groups along the way to validate the core group’s assumptions about what is feasible politically and technically.

Box 2.1. Who Advocates for the Poor?

Health insurance is not automatically pro-poor. It depends on the political willingness, social acceptability, and financial capability, and must be carefully designed to address inequities. Priority target groups such as urban slum residents, rural poor, widows, and orphans, are typically not sufficiently well-organized or funded to influence the political process. Consequently, a health insurance reform advertised as “pro-poor” may fail to actually reach poor populations as other groups influence design details and implementation. This *Handbook* highlights pro-poor policy options for each design element.

Countries often aspire to *universal coverage*—to provide all people access to all health services. This is reflected in Elements 2 and 3, population coverage and benefits. Careful planning and implementation of the other design elements—financing, service providers, organizational structures, and operations—determines the feasibility of expanding population and service coverage to eventually achieve universal coverage.

Financial Capacity

A country’s financial capacity for funding health insurance is a function of its current and expected economic status (gross domestic product per capita), the size of the formal sector economy that can be taxed and/or contribute to employer-based health insurance, the opportunity to find efficiencies in the current health system, and the current level of household health expenditures, some of which might be tapped to finance health insurance. Health insurance financing is discussed in detail under Element 2. Financial capacity is also a function of the country’s organizational and operational capacity to collect, pool, and spend funds¹ efficiently and effectively, discussed under Elements 6 and 7.

Ministries of Finance and Health must work together to determine the government’s capacity and commitment to finance health insurance. Economists, actuaries, and accountants can inform this process by analyzing different scenarios of the country’s financial capacity and insurance design.

Sociocultural Factors and National Solidarity

The feasibility of a particular health insurance design will be affected by ethical, behavioral, and sociocultural dimensions. For example, community-based health insurance is more likely to be feasible in a country where ethnic or geographic groups demonstrate high social cohesion. A social health insurance scheme may be more appropriate for a country with larger number of formal sector employees or with a strong sense of national solidarity among the population (boxes 2.2 and 2.3).

Box 2.2. Insurance is a Bad Word

At the beginning of the movement to establish community-based health insurance schemes in West Africa, organizers avoided the word “insurance” because people had poor experiences with property, life, and other kinds of insurance. Claims were paid slowly, if at all. The term “mutual health organization” (Mutuelle in French) was more socially acceptable because it emphasized social cohesion and people’s positive experience with mutual aid societies.

Box 2.3. National Solidarity and Attitudes toward Redistributive Mechanisms

Several recent examples—Côte d’Ivoire, Kenya, Nigeria, and the United States—arguably demonstrate that lack of national solidarity can impede the chances of successful health insurance reform. Europe, especially after the World War II, illustrates the case that strong national solidarity facilitates reforms.

Similarly, ready acceptance of relatively high marginal tax rates is a facilitating factor for success as well, especially as the incidence of such taxes usually falls most heavily on the rich. Such progressive taxes often constitute a precondition for financially feasible social health insurance as seen in Europe, or even Ghana and Rwanda.

Health insurance is more likely to be feasible when peoples’ expectations and technical design decisions are aligned. For example, if the government’s expectation of an appropriate level of citizen contribution exceeds that of the general population, there will likely be pushback and noncompliance with revenue collection. To ensure this kind of alignment, policy makers may need to assess the population’s expectations and willingness-to-pay for insurance, perhaps via a household survey or qualitative data collection.

Cultural norms can strongly affect the ultimate success of an insurance program (boxes 2.2 and 2.3). For instance, some people downplay the risks of ill health while others are strongly risk-averse. In some societies, people believe that planning for a bad situation, such as ill health, may bring bad luck. Popular beliefs vary greatly as to whether social or economic equity is an important national objective, and the extent to which caring for the poor and the sick should be the responsibility of the larger population. These strongly held social beliefs set the boundaries of what is culturally feasible for a national health insurance program. In some cases, the coexistence of multiple types of insurance and health care providers is the result of what has been deemed socially and economically acceptable to different groups. A possible way to reduce this fragmentation could be to establish a minimum package of care for a vulnerable group that society has identified as “worthy” of a subsidy—such as the poor, unemployed, low-income, handicapped, elderly, children, or women.

Service Availability, Quality, and Provider Capacity

Service availability and provider capacity affect feasibility at two levels:

- The physical presence of health workers and facilities near enough to target populations and their capacity to deliver quality services covered by insurance (do they have the skills, equipment, and supplies?). If policy makers fail to address gaps in service availability and quality, they risk making existing inequities worse if insurance funds will flow to the providers already in place in wealthier, urban areas.
- Providers' willingness to participate in the insurance program. Providers may not be willing to participate if, for example, the insurance payments are perceived as too low, patient volume increases significantly while health worker salaries stay the same, or insurance reduces user fee income (either formal or informal). In Vietnam, providers began refusing to provide services to those enrolled in the insurance scheme because the reimbursement rates were much lower than their actual costs and providers were losing money servicing the insured. In Ghana, the combination of high patient volume and flat income led health workers to strike in 2005.

Elements 5 (Provider Engagement), 6 (Organizational Structure), and 7 (Operations) all offer ways to address these issues.

Organizational Structure and Operations

Typically the legislative and executive branches of the government must work together to set broad policies for the insurance scheme(s) regarding financing, population coverage, and identifying which body will manage the insurance scheme (a line ministry or a semi-autonomous body such as an insurance fund). The insurance scheme authority can then define details such as the benefits package, quality standards for providers, beneficiary eligibility, standards for beneficiary communications, etc.; or delegate these details to be promulgated by the insurance scheme.

Feasibility of national health insurance depends significantly upon a country's existing operational capacity to execute a variety of different technical functions, including actuarial analysis, marketing and communications, enrolment, membership management, collection of funds, claims administration, quality assurance, and financial management. Health insurance often falters because of operational challenges: Claims are not paid on time and providers drop out; beneficiaries do not fully understand their benefits and do not access services; or information systems are slow and weak, so nobody knows the insurance fund's balance or its real liabilities.

While it is not prerequisite that a country have all operational functions in place (no country in the world has them completely figured out!), administration and management processes need to be taken into consideration while designing and implementing the insurance scheme. These issues are addressed further in Elements 6 and 7.

Country Example: Assessing Social Insurance Feasibility in Kenya

Kenya has been progressively working towards passing a National Social Health Insurance Fund (NSHIF) law that will eventually lead to universal health care coverage for its citizens.² Carrin et al., in an article in the South African Medical Journal in 2007, asserted that universal coverage is feasible in Kenya, but only after an adequate transition period widely accepted and supported by government.³

The Carrin study assessed the feasibility of the NSHIF by examining the challenges experienced by the National Hospital Insurance Fund (NHIF) established in the 1960s. Faced with economic and administrative problems and shortfalls in facilities and services, the NHIF tried expanding the network of accredited health care providers in order to expand access to care. The NHIF has also tried to improve administrative efficiency. Manual operations have been computerized, and strides have been made toward decentralization. The NHIF has also tried to be more responsive to contributor and stakeholder needs through marketing (building its image and responding to public inquiries), research and development, quality assurance, and prosecutions of fraud.

Steps to Address This Element

The feasibility assessment identified several investments and preparatory steps needed prior to launching a NSHIF:

- Improve remuneration of health care providers to improve morale and accountability
- Invest in physical infrastructure because most health care facilities are in need of renovation
- Modernize manual administration procedures that leave the system vulnerable to corruption
- Change the public's perception of government responsiveness to their needs and ability adequately to deliver services.

Looking at previous experiences with NHIF allowed Kenya to explore the feasibility of expanding to broader health insurance. Some stakeholders perceive that an NSHIF will succumb to the same vulnerabilities as the NHIF. The Ministry of Health (MOH) must work closely with employers, trade unions, health providers, existing insurance organizations, and other line ministries to design and plan the new scheme, address concerns, and build support for the proposed NSHIF.

3. Design Element 2: Choice of Financing Mechanisms

By the end of this session, you will be able to do the following:

- Understand the different mechanisms for financing health insurance and how many countries combine them
- Appreciate that health insurance does not automatically improve financial protection and access for the poor
- Understand the strengths and challenges of each financing mechanism, particularly as they relate to your country's health system and health financing goals.

Key Concepts

Community-based health insurance (CBHI) is not-for-profit private health insurance supported by an ethic of mutual aid among people in the informal sector and rural areas.

CBHI pools members' premium payments into a collective fund that is managed by the members. Several governments have embraced CBHI with national policies and administrative support (e.g., Ghana and Rwanda). Evidence indicates that CBHI schemes can effectively reach marginalized populations and increase access to health care for low-income rural and informal sector workers.

Financial risk protection is security from incurring catastrophic costs in case an insured event occurs (illness, fire, car accident, etc.). This is one benefit of having insurance.

Fiscal space refers to a government's ability to raise revenues without jeopardizing the sustainability of its financial position or the stability of the economy (e.g., causing inflation). A government can raise revenues through taxes, sales of natural resources, income from grants, cutting expenditures, and borrowing.⁴

Health insurance is a formal arrangement in which insured persons (beneficiaries) are protected from the costs of medical services that are covered by the health insurance plan (the benefits). Health insurance works best when risk pools are large and when the health risks associated with the covered population are diversified, in essence, when the healthy can subsidize the sick. In some schemes, cross-subsidization from the wealthy to the poor may be an additional goal. Health insurance can be financed and managed in various ways (box 3.1). Table 3.1 demonstrates a typology of four main approaches, which are often combined.

Box 3.1. Source of Financing is Not Insurance Destiny

The types of health insurance are defined primarily by the source of funds, but the source of funds need *not* determine how a country addresses the other elements of health insurance—population coverage, benefits, providers, organizational structure, and operations. Countries should consider a wide range of policy choices, not rigid formulas or labels.

Table 3.1. Major Types of Health Insurance

Types of insurance	Financing source	Management	Countries
National health insurance	General taxes	Public sector	Canada, Costa Rica, France, United Kingdom
Social health insurance	Payroll taxes from employers and employees	Social security agency, health fund, sickness fund(s)	Colombia, Germany, Japan, Republic of Korea, United States (Medicare)
Private voluntary insurance—commercial	Premium payments from individuals or employers/employees	Commercial insurance company, for-profit or not-for-profit	South Africa, United States
Community-based health insurance	Premium payments from individuals and/or community	Community or association	China, India, Philippines, Rwanda, Senegal

Source: Authors.

National health insurance is government-managed insurance financed through general taxation, usually with mandatory coverage for all citizens. Often, the government directly provides health services as well. The best-known example is the British National Health Service. This approach is also known as the Beveridge model, originating from the Beveridge report of 1942.

Premium is the amount to be charged for a certain amount of insurance coverage. The premium depends on the benefits to be covered by the insurance (the benefits package), the cost of those benefits, and estimates of the likelihood that the insured individual or group will use the benefits.

Risk pooling is the collection of funds from members of a group to finance the cost of a specific event (such as fire, illness, car accident). Risk pooling ensures that the financial risk of paying for unpredictable costs is borne by all the members of the group, instead of the individual, and protects individuals from catastrophic costs. In the case of health insurance, individuals are protected from the catastrophic costs of illness. The larger and more diverse the group—including rich and poor, men and women, old and young, healthy and unhealthy—the more effectively health insurance spreads risk.

Private voluntary health insurance is distributed by private for-profit or not-for-profit companies. Premiums are based on the purchaser's risk rather than his or her ability to pay. PVHI can be purchased on an individual or a group basis. It can provide primary coverage, or it may be purchased to supplement another health insurance policy ("secondary health insurance"). Unregulated PVHI can lead to escalating costs; competition for healthy, wealthy populations (cream-skimming); and avoidance of sick, poor populations. However, well-regulated PVHI can serve as the primary financial protection for workers and their families, while public funds can target the poor. PVHI may also be a transitional form of health insurance to develop local capacity to manage and finance health care (Sekhri and Savedoff 2005).

*Social health insurance*⁵ (SHI) generally has four features: (1) independent or quasi-independent management of insurance funds (such as by social security institutes or sickness funds); (2) compulsory earmarked payroll contributions; (3) a direct link between the contributions and defined medical benefits for the insured population; and (4) concept of social solidarity. Social health insurance is sometimes referred to as the Bismarck model reflecting its origin in Germany. Countries such as Germany, Colombia, and Korea have extended SHI from employer-based schemes to include other populations, with the government financing the inclusion of low-income groups.

Important Considerations

Feasibility and national health objectives are important considerations when financing health care.

What Financing is Feasible?

The population is the source of all a country's funds, except for external assistance and natural resources. Hence, low-income countries face real constraints to raising revenues to finance health in general, and health insurance specifically. Low-income countries are likely to have high fertility rates that result in a majority of the population being under 15. This is referred to as a *high dependency ratio*—when there are many more dependents (children and elderly who cost more than they contribute) than working-age population (who typically contribute more than they cost).

Government tax revenues average about 15 percent of GDP in low-income countries, compared with more than 20 percent among higher-income countries. If all countries in sub-Saharan Africa were able to meet the Abuja target and allocate 15 percent of government financing to health, 23 countries still would not reach \$34 per capita health

spending—the cost of a basic package of essential health interventions, as estimated by the Commission on Macroeconomics and Health in 2001. A projection analysis shows that even under optimistic assumptions about economic growth, population growth, and tax revenue collection, most sub-Saharan African countries will not reach \$34 per capita even by 2020 (Atim et al. 2008).

In addition to income constraints, financing is limited by the size of the formal sector economy from which taxes and payroll contributions can be collected. Generating health financing tends to be easier in countries that are more urbanized, where higher population density facilitates registration and revenue collection.

What Are Your Country's Health Financing Objectives?

When designing a health insurance system, it is critical that policy makers ensure that health insurance is aligned with the country's broader health system and health financing objectives. As suggested in the WHO World Health Report (2000), health financing objectives might include the following:

- Promoting universal protection against financial risk of ill health (Element 2)
- Promoting more equitable financing of health services, i.e., contributions based on ability to pay (Elements 2 and 3)
- Promoting equitable use and provision of services relative to need, i.e., access to services based on need, not ability to pay (Elements 2, 3, 4, and 5)
- Promoting quality and efficiency in service delivery (Elements 4 and 5)
- Improving transparency and accountability (Elements 6 and 7)
- Improving efficiency in the administration of the health financing system (Elements 6 and 7).

How Can Financing of Health Insurance be Pro-Poor?

In low-income countries where government health spending is low, high out-of-pocket health spending is not surprising. Heavy dependence on out-of-pocket payments is strongly correlated with households' experiencing catastrophic health expenditures and a lack of financial protection. Equity is a policy priority in many countries because of the strong link between disease burden and poverty (box 3.2). Health insurance can contribute to equity in three broad ways: revenue generation, pooling, and purchasing.

Box 3.2. Insurance and Free Care

Many countries have abolished user fees in public health facilities (e.g., Uganda, 2001; Liberia, 2005; and Zambia, 2006) with evidence of increased access for the poor. Both health insurance and free-care policies reduce financial barriers at the point of service. The interaction between the two approaches is complex and country-specific. The best advice is to ensure that both are a thoughtful, complementary part of your country's overall health financing policy.

REVENUE GENERATION

- Levy progressive general taxes (the rich pay higher income or property tax rates; no consumption tax on staples such as food)
- Levy progressive earmarked taxes for health (taxes on luxury goods)
- Institute “sin taxes” on products such as tobacco and alcohol, with collected revenue earmarked for use in health
- Make poor populations exempt from user fees or copayments; levy fees based on income; subsidize premiums
- Solicit external donor funds to subsidize premiums for the poor.

POOLING

- Establish compulsory universal coverage so the rich cannot opt out of the risk pool
- Require redistribution among multiple fund pools, e.g., richer districts subsidizing poor districts.

PURCHASING

- Exclude high-end, expensive, elective care from the benefits package
- Ensure an adequate supply of health providers and facilities where the poor live
- Establish incentives for providers to serve poor populations
- Provide vouchers or other incentives for poor to use priority services
- Shift financing away from inefficient delivery (e.g, hospitals with low occupancy).

See more under Elements 4 (Benefits) and 5 (Providers).

Advantages and Disadvantages of Different Health Insurance Models

Table 3.2 summarizes the advantages and challenges for the four most common types of health insurance. Please note that although certain countries are dominated by one approach, in most countries there is a mixture of the types mentioned below. For example, although Britain is known for its National Health System, complementary private insurance is available and has become popular with the middle and upper classes seeking to bypass waiting lines for care. Further, one scheme can also have a combination of funding mechanisms. For example, in Rwanda and in China, CBHIs are often financed both by the beneficiaries (through premium contributions) and by the government (through subsidies).

National and social health insurance systems need an effective and efficient system of tax collection. With more formal sector employees and thus a larger tax base, there will be greater capacity to generate revenue for the health system and greater ability to subsidize low-income groups. A prosperous country, with a limited number of informal workers, can more easily support a social health insurance system than countries with many informal workers. Instituting payroll taxes necessarily increases labor costs across the board, and this should be carefully deliberated as it may harm labor markets, increase tax evasion, and increase the attraction of carrying out business in the informal sector (Gottret and Schieber 2006: 91). Informal sector workers may be able to establish community-based schemes, which generally require a sense of mutual solidarity among the beneficiary group.

Table 3.2. Major Advantages and Challenges of Different Health Insurance Models

Health insurance model	Advantages	Challenges	Example
National/state-funded (Beveridge) <i>Funding source:</i> General tax revenues	• Comprehensive coverage of population • Progressive revenue collection • Large scope for raising resources • Simple mode of governance • Potential for administrative efficiency	• Funding subject to political pressures and available tax revenues • Potential inefficiency in health care delivery because of lack of competition and provider choice	United Kingdom, Canada, Costa Rica
Social insurance (Bismark) <i>Funding source:</i> Payroll taxes	• Mobilizes resources from employers for health • Funding typically earmarked for health • Can be progressive • Strong support from covered population	• Coverage limited to workers employed in formal sector • Less progressive if tax is capped • Burden of payroll contributions may increase unemployment • More complex to manage • Workers may leave formal sector to avoid payroll taxes	France, Germany, Japan, Thailand
Community-based (microinsurance or mutuelles) <i>Funding source:</i> Premiums paid by households	• Available to low-income groups and informal sector workers • Useful complement to other financing mechanisms, such as user fees or SHI • Facilitate government or donor funding to subsidize premiums to target populations	• Limited financial protection for members • Small risk pools risks sustainability (bankruptcy common) • Exclusion of poorest without subsidies • Limited effect on delivery of care • Require national-level political and financial support to achieve breadth and depth	China, Mali, Philippines, Rwanda, Senegal, Mali, Niger, Ghana before 2003
Voluntary (private) <i>Funding source:</i> Premiums paid by households or employers/employees	• Financial protection for higher-income population • Can supplement state or social insurance coverage • Can build local capacity in professional insurance management	• Typically limited to higher-income populations • Plans compete for healthy/wealthy members (cream-skimming) • Increases differentials in access based on income • Has high administrative costs	Namibia, South Africa, United States

Source: Adapted from Gottret and Schieber 2006.

There is no gold standard when it comes to the design of a health insurance system. Within each model, there are substantial differences in its application in-country. This variety is a healthy reflection of policy makers' designing their health insurance scheme for the realities of their situation and adapting the mechanism to the needs of their country and population.

Country Example: A Mix of Health Insurance Schemes in Rwanda

Aiming for universal coverage, Rwanda uses different insurance mechanisms to extend financial protection to its population.⁶ The three primary schemes are the Rwandaise d'assurance maladie (RAMA), the Military Medical Insurance (MMI), and the Assurances Maladies Communautaires (AMCs).

RAMA is a social health insurance scheme, compulsory for government employees. Private sector employees are also able to participate in the scheme on a voluntary basis. Its contribution rate is 15 percent of base salary, shared equally between employee and employer. MMI, also a social health insurance scheme, covers all military personnel. The contribution rate is 22.5 percent (5 percent paid by the employee and 17.5 percent by the government).

AMCs are *mutuelles* whose members live in predominantly rural settings and work in the informal sector. Once considered a partial solution to health financing but unlikely to lead to universal coverage, the AMCs have been unexpectedly successful in Rwanda. Although enrolment is voluntary, AMCs grew to cover 5.7 million Rwandans, 75 percent of the population, by 2007. This accomplishment is partly attributable to strong political will on the part of Rwanda's leadership, community outreach by insurance workers (*animateurs de santé*) to enroll AMC members, and the complementary roles of the MOH that manages and funds service provision (health centers and district hospitals, and a results-based financing system) and the Ministry of Local Government that administers the AMCs. Fifty percent of the funding for AMCs comes from annual member premiums; the other half is subsidized by the government (through general tax revenues) and donor support. The national network of *mutuelles* efficiently distributes funding from the government, donors, and nongovernmental organizations (NGOs) as premium subsidies that target the poorest.

Rwanda has seen several improvements in health financing indicators, including greater availability of financial resources for health (\$34 per capita in 2007 compared with \$13 in 1999), increased coverage of the rural and informal sector population (from 1.2 percent in 1999 to 75.6 percent in 2007), and lower out-of-pocket payments (from 24.7 percent of total health expenditure in 2000 to 15.9 percent in 2005). Still, challenges exist including making contributions more affordable to the poorest, adverse selection, reducing the cost of marketing/annual reenrolment, and improving financial management. Rwanda also is trying various approaches to reduce fragmentation of the different financing mechanisms, including developing a national legal framework governing all the health insurance schemes.

Steps to Address This Element

- Identify the different health insurance models that your country is currently using to finance health care.
- Identify the strengths and weaknesses of these insurance types.
- Determine if other financing mechanisms might be able to help overcome the challenges you may be experiencing.
- What is needed to improve how health insurance is being financed in your country?
 - More resources?
 - More efficient collection systems?
 - More efficient purchasing systems?
 - Involving other stakeholders, such as the private sector?
- Identify the political, social, and implementation considerations that would be required to achieve what you identified in Step 4.

4. Design Element 3: Population Coverage

By the end of this session, you will be able to do the following:

- Identify different types of populations to be covered by health insurance (the beneficiaries)
- Determine how to cover hard-to-reach populations such as low-income, rural, informal sector workers
- Understand the trade-off between expanding population coverage and the benefits package (Element 4).

Key Concepts

Adverse selection is the tendency of higher-risk individuals to be more likely to enroll in insurance. In the case of health insurance, adverse selection occurs when more people with high expected health costs (e.g., those with pre-existing health conditions or the elderly) elect to enroll than do those with low expected costs (healthy, young people). Adverse selection is possible with voluntary insurance schemes, only when people have a choice between enrolling or not enrolling. Adverse selection can reduce risk sharing and lead to premium escalation, as the cost of services is higher than expected.

Beneficiary is the insured person, the individual who is covered by the health insurance scheme. He/she may also be referred to as a subscriber, member, or enrollee.

Beneficiary population is the group of people covered by health insurance.

Direct targeting is the provision of free or reduced-price health insurance coverage to categories of the population defined by a means test. One way is for a third party such as a donor or charity to pay the premiums of the target population. In many countries in Africa, means testing usually occurs at the point of service delivery. Identifying who is eligible is difficult where wage and tax records are often unavailable or nonexistent. Facility administrators thus use their discretion to determine who is unable to pay fees, resulting in informal means testing that relies on income proxies. Because of time constraints on facility administrators and doctors, pressure to waive fees for acquaintances, and unwillingness of staff to grant waivers because their facility needs additional revenue, eligibility for fee waivers may ultimately be determined in a less-than-systematic manner.

Eligibility is qualification for participation. Within health insurance, eligibility can be the characteristics required for membership in a health insurance scheme, such as ability to contribute, employment by a specific entity, or existence below the poverty line. It can also refer to the characteristics required to access a particular benefit of the health insurance scheme, such as a subsidy. All health insurance programs have their own defined eligibility requirements.

Enrolment is the act of becoming insured. Enrolment can be *passive* as when a government legislates that all citizens are automatically covered or *active* as when people must take steps to enroll, such as registering and paying an enrolment fee or premium.

Formal sector is the employment sector in which workers have regular hours and are paid wages or salaries on which they must pay income taxes.

Health equity is the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage, such as wealth, power, or prestige. Inequities in health systematically put groups of people who are already socially disadvantaged (for example, by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group) at further disadvantage with respect to their health.

Informal sector refers to workers who are not employed in the formal sector and whose economic activity tends to be irregular.

Mandatory enrolment is the system in which all eligible members of the population group defined must enroll and pay the specified premium or tax for the coverage. For example, all citizens of the United Kingdom are enrolled in the National Health Service.

Voluntary enrolment means that individuals can choose to be covered by the health insurance scheme or opt out. When enrolment is voluntary, adverse selection can be a risk because people who are more likely to need medical services are more likely to enroll, and those who are healthier less likely to enroll. Voluntary enrolment also necessitates marketing the scheme to eligible people and possibly providing incentives for enrolment to reduce adverse selection.

Important Considerations

Increasing population coverage with quality services in a cost- efficient and culturally acceptable manner is key to the ultimate goal of achieving universal coverage.

Achieving Universal Coverage

In May 2005, the World Health Assembly endorsed Resolution WHA58.33 urging member states to work toward universal coverage and ensure that their total populations have access to needed health interventions without the risk of financial catastrophe (Carrin, Evans, and Xu 2007). Under this resolution, universal coverage incorporates two complementary dimensions in addition to financial risk protection: the extent of population coverage (who is covered) and the extent of health service coverage (benefits covered—see Element 4).

Only a few countries have achieved universal coverage, such as Denmark, France, Germany, Portugal, and the United Kingdom. Health insurance in most countries covers only select population groups. This is generally because countries have focused first on the “easier” population groups—those employed in the formal sector. For example, government-financed health insurance typically begins with civil service employees and military personnel. In the private sector, large companies may take the initiative to cover their employees and possibly their dependents. Wealthy individuals, especially professionals such as lawyers, accountants, and doctors, may elect to purchase private commercial insurance. However, developing countries often have a high proportion of the following population groups, which tend to be harder to reach (box 4.1):

- *Rural poor*: farmers, farm workers, mine workers, herders, fisherman
- *Self-employed or employed in the informal sector*: street vendors, kiosk owners, taxi drivers, guards, servants, community health workers, midwives, traditional healers
- *Formally employed in small businesses*: pharmacies, shops, light industry such as textiles, private schools, private clinics, security, small-office workers
- *Vulnerable populations*: the homeless, street children.

Box 4.1. Colombia: Subsidies to Extend SHI to the Poor

Colombia increased the share of its population protected by SHI from 23 percent in 1993 to 62 percent in 2003 by subsidizing premiums for the poor through an equity fund financed by general tax revenues and payroll taxes. Child mortality rates fell from 44 per 1,000 births to 15 per 1,000 among the insured.

Source: Escobar 2005 as referenced in Gottret and Schieber 2006.

Expanding Insurance Coverage to Hard-to-Reach Population Groups

For health insurance to reduce inequities, it must be designed to reach poor and marginalized populations. Populations can be grouped in terms of characteristics that help or hinder health insurance coverage:

- Individuals' relative ability to contribute to health insurance, both in terms of household income and the ease/difficulty of collecting their contributions. Formal sector employees have a greater ability to contribute because they have a stable income that can be taxed to pay for health insurance. They also tend to be easier to identify and collect taxes from.
- Political, social, or cultural characteristics that may help or hinder health insurance. Ethnic differences may hinder solidarity. Communities recovering from civil war may not have the social cohesion that is important for CBHI. Strong district administration can be an organizational platform to implement CBHI (box 4.2).
- Distance to service providers may limit a population group's effective inclusion (see Element 5).
- Age, gender, and health status influence what types of health services are needed and their cost (see Element 4).
- Membership in professional or social organizations, such as trade unions or associations, civil society groups, or networks. These groups may also provide a platform facilitating the extension of an insurance scheme.

Box 4.2. Rwanda: Broad Population Coverage

Rwanda has a sizeable informal and rural sector but has been able to expand health insurance coverage to more than 70 percent of the country. Coverage is provided through district mutuelle schemes run by district authorities in partnership with the public health facilities and funded by a mix of donor, government, and beneficiary funds.

Source: Gottret and Scheiber 2006.

Table 4.1 presents some strategies for overcoming these challenges.

Table 4.1. Challenges and Strategies to Insure Hard-to-Reach Populations

Challenging characteristics	Strategies
Geographically dispersed	• “Door-to-door” (or hut-to-hut) outreach by insurance workers such as the “animators” in Rwanda • Enrolment through professional associations, unions, or cooperatives
Difficult to communicate the concept and benefits of health insurance due to low literacy rates and unfamiliar concept of prepayment or risk sharing	• Build on existing mutuelles for funerals, solidarity loan schemes, or microfinance • Community meetings • “Door-to-door” (or hut-to-hut) outreach by insurance workers such as the “animators” in Rwanda
Living at or near poverty limits ability to pay premium or copayments	• Schedule premium collection with harvest • Subsidize premiums. Health care providers, municipal authorities, or community leaders with social standing may facilitate the application of means testing.
Health providers less accessible, especially in rural areas	• Expand supply of covered services by investing in infrastructure and/or building clinical skills • Decentralize service from higher to lower levels of facilities/personnel (task shifting) • Mobilize and use existing private resources—create public/private partnerships

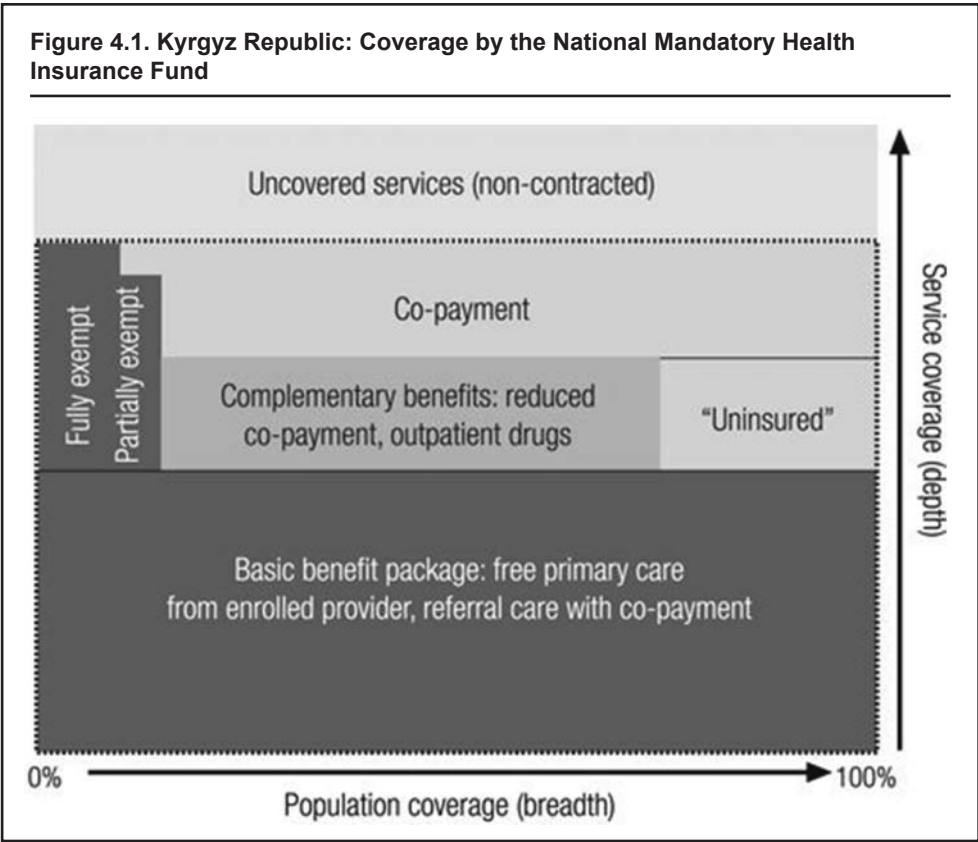
Source: Authors.

One of the risks of segmenting the population is that it could produce a tiered system with inequitable benefits packages for different groups. Another risk is that each segment tends to be homogeneous, limiting cross-subsidization among diverse groups. However, higher-level redistribution of resources among financing pools may be possible.

Linkages between Population Coverage, Financing Mechanism, and Benefits Package

Insurers face a trade-off between extending coverage to low-income and high-risk populations or covering additional services. No developing country has the financing to expand both at the same time. Charging wealthier populations extra (above cost) for services can be used to subsidize fully covered services for the poor. Insurers can also reduce administrative costs or increase the efficiency of service provision and expand population and benefit coverage while maintaining the same funding level. Elements 4 and 5 present cost-containment approaches.

The Kyrgyz Republic established a national mandatory health insurance fund (MHIF) to cover a basic package of primary care for the total population with fee exemptions (subsidies) for complementary benefits for the low-income population as can be seen in figure 4.1. The MHIF does not cover higher income populations for the complementary benefits (“uninsured”), does collect copayments for more sophisticated services from everyone except the poorest, and does not cover tertiary services at all.



Source: Futzing 2009.

A population-service matrix can help countries visualize the linkages between different target population groups, financing mechanisms, and benefits package options. The columns indicate the populations that the country intends to cover with health insurance. The rows list the different types of benefits packages (Element 4). The color-coded cells in the center reflect the type of financing (Element 2) to cover the corresponding population group and level of services.

Figures 4.2 and 4.3 are examples of population-service matrices from China. During the 1980s and 1990s, population coverage was limited, and benefits packages varied by health insurance scheme and population (figure 4.2). Employment-based health insurance covered all public sector and some private sector employees. Government provided some benefits to urban and rural poor. Private health insurance was available to the wealthy who could afford more comprehensive health insurance coverage. Figure 4.3 shows how in the past 10 years, China has expanded health insurance coverage in terms of both population coverage and services in the benefits package.

China began the process of achieving universal coverage by increasing health insurance coverage in different population groups with different types of health insurance schemes.

Figure 4.2. China: Population-Service Matrix and Financing Status, 1980s and 1990s

Level of services	Urban population			Rural population		
	Public sector employees	Private sector employees	Self-employed/unemployed	Public sector/employees	Private sector employees	Self-employed/farmers
Comprehensive Package of Health Services (CPHS)						
Expanded-BPHS (EBPHS)						
Basic Package of Health Services (BPHS)						

Lots of empty cells means that much of the population is not covered.

G+I Tax-based (G= government funding + I = Individual funding)
Er+Ee Employment-based (Er= Employer funding + Ee= employee funding)
I+G Subsidized community-based (I = Individual funding + G= government funding)
I+Er Individual private-based (I = Individual funding + Er= Employer funding)

Source: Bloom and Tang 2005; Anson and Sun 2005.

Figure 4.3. China: Population-Service Matrix and Financing Status, 2008–15

Level of services	Urban population			Rural population		
	Public sector employees	Private sector employees	Self-employed/unemployed	Public sector/employees	Private sector employees	Self-employed/farmers
Comprehensive Package of Health Services (CPHS)						
Expanded-BPHS (EBPHS)						
Basic Package of Health Services (BPHS)						

G+I Tax-based (G= government funding + I = Individual funding)
Er+Ee Employment-based (Er= Employer funding + Ee= employee funding)
I+G Subsidized community-based (I = Individual funding + G= government funding)
I+Er Individual private-based (I = Individual funding + Er= Employer funding)

Source: Dong 2009; Yip, Wagstaff, and Hsiao 2009.

For other countries, taking an incremental approach to expanding population coverage is likely to be most politically and financially feasible. After taking into consideration the current coverage in the country and identifying political and technical objectives for the national population, an appropriate next step is to draw up a prioritized list of groups to which to extend coverage over time, and then develop a phased plan that sets out the timing of these coverage expansions.

Country Example: Covering the Poor through Means-Tested Subsidies in Peru

From 1997 to 2009, Peru's health financing system evolved from several targeted insurance programs aimed at specific segments of the population to a universal system including the poor.

Since the 1930s, the Peruvian Health Social Security Agency (EsSALUD) has provided health care coverage to formal sector workers and their dependents (spouse and children under 18), pensioners, and some self-employed persons. EsSALUD is financed through a 9 percent payroll tax levied on employers. Pensioners and the self-employed have to contribute to premiums, although other formally employed workers do not. By 2006, the combined contributory coverage of EsSALUD, the Armed Forces, and the police had reached 5.8 million persons, about 20 percent of Peru's population. These were mainly nonpoor families.

In 1997, the Peruvian Ministry of Health took the first steps to extending public health insurance to the poor, which they referred to as "subsidizing demand for health care." The initiative started with an easily identifiable group, school children. The Free School Health Insurance program (Seguro Escolar Gratuito) provided exemptions from the cost of consultations and medicines to all public schoolchildren ages 5 to 17. To extend coverage further, the Maternal Child Health Insurance program was launched in 1998 and provided a package of free basic services to pregnant women and children under 5. This was started as a pilot project in five districts at first and expanded to eight districts in 2000.

The programs merged in 2001 to create the Integrated Health Insurance Program (Seguro Integral de Salud, or SIS) and coverage was extended from the eight pilot districts to the whole country. The program was targeted to those who could demonstrate financial need through a screening process that was improved in 2004 (see means testing below). Eligibility expanded to include all children under the age of 18 (whether enrolled in school or not), pregnant women, and adults needing emergency care, if they passed the means test.

In 2009, eligibility was extended to include entire families earning less than a certain income, as long as they had no other insurance coverage. Coverage is free of charge for those who are considered in a state of poverty, and is available at a subsidized rate for those with eligible incomes (under approximately \$200 per month individual income or \$500 per month family income).⁷ SIS, funded predominantly through tax revenues,⁸ grew from covering 5,860,000 beneficiaries in 2002 to 10,350,000 in 2008, out of a population 29 million.⁹

In 2009, Peru passed a Universal Health Insurance Law, which established an overall framework for health insurance reform in Peru. This policy comprises a two-pronged strategy: (1) increasing the breadth of insurance coverage by expanding the number of people with effective access to quality health services and protection against financial risk, with an emphasis on the poor; and (2) increasing the depth of insurance coverage by expanding the range and quality of health benefits according to the current and future demographic profile and epidemiological needs of the population.

Means Testing to Identify and Subsidize Insurance for the Poor

In 2004, SIS, with the technical assistance of the USAID-funded Partners for Health Reform *plus* project team, developed a mean test index to target health subsidies to the poorest in the population, similar to the methodology employed by the National Targeting System of Colombia.¹⁰ This methodology determines eligibility for SIS based on the estimation of a composite index of a household's economic welfare (box 4.3).

Box 4.3. SIS Methodology for Means Testing

Household economic status is estimated based on a set of qualitative and quantitative variables related to the consumption/ownership of durable goods, human capital endowments, and other factors. Working with the National Household Survey (ENAH) of 25,000 households, the household welfare index was derived using the statistical algorithm of Alternating Least Squares and Optimal Scaling (Qualitative Principal Components). This algorithm provides (1) a metric for the different categories of the variables collected in the survey for each geographic area, and (2) weights for each variable according to its contribution to the first principal component of the system (which is the unobservable utility index that must be constructed).

The final variables selected by the algorithm were those most efficient in predicting household welfare differences and poverty. Seguro Integral de Salud easily collected this information in a short interview by applying the Socioeconomic Evaluation Sheet (Ficha de Evaluación Socioeconómica, or FESE). With the aid of customized software, SIS calculates household welfare scores and ranks potential beneficiaries.

Several evaluations have shown that these indexes are reasonably good at determining eligibility for social programs. Although they do not eliminate the undercoverage problem completely, they reduce leakage to wealthier groups, and as a result their capacity to reduce poverty is significantly increased.

The methodology was so successful that the Prime Minister's Office and the Ministry of Economics adopted the methodology as the basis of the National Household Targeting System (SISFOH established by DS. 130-2004-EF) for use in a wide range of subsidized social programs to allocate subsidies to the poor and limit leakage.

Steps to Address This Element

- Identify who is currently being covered by health insurance in your country. Determine what benefits they receive from the insurance and how it is being financed.
- Determine the other population or beneficiary groups you would like to be able to cover with health insurance.
- Identify the options you have for financing the expansion of health insurance to these population groups (given the different benefits package options you have identified, which is discussed in Element 4).
- Determine some of the operational considerations that need to be made to expand health insurance to these new population groups, such as enrolment, collection, service delivery, provider engagement and payment, and claims processing. These issues are addressed in further detail in Elements 6 and 7.

5. Design Element 4: Benefits Packages and Cost Containment

By the end of this session, you will be able to the following:

- Determine what services should ideally be covered within the benefits package
- Understand methods of cost containment
- Understand the trade-offs between benefits, population coverage, and cost containment methods.

Key Concepts

Actuarial analysis is the statistical calculation used to determine the insurance premium to be charged based on projections of service use and cost. Actuaries use historical use data, such as claims data, to predict future use patterns. However, claims data are not available in many developing countries. Alternative data sources such as household surveys, facility data, or other proxy data may be necessary to calculate premiums.

Benefits package refers to the health services and products covered by the health insurance scheme. The benefits covered are a major driver of the overall cost of the health insurance and the scheme's political acceptability and marketability to consumers.

Claim refers to each use of the benefits covered by insurance, generating payment to the insured person or to a service provider (e.g., doctor, car repair shop). Claims under auto, property, and life insurance are relatively small in volume compared with health insurance claims.

Coinsurance refers to the insured person's payment for a percentage of the cost of covered health care services utilized. For instance, an insurance scheme might cover 80 percent of the costs of a hospital stay; the remaining 20 percent would be the insured person's coinsurance.

Copayment refers to a fixed payment defined in the insurance policy and paid by the insured person each time a medical service is accessed.

Cost containment comprises a variety of techniques to promote efficiency in service provision and use and to avoid unnecessary, wasteful spending.

Deductible is a fixed amount that must be paid out-of-pocket in a given year before an insurer will cover any expenses.

Insurable risks are unpredictable, uncommon, and usually high-cost events such as car accidents or cancer that health insurance traditionally is intended to cover. Many health services that are public health priorities—such as immunization, family planning, or health education—are not insurable risks, because they occur with predictable frequency and are needed by the bulk of the population.

Merit goods are similar to public goods, but they generate both private and public benefits. Because their total value to society is greater than their private benefit, they have a tendency to be underconsumed. Examples include vaccinations, insecticide-treated bednets, and condoms to prevent HIV. Public and merit health goods are generally not insurable risks, but are highly cost-effective health system investments.¹¹

Moral hazard occurs when the behavior of an insured person changes—usually to become less risk-averse—because they no longer bear the full cost of their behavior. For example, once insured, they are likely to use more medical services than they otherwise would because they no longer pay the full cost of those services. Moral hazard can lead to unnecessary service use and cost escalation in the health system. However, increased use of some priority health services (e.g., assisted deliveries) may be a policy objective in developing countries.

Public goods are goods that, when consumed by one person, do not become less available to another person, and which cannot be effectively withheld from another person. Examples are clean air, national defense, and spraying for mosquitoes to prevent malaria. Since no one can be excluded from enjoying the benefits of a public good, individuals tend to be less willing to pay for them.

Reinsurance is insurance for insurance companies. Insurers pay a premium for protection from the risk of unexpectedly costly claims. Reinsurance enables an insurance scheme to cover risks that would be too great for any one scheme to assume.

Important Considerations

Important considerations when composing the benefits package include what to incorporate in the statement of the package, what criteria to use in designing the package, what services to cover, financial and political aspects, and cost containment.

What Is In a Statement of the Benefits Package?

The benefits package is usually a list or table of general categories of care (e.g., outpatient care and hospital care) with details regarding the level of coverage in each category. The details can include the type of provider, specific services or conditions covered or excluded, limits on services (e.g., number of days in the hospital), and any copayments or deductibles (see cost containment, below). Samples of benefits packages from Ghana, India, and the United States are in appendix B.

What Criteria Should Guide Design of the Benefits Package?

In 2001, the Commission on Macroeconomics and Health (CMH) recommended four criteria for choosing essential health interventions to be included in benefits packages: “(1) They should be technically efficacious and can be delivered successfully; (2) the targeted diseases should impose a heavy burden on society, taking into account individual illness as well as social spillovers (such as epidemics and adverse economic effects); (3) social benefits should exceed costs of the interventions (with benefits including life-years saved and spillovers such as fewer orphans or faster economic growth); and (4) the needs of the poor should be stressed” (CMH 2001: 10). In addition to the CMH criteria, policy makers must also consider the priorities of the population groups that are providing most of the financing, who may withdraw their political support for an insurance scheme that does not cover services that they value.

What Benefits Should Your Insurance Scheme Cover?

Given resource limitations, most developing countries must make difficult choices between covering services most likely to improve the population’s health outcomes and services that protect households from catastrophic health expenditures (box 5.1).

Box 5.1. Kyrgyz Republic: Financing Reforms Reduce Costs for the Poor

The Kyrgyz Republic's comprehensive health financing reforms consisted of national-level pooling of funds, prospective purchasing methods, explicit definition of benefits, and downsizing in the hospital sector. The benefits package consisted of free primary care for the entire population and copayment for inpatient care. Due to these reforms, from 2001 to 2004 excess hospital capacity was reduced from 1,464 buildings to 784 with a concomitant cost reduction. Conditional on hospitalization, the poorest 40 percent experienced a significant increase in out-of-pocket payments in control regions but a slight decline in reform regions. For all income groups, reforms were effective in limiting the increase of out-of-pocket payments for hospitalization by US\$10 for an average household. The Kyrgyz experience provides evidence that patient financial burden may be reduced through more efficient use of public resources and that in settings with high informal payments, introduction of copayments for hospitalization may not have a negative effect on financial protection.

Source: Yazbeck 2009.

To improve health outcomes, policy makers should consider the population's burden of disease, demographics (age, gender, location, and income), mortality and morbidity rates, epidemiological trends, historical data on service use, and evidence regarding the most cost-effective interventions.¹² Many of these services are high in volume, low in cost and have high potential for health impact (e.g., family planning, treatment of upper respiratory infections and infectious diseases). Many are public or merit goods with large social benefits (such as immunization), and insurance coverage can help compensate for low willingness-to-pay for such services. However, these types of services are not considered "insurable risks" because they are not random and unpredictable. Comprehensive coverage of these services may be very expensive. For example, HIV/AIDS prevention, testing, and treatment have high public health value, but need for these services is common and highly predictable where HIV prevalence is high and many people are likely to use the services.¹³

To protect households (especially poor households) from catastrophic costs, household surveys and health facility data can be used to analyze the target population's current pattern of out-of-pocket health expenditures: Which medical services are people buying and which tend to be catastrophic for households in the target population? Typically, households prioritize curative care and drugs. To reduce out-of-pocket expenditures and achieve financial protection, the benefits package will likely need to cover curative outpatient services, drugs, and inpatient care. However, great care must be taken to not create incentives for unnecessary hospitalizations and overprescribing.

Table 5.1 summarizes the characteristics of major categories of services. Note that primary care includes preventive care, integrated management of childhood illness (IMCI), maternal care, and outpatient care.

Ministries of Health may support inclusion of primary health care in an insurance package to expand access to and utilization of health care facilities. Including primary care services in a benefits package can also help a country make the transition from facility-based input budgeting to an output-based system where funds "follow the user," and payments to facilities are based on use. Many community-based schemes (such as

Table 5.1. What Services to Cover?

Type of service	Public or private good?	Predictability of use	Rare or common?	Unit cost
Vaccines	Both	High	Common	Low
IMCI	Both	High	Common	Low
Family planning	Both	High	Common	Low
Maternal	Private	High	Common	Varies
Outpatient curative	Private	Low	Mix	Varies
HIV/AIDS prevention	Both	Varies by country	Varies by country	Low
HIV/AIDS treatment	Both	Varies by country	Varies by country	High
Inpatient	Private	Low	Rare	High
Drugs	Both	Varies by drug	Mix	Varies
Diagnostic	Private	Low	Mix	Varies

Source: Authors.

those in Rwanda) offer a basic package including some primary health care. In addition, although the cost of primary health care services may be low in relative terms, these costs can be catastrophic for the very poorest.

Benefits Packages and Financial Sustainability

Choosing a benefits package requires close financial analysis and political sensitivity.

FINANCIAL CONSIDERATIONS

Selecting an appropriate benefits package requires financial analysis. Household surveys and health facility data can be used to analyze the target population's current pattern of out-of-pocket health expenditures. Policy makers can then outline a draft benefits package that balances coverage for the most financially burdensome services and the services with the greatest health impact.

Health actuaries can help estimate the cost of the proposed benefits package to determine if sufficient resources exist to finance the package. They can estimate the costs of services using historical utilization data (e.g., medical claims, household surveys, facility data), as well as determine the potential rate of increase in use of services once health insurance is implemented, which will affect the overall cost of the benefits. The cost estimate must be compared with revenue projections. If revenues are inadequate, medical costs must be reduced by removing services, adding cost-containment methods (see below), or reducing the covered population (without reducing revenues). These calculations ensure that premium rates for scheme participants (for voluntary and social insurance systems) or tax revenues (for national health insurance systems) are affordable, politically acceptable, and sufficient for long-term viability.

Table 5.2 summarizes the essential balance to be achieved between revenues and expenses within the insurance system. Health insurance revenues can come from individual premium payments, employer contributions such as payroll taxes, and government and donor financing. Insurers typically receive premium revenues before incurring medical costs and therefore are able to invest funds and earn interest, another source of income.

Table 5.2. Balance of Insurance Revenues

Insurance revenues and other income must cover total expenses						
Revenues and other income				Expenses		
Individual premiums	Employer payroll taxes	Government or donor funds	Interest earned	Medical costs ^a 85–90% ^b	Administrative costs 5–10% ^b	Reinsurance premium < than 1%

Source: Authors.

a. Medical costs can be reduced by shifting some of the cost to the beneficiary through copayments, deductibles, or ceilings.

b. Illustrative percentages.

Health insurance expenses include medical costs in the form of payments to providers or reimbursement to patients, administrative costs, and premium payments for reinsurance to protect the insurer from the risk of higher than average claims. The reinsurer agrees to cover medical expenses above an agreed threshold in return for a small contribution. The ILO's initial calculations suggest that the premium would be \$0.075 per family per month to cover risks up to \$1,000.¹⁴ Medical costs are estimated based on the previous year's medical costs, plus an estimated annual increase:

$$\begin{aligned} \text{Projected medical cost (reimbursements)} &= \text{Previous Year's Expenditure} \\ &\times (1 + \text{Annual Increase Rate}) \\ &\times \text{Reimbursement Rate} \end{aligned}$$

The prior year's health expenditure related to the use of services is the key information to estimate medical costs for the coming year. Health expenditures can be grouped into outpatient and inpatient or diagnosis-related groups (DRGs), based on the design of the benefits package and provider payment system (see Element 5). If your country lacks data on the prior year's health expenditure, it may be possible to estimate based on data from another similar country. Annual increases are due to many factors such as: Increased prices (provider payment rates), increased demand (service utilization), increased use of technology, and changes in the provider payment mechanism (see Element 5).

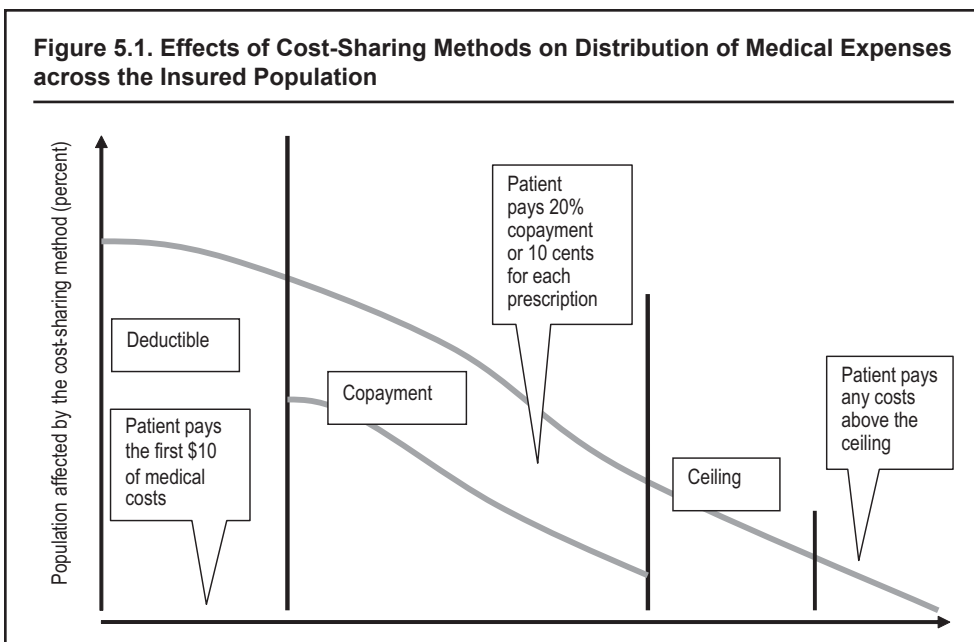
POLITICAL CONSIDERATIONS

Political acceptability is of key importance in designing the benefits package, especially among the people who are paying for the insurance. Under a voluntary scheme, if beneficiaries are expected to pay the premium, they must understand the concept of insurance and find the benefits package worth paying for. In many CBHI schemes, the members debate and vote for which benefits to include. If the government will fund a mandatory insurance scheme through general tax revenues, national health goals are likely to guide design of the benefits package. In addition, to sustain political support for the national scheme, the tax-paying population should perceive the benefits package as valuable. The priorities and political power of the paying population may be at odds with those of the nonpaying, poor population, requiring an incremental, consensus-building approach to expand insurance to nonpaying populations (see Elements 1, 2, and 3).

How Can Costs of the Benefits Package Be Contained?

The goal of cost containment is to make the insurance scheme solvent and financially self-sustaining. As part of the benefits package, cost-containment methods can discourage unnecessary, wasteful spending so more funds are available for needed health care services. Some methods can promote quality; others can erode quality and must be closely monitored. Costs are incurred when implementing cost containment. Most methods are annoyances to beneficiaries and providers and require administrative systems and labor to implement. Policy makers must confirm that the cost-containment method saves more money than it costs to put the system in place, run it, and monitor compliance.

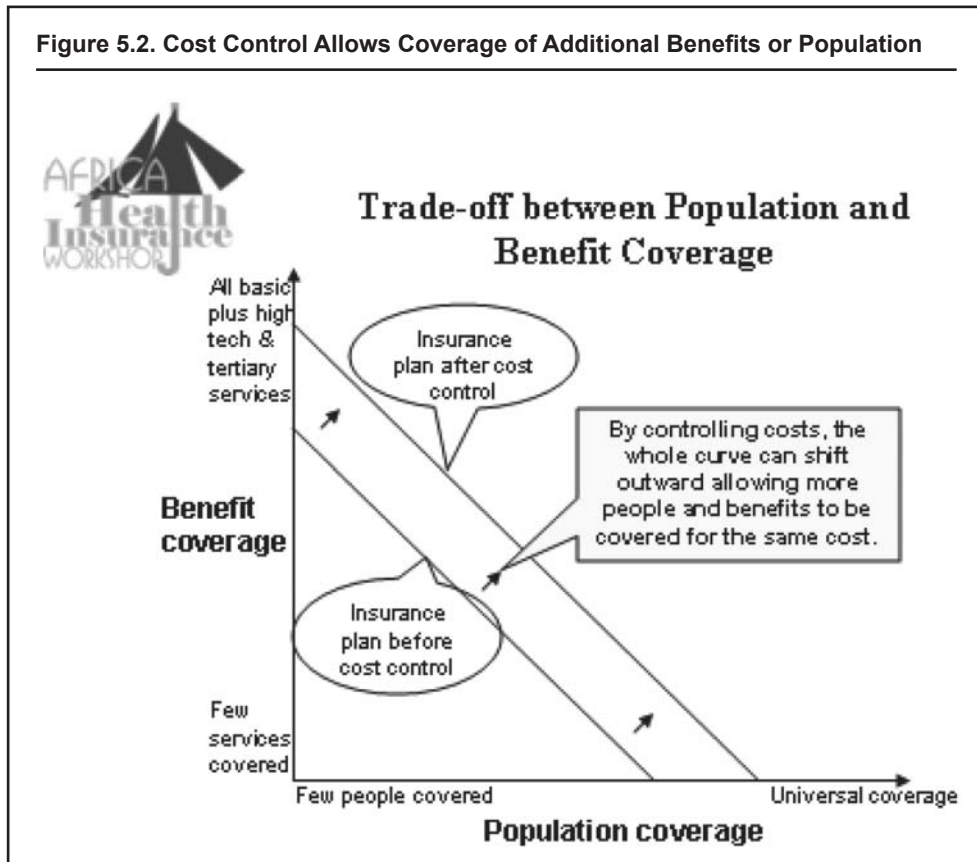
The benefits package design process itself can contribute to cost containment. Figure 5.1 shows how many health insurance plans control costs through deductibles and copayments since these mechanisms control the tendency to overuse health services (moral hazard). These deductibles and copayments, however, may be unaffordable to the poorest groups. Some schemes set a ceiling on the benefits an individual may be paid within a given time frame, such as a year, although such maximums may leave beneficiaries at risk of catastrophic expenditures. Many insurers exclude expensive services such as organ transplants and dialysis. Insurers may cover only generic drugs, or use an essential drugs list. Clear and rational processes, based on evidence of cost effectiveness, should always be followed for modifying the benefits package and reviewing new interventions, products, and technologies for possible inclusion.



Source: Feldstein 1993.

Figure 5.2 demonstrates how effective cost-containment policies and measures to incentivize efficient provision of services may even allow policy makers to expand the proposed benefits package without additional resources.

Figure 5.2. Cost Control Allows Coverage of Additional Benefits or Population



Source: Hong Wang, Health Insurance Workshop, Abt Associates Inc, Accra, October 19–23, 2009.

Other cost-containment methods can include:

- Mandatory enrolment and eligibility policies that diversify risk and combat adverse selection, for example, requiring that the whole family enroll, not just the sick and elderly (Elements 2 and 3)
- Waiting periods for beneficiaries to use certain benefits to prevent people from enrolling just after diagnosis or when a service is needed (Element 3)
- Provider selection and payment methods that reward quality and efficiency (Element 5)
- Assigning a gatekeeper, often a primary care physician, responsible for authorizing the insured person's access to specialized tests and services covered by the insurance scheme; and gatekeeper determining whether the patient meets the conditions for referral for specialized services, what is the appropriate level of service, and sometimes where the services should be provided (Element 5)
- Effective communication among stakeholders, such as the insurer, beneficiaries, and providers, so they understand roles and responsibilities, rights under the scheme, and ways to collaborate to avoid wasteful spending (Elements 6 and 7)

- Controlling fraud or abuse by either the beneficiary, the provider, or both (Element 7)
- Promoting the use of protocols or clinical guidelines among providers to standardize service delivery for certain diagnoses or types of care to contain costs and improve quality (Elements 5 and 7)
- Case management of chronic diseases to promote health and avoid inpatient admissions (Elements 5 and 7).

Country Example: Expanding Access to Primary Services through the Benefits Package in Bolivia

Bolivia is an excellent example of using a health insurance benefits package as the mechanism for expanding access to a priority service. Prior to 1996, only formal sector workers and those with private insurance benefited from health insurance coverage. However, maternal and child mortality rates (key indicators for MDGs 4 and 5) were among the highest in the region. The political decision was made to increase the use of maternal and child health services by removing financial barriers to care through health insurance.

National Mother and Child Insurance (Seguro Nacional Materno Infantil) was passed into law in July 1996 (Dmytraczenko et al. 2000). The eligible covered population included pregnant women, postpartum women, and children under five years old. Ninety-two key services were covered related to childbirth, postnatal care, and services for children under five. Public sector, not-for-profit private sector, and social security providers originally participated in delivering the service package. The initiative was financed through national tax revenues (Ley de Participación Popular) channeled through municipal governments. Facilities were reimbursed on a fee-for-service basis, and payment was made by the national payer (Unidad Nacional de Gestión) through the municipal governments to the district-level public facilities.

While the Mother and Child Insurance had a significant impact on maternal and child health indicators (e.g., infant mortality declined from 94 per 1,000 in 1989 to 54 per 1,000 in 2003), it was noted that utilization, and therefore coverage with key services, was low among indigenous mothers and children.¹⁵ In an effort to address this issue, coverage of this group was expanded in January 2002. The Seguro Básico Indígena e Originario attempted to build on the achievements of the Mother and Child Insurance to increase the use of modern services by indigenous women and children. This new package of services covered the 92 original ones as well as 10 “native” conditions such as evil eye (*mal de susto*) and delivery of the placenta to the mother for burial (*entrega de la placenta*).

Later in 2002, a new law was passed (Seguro Universal Materno Infantil), which substantially expanded the benefits package for women and made all women ages 5 to 60 years eligible for the program. Specific attention was paid to prevention of cervical cancer (pap smears), family planning services, and treatment of sexually transmitted diseases.¹⁶

Steps to Address This Element

- Identify the health priorities that you would like to see covered by your health insurance scheme.
- Weigh the relative importance for health insurance to provide catastrophic coverage and/or access to basic health care.

- If interest is in providing basic health care, define what that means for your situation.
- Review what is currently covered by your national health insurance or by public health programs.
- Identify where and how coverage of the insurance benefits package could be modified to better meet your country's goals and objectives. Consider quality and accessibility of care.
- Determine how the expanded coverage can be achieved:
- What will the new benefits package cost?
- How will it be financed?
- Who will deliver the services?
- Are the service providers accessible to the beneficiary population?
- How will the health system ensure adequate supplies in the facilities for new services? (This is particularly relevant for some priority services, such as family planning, maternity, or immunizations.)
- How will providers be paid for the new services added to the benefits package?
- How will moral hazard be minimized with addition of the new services?
- Are there cost-containment methods that can be included to help reduce moral hazard and overall costs the insurance scheme?

6. Design Element 5: Engagement, Selection, and Payment of Health Care Providers

By the end of this session, you will be able to do the following:

- Understand how to lay the groundwork for identifying, selecting, and engaging health care providers
- Understand how all payment systems create incentives that help (or hinder) quality improvement, efficiency, and reaching the poor
- Preview the operational and cost implications of different provider payment systems (further discussion in Element 7).

Key Concepts

Accreditation of health care organizations is defined as an external assessment of the entire organization's performance against a predetermined set of objective and measurable standards. Unlike licensing, which tends to focus on the capability to deliver health care services, accreditation focuses on the quality and safety of the services. Accreditation is time limited, and the organization must periodically be re-evaluated to ensure that it continues to meet the standards in order to maintain its accreditation status. Therefore, accreditation not only fosters, but requires, a process of continuous improvement (Shwark 2005).

Market structure refers to the characteristics and relative strength of buyers and sellers in a market. In the health market, buyers are individuals and purchasing organizations (national, single payer; regional payers) and sellers are individual providers and provider organizations (such as provider networks or associations of health care facilities). The market structure influences the types of payment methods that can be established.

Payment method is the mechanism used to allocate resources from buyer (insurer, government, etc.) to provider. The payment method has an impact on the quantity and quality of care and transaction costs. A payment method can be based on inputs (e.g., salaries or drugs), outputs produced (e.g., patient visits, hospital days, cases treated), or results (e.g., percentage of children in a catchment area fully immunized). Specific payment methods are defined below:

Fee-for-service (FFS) is payment per service provided. This may be designed to cover all costs incurred by the provider or only to add incentives to encourage providers to devote effort to priority services and have no relationship to providers' actual costs. Under FFS, providers face an incentive to increase the number of services delivered, possibly above what is medically necessary ("supplier-induced demand") and therefore increase reimbursements from the payer. To manage this, a fixed cap (ceiling) on costs or number of visits per year may be imposed. FFS can also motivate providers to provide needed services or work longer hours, which may be appropriate for certain target populations. FFS is often used in the private sector and is used in several countries, such as Canada, China, Ghana, Japan, and the United States.

Per diem payment is a fee paid to hospitals for each bed-day. This payment method incentivizes providers to raise the number of hospital admissions and the length of stay, and even shift some outpatient services to the hospital. Like FFS, per diem payment is associated with cost escalation. To combat this, per diem can be used with a fixed cap on total costs or days per year. The method is simple to implement, and the per diem rate can be adjusted for the hospital's case mix. Per diem rates based on case mix may be a way of making a transition to a case-based payment system.

Salary is the dominant payment method whenever providers are direct employees, for example, in the public health sector and in staff-model health maintenance organizations (e.g., Kaiser in California). Paying providers a salary can remove their incentive to over- or underprovide care, but it can also remove incentives for high productivity and quality and may be associated with high absenteeism. Combining salary payments with performance-based financing may help address these negative incentives.

Capitation is an advance payment of a predetermined fixed amount to providers for delivering a defined set of services for each beneficiary registered with the provider for a fixed time period. The payment is not linked to the providers' incurred costs for treating an individual patient or to the volume of services. Therefore, capitation shifts risk to the provider. If the provider's costs are higher than the capitation revenue, the provider suffers a loss. If the provider's costs are less than the capitation revenue, the provider keeps a surplus. There is a clear incentive for the provider to be efficient but also potentially to reduce quality or withhold needed services. If beneficiaries are free to choose their provider, providers have an incentive to attract healthy beneficiaries.

Case-based payment is a fixed payment per "medical-case" category defined by average cost per case, regardless of the actual cost incurred by the provider. This payment method incentivizes providers to reduce inputs and costs per case, for example,

by shortening the length of stay in the hospital or shifting services from inpatient to outpatient. This method also may create an incentive to increase the number of cases by increasing admissions and unnecessary readmissions. The DRGs used by the U.S. Medicare insurance program are an example of case-based payment.

Line-item budget is one that allocates a fixed amount of funds to a provider to cover specific line items (input costs) such as personnel, utilities, medicines, and supplies for a certain period (e.g., a year). This is the most common method for public primary health care systems such as in Bangladesh, the Arab Republic of Egypt, Mozambique, and Vietnam. Line-item budgets are not based on outputs, such as number of visits, but they may be adjusted from year-to-year to reflect changes in outputs.

A *global budget* is a fixed maximum expenditure, set by the payer, for a defined set of health care services.¹⁷ The size of the budget may be set by an assessment of projected health needs or relative to an objective metric, such as a proportion of gross domestic product. For example, provinces in Canada allocate annual budgets to hospitals each year. Global budgets for health are intended to constrain both the level and rate of increase in health care costs by limiting them directly. Facilities or systems that face a global budget have clear incentives to control costs and operate efficiently. However, political pressure may make global budgets difficult to enforce. Also, so long as the liability for exceeding the budget is collective, individual providers may have little incentive to restrain costs.

Performance-based payment explicitly links an incentive payment to the achievement of a predetermined result or output. Also known as Pay for Performance (P4P) and Results-Based Financing, it financially rewards providers for achieving measurable health results. In many developing settings, this has been interpreted as additional payments to providers (on top of salaries and input-based financing) to provide priority services. Also seen are rewards for achieving performance target or improvements in quality. P4P is currently being implemented around the world, though not always as part of a health insurance system (box 6.1).

Box 6.1. Pay for Performance

In the Czech Republic, primary health care providers receive an age-adjusted per capita rate plus a bonus if they keep referrals to specialists and diagnostic tests below a specified limit (Langenbrunner 2009).

In Rwanda, primary care clinics receive a fixed budget plus a bonus payment for specific services. A recent evaluation found a larger impact on services within the provider's control (e.g., tetanus vaccination) and services with higher incentive rates such as HIV/AIDS services. For example, institutional deliveries have the highest payment rate (US\$4.59), leading providers to not only encourage women to deliver in the facility during prenatal visits but also commission community health workers to reach out to pregnant women in the community (Basinga et al. 2010).

Provider contract is the written, legal agreement between a buyer and health care service providers for delivering health care paid by insurance.

Purchasing is the transfer of resources from buyers to service providers in exchange for the delivery of services to beneficiaries.

Third-party administrator (TPA) is a company that provides administrative services to insurance companies or self-funded health plans.

Important Considerations

The methods by which health care providers are selected, engaged, and paid are key to the efficiency of the system as a whole.

Health Insurance Goals

All payment methods create incentives for providers that affect their behavior. The first step in deciding how to select and pay service providers is to review the policy goals of a health insurance scheme—access, quality, revenue, efficiency, administrative simplicity—and select the provider payment method(s) that create incentives that are consistent with scheme goals. For example, if a goal of the health insurance scheme is to increase use of primary health care services, then you may choose to pay providers on a fee-for-service basis for primary health care and use strict global budgets for hospitals. It is important to anticipate how you will evaluate the effects of the selected payment method (see Element 8) so that you can make changes as needed.

Current Service Delivery Market

Provider selection is an important design issue for health insurance because provider behavior is a major determinant of beneficiary satisfaction, as well as medical costs. A country should begin by reviewing the current market structure among health service providers, especially in relation to the target population and the benefits package. Issues to be considered include: Where are people going for services—public or private facilities? What are the cost and quality differences for service provision in the public versus private sector? What is the geographic distribution of providers (public and private)? What is the population's perception of public and private providers?

Policy makers should review the following information on providers to determine if the benefits package is feasible, decide how to select providers to maximize access by target beneficiaries, determine how to pay the providers and how providers at different levels will be linked (referral system), and identify possible efficiencies that can be realized through better provider payment (e.g., downsizing empty hospitals).

- How are providers organized (individual practitioners, networking, institutional providers, and referral systems)?
- Where are they located, especially relative to target populations?
- What are the main types of health facility ownership (public, religious, NGO, private for-profit, cooperative)?
- What are the most common types and sizes of facilities (single private practice, group practice, network, clinic, hospital)?
- At what level of care do different types of service providers operate (primary, secondary, tertiary)?
- To what degree are services integrated? (single services, general health care services, vertical programs)?
- What is the reputation of different health care providers? How are they perceived by consumers?

Data on the following characteristics are often scarce, but extremely useful if available:

- How well do different service providers manage health services?
- What is the quality of service provision?
- How efficient are different providers?

Provider Choice

In areas where there is a mix of providers, a key insurance scheme design decision will be the degree of freedom that beneficiaries will be given to choose their provider. Can they go to a private provider? Can they go directly to a hospital or specialist or do they need to be referred by a primary care physician? This issue affects beneficiary satisfaction (people prefer to choose their doctor) and medical costs (people tend to choose more expensive levels of care if they are not paying for it directly). Greater provider choice may be possible if the insurer can contract private providers and contain costs. To encourage beneficiaries to use primary health care, many insurers require primary care providers to serve as “gatekeepers” who determine the medical necessity for referral to hospitals and specialists.

Within many countries, shortages of health workers and facilities present a difficult challenge. Health care providers may not be available in all geographic areas, or may be disproportionately located in urban areas with very few, if any, in rural areas. If no providers are available, having health insurance is irrelevant. In other situations, the quality of providers may be so poor that people choose not to access services, so again, having health insurance could become irrelevant if the population is uninterested in using poor-quality services. Thailand, for example, invested heavily to improve the coverage and quality of primary health care and district health systems.

Provider Quality

Health insurance can offer a powerful means of improving quality by linking provider payments to quality standards and outputs. There are different ways to make this link. The insurer can:

- Require that providers be accredited in order to be eligible to participate in the insurance scheme.
- Address complaints by beneficiaries regarding provider quality.
- Require that health workers comply with clinical guidelines or continuing education. This is more common if health workers are employed by the insurer, for example, in a national health system, provider-owned insurance scheme (e.g., UNIMED cooperative in Brazil), or health maintenance organization (e.g., Kaiser Permanente in California).
- Regulation and accreditation can be functions of the government, a provider association, or an independent entity recognized by the government to carry out these functions. When these systems do not exist, the insurer can support their introduction and ensure the required compliance is made explicit in contracts. In India, for instance, there is no formal accreditation body for private providers. Therefore, the insurance companies may develop quality standards for participation in the insurance program.

Provider Payment Methods

Payment methods are one of the most sensitive issues for health workers and facilities since payments directly affect their economic interests (Mills 2007). There are many different methods, and they can be used in combination. Some payment rates can be for a single service or a package of services. Note that pay-for-performance can be combined with *all* other payment methods. How do policy makers choose the most appropriate payment method(s)? Table 6.1 presents the characteristics, advantages, and disadvantages of the main provider payment mechanisms.

Table 6.1. Characteristics of Provider Payment Methods

Payment methods	Unit of payment	Financial risk to providers	Incentives for providers on			Administrative complexity
			Quantity of services	Quality of services	Cost control	
Fee-for-service	Per service item	Provider: Low Payer: High	Tendency to overprovide	Facilitates high quality	Low	Medium
Salary	Monthly payment regardless of services rendered	Low	Not large effect on quantity of services	Not large effect on quality of services	High	Easy
Capitation	Per patient	Provider: High Payer: Low	Tendency to underprovide	Possible sacrifice of quality to contain their financial risk	High	Medium
Case payment	Per case of different diagnosis	Moderate	Not large effect on quantity of services; tendency to increase cases	Can facilitate higher quality	Medium	Complex
Line item budget	Budget line	Low	Tendency to underprovide	Quality may be sacrificed to contain costs	Medium	Easy
Global budget	All services	Provider: High Payer: Low	Tendency to underprovide	Quality may be sacrificed to contain costs	High	Medium
Results-based (P4P)	Verified achievement of predetermined targets	High	Can be combined with any of the methods listed above to reward achievement of measurable targets			Complex

Source: Wouters 1998.

Note: All the methods can be combined.

PERFORMANCE-BASED PAYMENTS

Performance-based payment, also known as pay for performance (P4P) and results-based financing, explicitly links an incentive payment to the achievement of a predetermined result or output. It financially rewards providers for achieving measurable health results. In many developing settings, this has been interpreted as additional payments to providers (on top of salaries and input based financing) to provide priority services. Also seen are rewards for achieving performance target or improvements in quality. P4P is currently being implemented around the world, though not always as part of a health insurance system.

Taiwan has turned to P4P to address problems created by the FFS payment system (including “fast food health care” of high volume of services and prescriptions) that led the National Health Insurance Fund to the brink of bankruptcy in 2002. Called “fee-for-outcomes,” the NHIF pays providers based on clinical processes and outcomes for five major diseases as part of a broader effort to contain costs and improve quality (Cheng 2003).

The Philippines Social Insurance system, PhilHealth, increases reimbursement payments received by hospitals that improve scores on “clinical vignettes,” knowledge tests that determine how physicians diagnose and recommend treatment on paper cases. Physicians in hospitals are randomly selected to be tested and if they score higher than in the previous period, the reimbursement rates for the hospital increase.

The National Health Insurer in Belize provides incentives for health centers and hospitals to increase efficiency, improve management and reporting of health information, and increase user satisfaction in addition to capitation payments. To minimize excessive use and control costs, incentives are linked to reaching targets for the average numbers of prescriptions, lab tests, and imaging tests per encounter. Facilities are also rewarded for improved scores on patient satisfaction surveys and for accurate medical records and reporting.

Argentina has incorporated results-based financing into the way federal resources are transferred to provinces as part of a program that provides insurance for poor women and children. Provinces receive national transfers based on the numbers of poor women and children they enroll and how provinces perform on 10 tracer services. Provinces contract providers to serve this poor population and pay them fee-for-service for the list of services included in the benefits package.

Provider Contracts

An insurer may choose to contract-out service provision for many reasons, such as to focus on its role as a purchaser and outsource service delivery (also known as “payer-provider split”), to allow beneficiaries to choose private providers, or to engage desired providers in specific locations or for specific services. Contracts are the written terms and conditions of the agreement between the insurer and the provider to clearly define the services covered; the price/rate to be paid; the payment method, minimum quality, and performance incentives for efficiency and quality; and administrative procedures (forms, billing cycles). The contracting process works best when it reflects a partnership instead of an adversarial relationship that requires legal protection. Insurers should state their policy goals for health insurance clearly and specifically and ask providers how they can supply services to meet these goals. Contracting is discussed further in Element 6.

Operational and Information Constraints

When engaging providers and choosing a provider payment method, it is important for policy makers to consider realistically the extent to which valid information is available on medical costs, utilization rates, case mix, and population and provider characteristics. Some payment methods require extensive information while others do not (table 6.1). Other important considerations include the technical capacity of both the insurance entity (the payer) and the providers to use new forms, enforce/comply with new procedures, and collect accurate data. Some developing countries may not have the data, capacity, and time needed to design the optimal payment system. Therefore, it is preferable to “start simple” so the insurer can avoid delays in providers’ receipt of payments, since delays erode the trust and cooperation needed to work with providers over the long term. Finally, to be affordable, payment and administration systems must have reasonable transaction costs and offer value for money. These and other operational issues are addressed further in Elements 6 and 7.

Country Example: The Impact of Provider Payments on Cost and Quality in China

Lessons from China provide evidence that policy makers implementing health care system reforms should not ignore the powerful effects of provider payments on doctor behavior.¹⁸ After the late 1970s, patients paid village doctors in rural China on a FFS basis by patients. Additionally, the Chinese government had a compensation policy for doctors that allowed them to earn a 15 percent to 25 percent markup on drugs prescribed. Both the FFS provider payments and the drug markup policy created incentives that resulted in undesirable doctor practices such as overprescribing drugs, favoring more expensive drugs, and overproviding inappropriate services with higher profitability margins. In turn, these provider behaviors increased costs and reduced service quality.

Since 2003, the Chinese government has been establishing the New Rural Cooperative Medical Care System across rural China as a means to address the lack of health insurance. While this scheme provides heavy government subsidies for premiums and has achieved remarkable coverage for its rural population, it did not solve the problems inherent to FFS payment or the drug markup policies.

In 2003, a salary-plus-bonus payment method was introduced in Guizhou Province through a subsidized CBHI experiment, Rural Mutual Health Care. The experiment concluded in 2006 with the analysis suggesting that in comparison with the traditional FFS payment method, a mixed payment method was able to reduce the cost of health services. The analysis of a household survey showed a 12 percent reduction in the cost of services at the village level after the payment change. The cost per visit at the village level declined by 20 percent, and the cost of drug prescriptions per visit declined by 25 percent. The drop occurred mainly among nonpoor-health patients, not among poor-health patients, implying provider payment change has more effects on reducing unnecessary services rather than reducing medically necessary care. Guizhou Province showed that appropriate provider payment incentives could be used as a cost-control mechanism to improve the efficiency of resource utilization.

Country Example: Synergy between PBF and CBHI in Rwanda

There are synergies in Rwanda between performance-based financing (PBF) and the CBHI schemes (see Country Example in Element 2).¹⁹ In the PBF model for a health center, performance payments are based on the quantity of outputs achieved conditional on the quality of services delivered. The outputs are measured monthly, quality quarterly, through the use of an elaborate supervisory checklist. Health center staff can increase their performance, and hence their earnings, by increasing the quantity of outputs, the quality of services delivered, or both. When both quantity and quality increase, earnings are highest.

The increase in the number of health visits that result from the removal of financial barriers by CBHI schemes boosts the quantitative indicators for PBF to the financial benefit of the health facility and its staff, thus reducing the concerns of the latter about seeking money from curative care. Financial constraints for accessing health services are reduced for the poor, since a certain number of indigents receive health mutuelle membership cards and thus have easy access to health care. Moreover, easy access to health care also means that beneficiaries seek early care, before the onset of potential complica-

tions, and drugs therefore become more affordable. In addition, direct payments of uninsured patients and copayments from insured patients enable health facilities to secure funds that may be used to satisfy their daily needs. Finally, regular reimbursements from health mutuelles and the PBF mechanism provide a predictable and sustainable resource base that enables health facilities and managers to engage in long-term planning in regard to operations, investments, staff wages and bonuses, and technical assistance.

Steps to Address This Element

- Review your current health insurance scheme and document how providers are being included in the scheme and how they are paid.
 - Identify the geographic distribution of providers participating in the scheme. Are there enough to provide services to the beneficiaries?
 - Identify the standards being used to determine provider participation.
 - Identify the incentives or disincentives that are created by the provider payment method(s) being used.
- Determine how this is affecting overall costs and performance of your health insurance scheme.
- Determine if the current method of provider payment is helping to ensure quality of care and minimize costs.
- If costs are not being minimized or quality care is a challenge, consider your country's current operational and information capacity and discuss how different payment methods could be used to improve quality in your system.
- Determine which payment methods are feasible in the short run and which payment method seems to be most ideal in the longer run.

7. Design Element 6: Organizational Structure

By the end of this session, you will be able to do the following:

- Understand the functions necessary for health insurance administration and the range of possible organizational structures
- Critically review your country's existing institutions to determine how to build on existing strengths and address gaps
- Identify critical organizational characteristics that will help health insurance flourish and ensure accountability.

Key Concepts

Accountability denotes a relationship between a bearer of a right or a legitimate claim (e.g., a consumer or beneficiary or a doctor) and the persons or agencies responsible for fulfilling or respecting that right (e.g., an insurance fund). Accountability mechanisms operate according to three principles:

- *Transparency*, meaning that decisions and actions are taken openly and sufficient information is available so that other agencies and the general public can assess whether the relevant procedures are followed
- *Answerability*, meaning that an agency is required to justify actions and decisions)
- *Controllability*, meaning that an agency faces consequences for its actions and decisions).

Audit refers to an official examination of an organization's accounts to make sure money has been spent correctly, in compliance with rules, regulations, and norms. Audit institutions such as national and regional Auditors General, Audit Offices, State Comptrollers, Ombudsmen, Tribunals de Cuentas, and Cours de Comptes make a vital contribution to good governance by detecting poor management and inappropriate use of public money. Auditing institutions can be considered the taxpayers' independent and professional watchdogs.

Conflict of interest arises when an individual with a formal responsibility to serve the public participates in an activity that jeopardizes his or her professional judgment, objectivity, and independence. Often this activity (such as a private business venture) serves primarily personal interests and can negatively influence the objective exercise of the individual's official duties.

Grievances are formal complaints from consumers or providers demanding formal resolution from the health insurance payer.

Health insurance claims are itemized statements of health care services provided by a hospital, physician's office, or other provider facility, and the provider's charges. Depending on the model of insurance, claims are submitted to the insurer by either the plan member or the provider for payment of the costs incurred. Under some provider payment systems, such as capitation or global budgeting, there are no claims.

Managed care is any system that regulates health care delivery with the aim of controlling costs. Managed care systems typically rely on a primary care physician who acts as a gatekeeper through whom the patient has to go to obtain other health services such as specialty medical care, surgery, or physical therapy.

Organizational structure is a framework within which an organization arranges its lines of responsibility and authority, relationships and communications among members, and their rights and duties. Organizational structure determines the manner and extent to which roles, power, and responsibilities are delegated, controlled, and coordinated and how information flows among entities within the organization and among levels of management. This structure depends on the organization's objectives, culture, and the strategy chosen to achieve the objectives.

Reinsurance—see Element 4.

Important Considerations

The previous design elements of financing, population coverage, benefits package, and provider payment mechanisms referred to many functions and tasks without specifying who was responsible for their implementation. We now turn to this very critical element: Who is going to do all this work? What checks and balances can be established to ensure that the health insurance achieves its policy goals and funds are protected from misuse?

Principles for the Organizational Structure of Health Insurance

A wide variety of factors can influence how health insurance should be organized and managed in your country. While there is no single, optimal organizational structure, there are two guiding principles:

- Build accountability into the organizational structure. Hold entities accountable for honest and effective execution of their roles through control mechanisms such as regulation, checks and balances, clearly defined management functions, and clear and enforceable contracts (Savedoff and Gottret 2008). Accountability also requires institutional capacity in terms of trained personnel and information systems. Some examples of effective approaches to ensuring accountability include:
 - Ghana’s National Health Insurance Authority (NHIA), an autonomous government entity, is overseen by a council that represents the MOH and other stakeholders. The NHIA and all district-level schemes are required to submit annual audits.²⁰
 - The Rwandan law governing RAMA, the health insurance scheme for civil servants, forbids members of the board of directors from having any conflict of interest, e.g., they cannot own a business that would receive funds from RAMA.²¹
 - Argentina’s insurance program for poor women and children, Plan Nacer, used pay-for-performance to strengthen the steering role of the national MOH in a decentralized context. It linked fund transfers to provinces with insurance enrolment, achievement of performance targets, and civil society with access to information to hold the provinces accountable.²²
 - Brazil passed major reforms of the private health insurance sector after decades of weak regulation that allowed companies to abandon the market, leaving consumers without coverage and providers without reimbursement. The National Agency for Supplemental Health (ANS) was established to regulate all private health plans, guarantee their operations, and protect consumers. ANS is accountable to the MOH through an annual management contract.²³
- Build on existing organizations instead of creating entirely new ones for insurance administration. Look for existing capacity and competencies. Establishing new organizations is not only expensive; it can generate competition for funds and political influence, and confusion about roles and responsibilities. Two examples highlight these issues:

Following advice to split the payer and provider functions, Albania created an independent health insurance fund in the 1990s that initially competed with the MOH for funding and the stewardship role.

Rwanda scaled up *mutuelles* by defining clear, complementary roles for the Ministry of Local Administration to implement financial and beneficiary management functions and the MOH to take on provider management functions.

Critical Functions for Health Insurance

Several functions or tasks remain more or less constant across different types of insurance schemes, from small CBHI schemes to national programs.²⁴ Some ways to execute these functions may be more “sophisticated,” faster, and more precise, but also more expensive; there may be simple and less costly ways also.

1. POLICY AND REGULATORY FUNCTIONS (ELEMENTS 1 AND 2)

- Designing the scheme, including financing methods, eligibility criteria, benefits package
- Identifying which body will manage the scheme (e.g., line ministry, semi-autonomous insurance fund, community organization)
- Setting quality standards for providers
- Setting standards for communications with beneficiaries
- Establishing financial regulations to ensure solvency and protect consumers (e.g. reserve requirements, regulations regarding market entry and exit, or grievance procedures for consumers or providers).

Who

- *Public sector insurance.* Typically the legislative and executive branches of the government work together to set broad policies for the insurance scheme(s) regarding financing, population coverage, and management. These broader policy directives are followed by legislation (an example is the Ghana NHI Act²⁵) and regulations that define roles and responsibilities. The insurance scheme authority can then define operational details. Specifics regarding the benefits package, quality standards for providers, beneficiary eligibility, and standards for beneficiary communications may be defined by law (a more rigid but possibly more transparent approach) or by the insurance scheme authority (a more flexible but possibly less transparent approach).
- *Private sector insurance.* A regulatory body can be established by law to enforce regulations to ensure solvency and protect consumers. The body can be public or independent.
- *CBHI/mutuelles.* A network or NGO can provide technical assistance and management services or arrange for reinsurance to support the growth and sustainability of mutuelles. The Union Technique de la Mutualité (UTM) in Mali is an NGO that supports mutuelles and is formally recognized by the government to help implement its national policy for regulating mutuelles.

2. PROVIDER MANAGEMENT (ELEMENT 5)

- Selecting providers
- Promoting quality through payment mechanisms, provider accreditation, quality audits, and other methods
- Negotiating with providers and other entities, including negotiation of the payment system
- Managing compliance with parameters set forth in the contract and budget
- Processing medical claims (if paying fee-for-service), including checking for compliance with fee schedules and benefit regulations, ensuring that patients are entitled to the benefits claimed, and preventing fraud and controlling costs through other steps
- Paying providers on time and according to the agreed payment basis.

Who

- Line ministry (e.g., MOH), district/provincial health authority, a federal or national insurance authority or insurance fund, social security institute, third-party administrator to process medical claims, private insurer or health maintenance organizations (HMOs) (box 7.1).

Box 7.1. Reaching Poor and Rural Communities

Educating and enrolling beneficiaries may be decentralized to an entity that can more easily establish rapport with community members. In Rwanda, health workers (animateurs de santé) visit hut-to-hut. In the Philippines, local government units are paid by the central government to enroll poor families. In Ghana, district health offices are closer to rural communities. Collection may also be worth decentralizing to an entity that is based in the community and already has a mechanism to collect resources from potential beneficiaries, such as microfinance institutions.

3. FINANCIAL MANAGEMENT

- Financial management (in addition to provider payment) and planning to ensure solvency, including cash management to ensure providers are paid on time and interest is earned on any cash balance.
- Performing actuarial analysis to anticipate and avoid potential budget deficits by taking preventive action such as raising premiums, reducing benefits, controlling costs, or revising reinsurance coverage
- Ensuring accurate, transparent financial reporting to all stakeholders; including an annual audit by an independent accounting firm
- Applying, if needed, risk adjustment across multiple insurance funds (e.g., operating a central risk pool or redistributing resources among district, community, or sickness funds to adjust for population differences such as age or income).

Who

- Social security institute, a federal or national insurance authority or insurance fund, private insurer or HMOs.

4. BENEFICIARY COMMUNICATIONS/MARKETING, ENROLMENT, AND REVENUE COLLECTION

- Educating the public about the insurance scheme
- Generating demand for enrolling (in voluntary schemes); reaching out to special populations
- Educating members about entitlement to benefits
- Enrolling eligible beneficiaries
- Collecting premium payments or taxes
- Reviewing and redressing grievances
- Ensuring that employers register their employees and deduct contributions properly.

Who

- Local government authorities, social security institute, a federal or national insurance authority or insurance fund; NGOs; community, or civic organizations; private insurer or HMOs.

5. MONITORING AND INFORMATION SYSTEMS (ELEMENT 8)

- Designing (or purchasing) and running information systems and using the information for all the functions listed above: provider, financial, and customer management

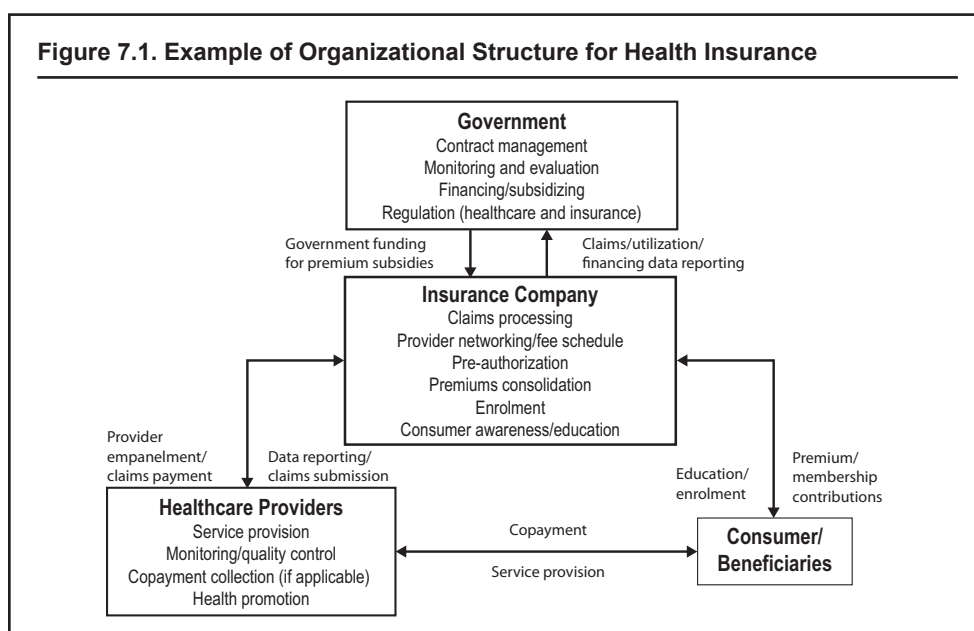
- Capturing data from providers on service use, diagnoses, practice patterns, clinical outcomes
- Supporting analyses of these data for management decisions to improve quality, equity, and efficiency
- Developing systems to support cost control and quality assurance (such as prior authorization and utilization review) and monitoring compliance by providers and beneficiaries with rules for referrals, copayments, waiting periods, and case management.

In addition to the functions listed above that are specific to health insurance, all organizations have to manage these functions:

- Personnel administration, training, and staff development and organization
- Acquisition, management, and maintenance of buildings and equipment that support insurance administration (information technology, furniture, materials, etc.).

Organizational Structure and Size

Organizational structures vary across countries and schemes.²⁶ One national agency may sometimes assume the lead role in the health insurance program, having the mandate to oversee its main functions. For example, Ghana's National Health Insurance Authority (NHIA) was established as an autonomous government entity to implement the national health insurance policy. NHIA leads financial management, monitoring, and regulatory functions, while district-level health offices handle provider and beneficiary functions. The Philippines established an independent insurance company, PhilHealth, in the 1990s that consolidated the former social health insurance (Medicare) and public health systems. Its organizational structure is similar to figure 7.1.



Source: Authors.

Note: This is not intended to prescribe an organizational structure, but rather is presented purely as an example to illustrate how one country has “mapped” out the different functions and stakeholders of health insurance.

In this example, the government is the main overseer of the health insurance company and is responsible for monitoring and evaluating the overall scheme and regulation, while the insurance company interacts directly with providers and consumers.

Alternatively, a private provider assumes the lead role in many countries. For instance, a private hospital or association of doctors might form an HMO that combines the roles of insurer and provider. For example, UNIMED, an association of doctors founded in 1967 in Brazil, has grown into a network of 377 nonprofit physician cooperatives throughout the country that provide HMO-style health insurance to 15 million individuals and 73,000 companies. Each UNIMED cooperative has its own administration and competes in its geographic area with other private health insurers and providers. Uganda also has several provider-based insurance organizations.

The financial performance of a health insurance scheme is influenced by the quality and motivation of its managerial and administrative staff, in addition to the behavior of clinical providers. The number of managerial and administrative staff needed will depend on:

- The overall size of the scheme in terms of population and geographic coverage. Larger schemes achieve economies of scale by spreading fixed administrative costs across more members.
- How the scheme is financed (collecting premiums from the informal sector is more labor intensive than collecting payroll taxes) and pays providers (paying individual claims is more labor intensive than paying salaries (Elements 2 and 5).
- The degree of automation and use of information technologies.

Governance within the Organizational Structure

Without good governance, efforts to expand health insurance could waste resources, destroy public trust, and fail to achieve policy objectives. Governance of health insurance can be defined as accountable and transparent relationships between health insurance stakeholders, such as the government, the beneficiaries, payers, health care providers, and other insurers. Good governance within an insurance scheme can be achieved in the following ways (Savedoff and Gottret 2008):

- *Coherent decision-making structures.* Decision makers are empowered with the authority, tools, and resources to fulfill their responsibilities; and face consequences for their decisions. For instance, if the law makes insurance funds responsible for their own financial sustainability, fund managers must have the authority, tools, and resources to control costs by managing provider payments or the benefits package, or by increasing revenues by increasing the premium rate.
- *Stakeholder participation.* Stakeholder input can be incorporated into decision making and oversight. For example, the council that oversees the Ghana NHIA consists of stakeholders from the government, district officials, private sector, and civil society.
- *Transparency and information.* Information should be accessible to decision makers and to the stakeholders who can hold decision makers accountable. For example, the private insurance regulator in Brazil publishes performance ratings for all private insurers on its Web site for consumers and providers to see. This has led one insurer to pay its contracted hospitals to seek accreditation based on quality improvements.²⁷
- *Supervision and regulation.* Actors must be accountable for their actions and performance. This type of accountability involves consequences for poor performance. For example, in India, a state government paid an insurance company to

enroll the poor population for one year. However, the insurance company failed to educate beneficiaries about their rights to services, so there were few medical claims for the entire year, allowing the insurance company to keep the premium revenue as pure profit. There was a failure of governance due to inadequate supervision and a lack of incentives for the insurer to promote access and use of benefits.

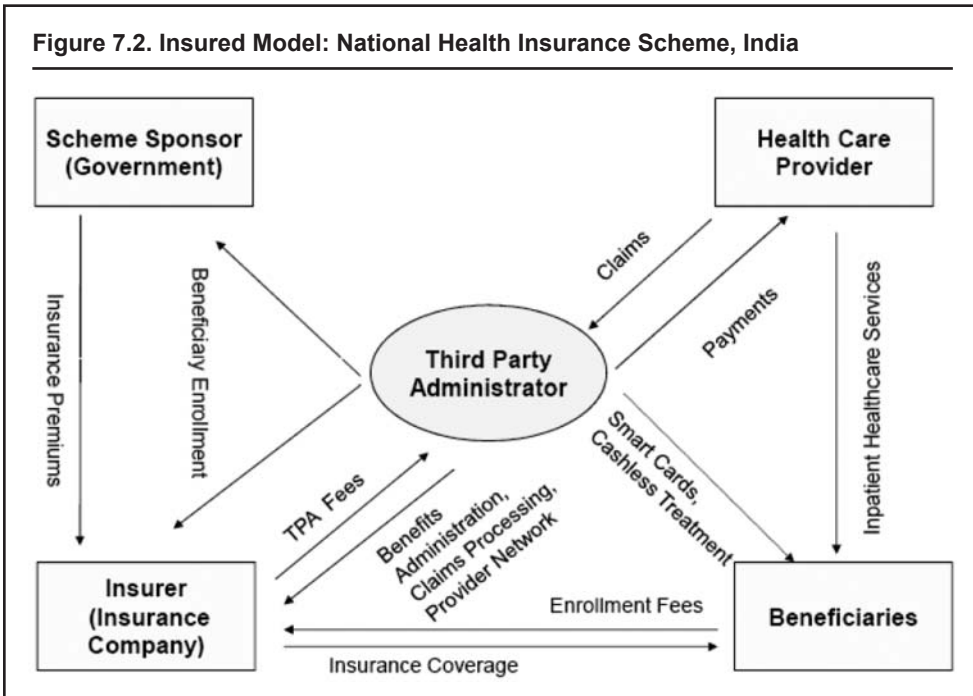
- *Consistency and stability.* An insurance scheme that is a stable institution behaving consistently helps avoid uncertainty around rulemaking and processes over time, and the potential disruptions of political change. This encourages longer-term investments by providers and greater uptake by consumers. For example, private providers are more willing to invest in information technology to improve quality and efficiency if they are confident that the payments they receive from the health insurance system will continue.

Country Example: Many Health Insurance Models and Different Organizational Structures in India

India is a good example of a country with many different models of health insurance, each with a different organizational structure. None of these models is considered a “gold standard,” and each has its benefits and challenges in terms of achieving health insurance objectives. The two highlighted here are the National Health Insurance Scheme (RSBY) and a CBHI program (Yeshasvini).

National Health Insurance Scheme

Figure 7.2 shows the Indian National Health Insurance Scheme, launched in 2007. It aims to protect unorganized sector workers below the poverty line from major health expenses associated with hospitalization. The scheme is sponsored by the central and



Source: Authors.

state governments. The state governments contract with insurance companies to manage financial risk and run the schemes (each state government goes through its own procurement process to select an insurance company).

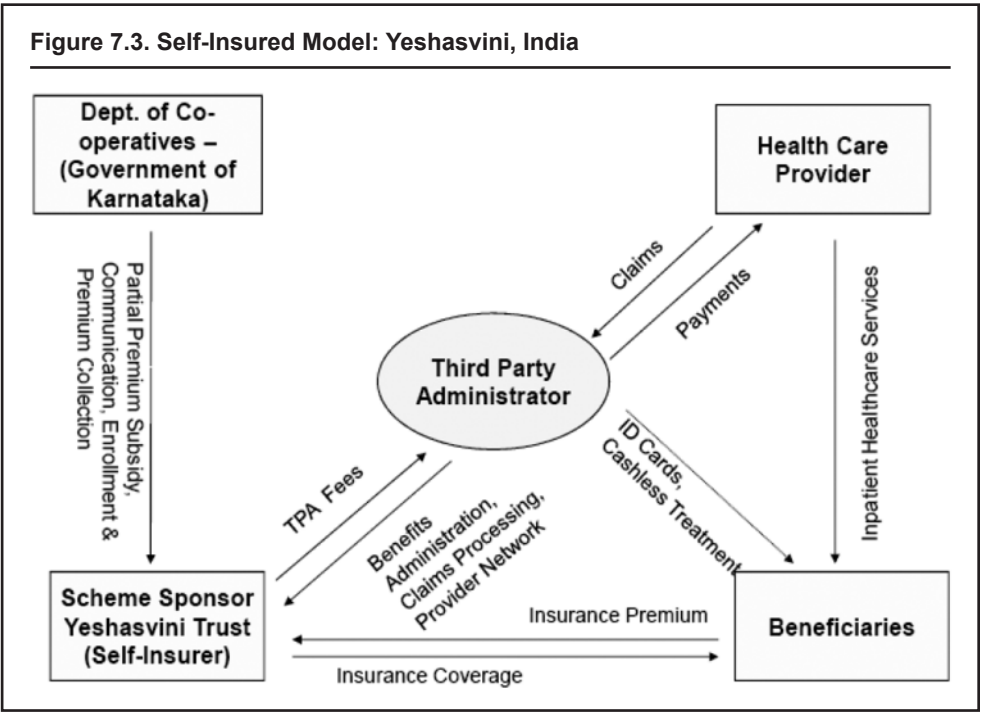
The benefits package is limited to hospitalization and surgical services. Outpatient procedures, pre- and post-hospitalization expenses, and a transport allowance are also included, as are maternity expenses. A provider network consisting mainly of private hospitals may be accessed for no fee by the beneficiaries. The network of hospitals is established by an insurer-appointed TPA, which evaluates them on a set of quality-of-care standards.

The central government contributes significant resources to subsidize premiums. State governments are also responsible for a portion of the premium. Beneficiaries pay a nominal registration fee (Rs.30, or \$0.63) per annum. Additional administrative costs not covered by premiums are borne by the state government.

The administration of the scheme is generally outsourced by the selected insurer to a TPA. The TPA authorizes hospitalizations and surgeries, processes claims, and maintains a register of the members. In states where the insurer does not use a TPA, all the functions of the TPA are performed by the insurer itself.

Community-Based Health Insurance: Yeshasvini

Figure 7.3 shows the self-insured model, the Yeshasvini Cooperative Farmers Health Care Trust launched in 2003 to insure members of the cooperatives in the state of Karnataka. Operations and financing rely on several agencies, including the government of Karnataka for partial premium subsidies, the Karnataka State Cooperative Department for marketing the plan, cooperative societies for enrolling members, cooperative banks



Source: Authors.

to assist in premium collection, and a TPA to administer the scheme. The provider network consists mainly of more than 150 private hospitals throughout the state of Karnataka, which were selected by the TPA after passing a quality-of-care evaluation. The TPA company authorizes surgeries, processes claims, and maintains a register of members.

Yeshasvini has received government subsidies in every year of operation so far (since 2002). With increased premium contributions by beneficiaries, the scheme is expected to eventually become financially viable and self-sustaining.

Steps to Address This Element

- Identify all the stakeholders in your health insurance scheme and identify the managing entity.
- Identify the operational functions of the health insurance scheme and “map” them to the different stakeholders and to the management entity.
- For this step, it may be useful to draw a map or organizational chart to visually show the different stakeholders and their relationship to one another. This step will also likely require stakeholder consultation to determine how the functions will be distributed across the stakeholders.
- If multiple organizational structure options are being considered or discussed, consider the advantages and disadvantages of each one from different perspectives, such as from the perspective of the insurance company, the government, providers, and beneficiaries.
- Discuss how to ensure the right governance structures are in place.
- Does your health care system incorporate the five elements addressed above? Which ones are in place and functioning well? Which ones need improvement?
- How can you facilitate effective governance throughout the organizational structure (e.g., through contracting arrangements, standard operating procedures, or other documentation/processes that instill a culture of transparency and accountability)?

8. Design Element 7: Operationalizing Health Insurance

By the end of this session, you will be able to do the following:

- Understand key operational functions necessary for running a health insurance scheme
- Understand options for performing the functions and key considerations to be made when determining how functions will be performed
- Identify specific operational strengths and weaknesses in your own health insurance scheme and identify specific ways to strengthen the operational system.

Key Concepts

Characteristic targeting is the provision of free or reduced-price benefits to people with certain attributes regardless of income (e.g., certain contagious illnesses, services, or demographic and vulnerable groups, such as children). Under characteristic targeting,

exemptions are automatic within facilities to encourage certain people with certain characteristics to use certain health services.

Cost containment is the practice of moderating the volume, cost, or kinds of health services provided under a health insurance plan.

Direct targeting is the provision of free or reduced-price benefits to people who cannot pay because of low income, often using some form of means testing to determine how much people can afford and recommending that they receive fee waivers. In many African countries, means testing usually occurs at the point of service delivery and rarely before the need for health care arises. Wage and tax records are often unavailable or nonexistent in these countries. Facility administrators thus use their discretion to determine who is unable to pay fees, resulting in informal means testing that relies on income proxies. Because of time constraints on facility administrators and doctors, pressure to waive fees for acquaintances, and unwillingness of staff to grant waivers because their facility needs additional revenue, eligibility for fee waivers may ultimately be determined in a less than systematic manner.

Hold harmless provision is a contract clause that forbids providers to seek compensation from patients if the health plan fails to compensate the providers because of insolvency or for any other reason.

Managing entity takes the “lead” in implementing health insurance. This may be a government entity or a private sector entity, depending on the model of insurance being implemented.

Medical necessity is when a medical service may be justified as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care.

Important Considerations

In previous design elements, the design issues related to health insurance, as well as the organizational structure, were discussed. This section focuses on the operational systems that will help ensure that the health insurance scheme runs smoothly and health insurance objectives are achieved.

In this context, *operational systems* refers to the administrative and management systems, functions, and processes that support the execution of health insurance. Once you determine the critical functions to help the insurance scheme operate (Element 6), it will be necessary to identify what capacity-building is needed so that the actors involved in the health insurance scheme are ready to carry out their new responsibilities. You may also have to plan to educate other stakeholders in your health system about the overarching management structure and operational issues. These steps may be a part of your action plan.

Financial Processes and Management

Financial management is critical to ensure adequacy of financial resources to cover operating costs, keep the health insurance funds in financial equilibrium, and ensure transparency for sound monitoring, management, and viability. This includes maintaining an adequate operating reserve to cover known costs, risks, and unforeseeable short-term risks. When several stakeholders are involved in the implementation of health insurance and potentially multiple sources of income for the scheme (individuals, employers, and government), maintaining the management and integrity of these funds is vital to optimize efficiency and effectiveness.

The financial management system should have the following three main elements:

- A budgeting system to plan for and understand all costs related to the health insurance scheme
- An expenditure tracking system to ensure the proper internal controls to manage the flow of funds
- A cost management system to ensure payments and costs are in line with what is budgeted for financial viability.

BUDGETING SYSTEM

The *budgeting system* refers to the planning and budgeting of expenses related to the health insurance scheme. These expenses include administrative costs, marketing costs, legal costs, and claims or benefits costs. During the planning phases of health insurance, all costs must be estimated and planned for to ensure that the revenues collected are adequate to meet the needs of the insurance scheme.

If the budget reveals a funding gap, the gap must be addressed. This can be done by revising the benefits package, revising premium amounts, reducing administrative costs, and/or taking other actions. These changes are not easy to make and often take considerable time to address because of contractual obligations and other variables.

EXPENDITURE TRACKING SYSTEM

The expenditure tracking system refers to the internal systems in place to manage the flow of funds. This includes robust accounting and cash-management systems, as well as internal controls to receive and document the flow of funds and accounts payable. A well-functioning expenditure tracking system is essential for monitoring the use of funds, detecting fraud, and determining areas for cost containment.

The expenditure tracking system will also likely be the system that pools all incoming financial resources and manages the use of the resources to finance the insurance scheme. For example, all resources collected from the beneficiaries, employers, and government will be pooled and tracked in the expenditure-tracking system.

COST MANAGEMENT

Cost management refers to the mechanisms by which a health insurance scheme can control the resources that are being spent. It is the feedback loop to ensure that expenses stay within the budgets forecasted. Effective cost management is critical to ensure the viability of the health insurance scheme and includes utilization management, expenditure tracking and reporting, and financial adjustments during implementation of the scheme.

Once a health insurance scheme is established, health care utilization rates will likely increase because of moral hazard and the effectively lower cost to health care consumers. Moral hazard is inevitable when a traditionally costly service for which there is unmet need becomes financially accessible. It is very difficult to forecast the amount of moral hazard a new health insurance scheme will experience. That is why it is critical to manage expenses after start-up and maintain the flexibility to revise program benefits and payment arrangements; adjustments will probably have to be made along the way to stay within budget. For example, a scheme may need to institute copayments or coinsurance to help generate revenue and limit utilization, or alter the mode in which providers are paid in order to discourage overprovision of services.

While many stakeholders provide inputs into the financial management system, it is important that the main managing entity of the scheme (the “owner” of the scheme) be responsible for its overall financial management, managing and controlling costs, and making necessary changes to maximize efficiency without compromising quality. When multiple stakeholders are involved in the implementation of the insurance scheme, the managing entity must develop systems for collecting the relevant data on a timely basis. This includes financial data (expenses for services, administration, human resources, etc.), as well as claims and utilization data.

Contract Management

Often, the entity managing the overall health insurance program does not have the skills or capacity to accommodate all health insurance functions. Therefore, to fulfill specific functions, it may be necessary to contract with different actors.

Possible contractual relationships will depend on the scheme’s organizational structure. Examples of contractual relationships include:

- Managing entity may contract with the health insurance company to manage the health risks of the beneficiaries.
- Health insurance company may contract with a TPA to administer claims and register participating providers.
- Health insurance company may contract with providers to deliver services based on quality standards.
- TPA may contract with providers to deliver the services.
- Ministry of Health may contract with providers to deliver services.

For example, in a government-led scheme, the government may decide that it does not want to manage and administer claims or perform other operational functions, so it may contract with a TPA that has the skills to perform these functions and can do so more efficiently. In other circumstances, the government may contract with private providers to deliver covered health services, expanding consumers’ choice of providers and possibly increasing the quality of available care. A group of doctors or a hospital may contract with an insurance company or managed care organization to manage the costs of health care services.

The managing entity may not always be the contract holder. While the government may contract with an insurance company to administer the scheme, the insurance company itself may contract with a TPA or other organization to fulfill some of the functions of administration, such as claims processing or enrolment. Regardless of who the contracting parties are, effectively written contracts must always specify mechanisms to ensure compliance. Contract language should be laid out not just to identify the functional responsibilities that are being transferred, but to also lay out regulations by which the contractor must abide. This will ensure that other stakeholders, particularly beneficiaries, are protected.

To illustrate, take the example of a government that decides to contract with an insurance company to enroll beneficiaries and manage financial risk. The entity writing and managing the contract would want to ensure that the contract includes clear and enforceable guidelines defining:

- Eligibility (who can participate)
- Enrolment (specific guidelines for enrolling, documentation needed from beneficiary for enrolment, contribution requirements, pre-existing condition exclusions, etc., as well as parameters to ensure the insurance company is not simply enrolling the healthiest individuals and deeming the sick ineligible)
- How the insurance policy can be marketed
- Claims payment (how quickly must the insurance company make payment on a claim, pre-authorization requirements, processes to adjudicate the claim, etc.)
- Grievance redress (who will be responsible, how grievances will be handled, how quickly the grievance must be addressed, and so forth).

Another example involves providers. Many managing entities have a clause in contracts with providers that holds the beneficiaries harmless in the event that a service costs more than the agreed-upon reimbursement rate to the provider. For instance, if providers are paid on a capitation or a case-management basis (DRG or other model), but the cost of delivering services to an individual patient exceeds the amount paid to the provider, the provider might expect the beneficiary to cover the extra cost. A “hold harmless” provision prevents the provider from doing so, which can be very important from the beneficiary perspective and can help control total costs.

Contract management becomes increasingly important in more complex health insurance schemes. But even the most basic system will likely contract out some functions, and this can be critical to the success of the scheme and the efficient provision of services.

Possible functions that may be contracted out include:

- Actuarial analysis
- Claims management and processing
- Provision of health care
- Grievance redress
- Risk bearing (sometimes the government is not in a position to bear the risk for health care, so it contracts an insurance company with the necessary capital to bear the risk) or reinsurance
- Beneficiary enrolment and premium collection
- Customer service and marketing/education to beneficiaries.

Marketing and Communication

Communications about the health insurance scheme can serve several purposes. They can be used to educate the population about the scheme to generate demand for enrolling (marketing). They can be used to educate the beneficiaries about what benefits they are entitled to, the process for using the scheme, and their rights within the scheme.

Different stakeholders may take on the function of marketing and communications, depending on their interests. For example, where health insurance schemes are predominantly private, the government may have an incentive to educate beneficiaries about their rights under the schemes. Stakeholders responsible for enrolment may have an incentive to market the health insurance scheme to generate demand for enrolling. Marketing and communication become particularly important in a voluntary scheme if beneficiaries are expected to contribute to the premium. In that case generating demand and persuading people to join becomes a high priority.

It may be necessary to regulate marketing and communication strategies to ensure that beneficiaries understand their rights and coverage. As mentioned in Element 6, a state-led health insurance scheme in India was launched to cover all of the people living below the poverty line. The state government fully subsidized the premium and contracted an insurance company to cover this population. However, the insurance company was required to do very little marketing and communications. After one year of implementation, there were few claims because beneficiaries did not know they were covered by the health insurance program.

Some countries have very strict guidelines for marketing insurance schemes. For example, when the U.S. government introduced the Medicare prescription drug benefit, it put in place strict guidelines for how pharmacies and others could market the benefit to the population. In fact, the Center for Medicare and Medicaid Services contracted with a third party to establish the marketing guidelines and monitor compliance with those guidelines.

Beneficiary Identification and Enrolment

Enrolment of beneficiaries can be a critical bottleneck to the success of a health insurance scheme. The process of enrolment can be administratively expensive and requires different strategies for different types of beneficiaries. Prospective clients must be educated about what the health insurance program is, why it benefits them, and why they should enroll. A mechanism must be established for individuals and families to show they are enrolled, such as through an identification card. Systems must be established to minimize the opportunity for fraud.

Assessing eligibility for the insurance and any subsidies can be very challenging. If a segment of the population receives subsidized coverage or the health insurance program is targeted to a specific segment of the population, the enrolment agency needs to be able to distinguish between those who are eligible for the scheme or subsidy and those who are not. This is critical to the viability of the scheme, as it has great potential for fraud.

Various mechanisms have been developed to identify eligibility for benefits, such as subsidies for the poor, including means testing,²⁸ direct targeting, characteristic targeting, waivers, and exemptions. There is no gold standard for identifying eligible beneficiaries—each mechanism has benefits and drawbacks. For example, if the entire target population is not identified, a health insurance scheme risks not covering everyone it intends to cover. If the targeting mechanism is not strict enough, there is risk of leakage, with too many people receiving a benefit.

If the insurance scheme issues an insurance card to demonstrate membership, other operational considerations need to be made. How will the insurance card be linked to any verifiable information about the beneficiary? How can fraud be minimized and the integrity of the insurance card maintained? How will providers monitor and manage their health delivery system with different insurance schemes, and therefore different insurance cards, to ensure accurate payments? How will insurance cards be printed and distributed, particularly in resource-constrained settings? These are just some of the questions that need to be addressed if an insurance card is used to verify membership in an insurance scheme.

Collection of Financial Contributions

Premium collection is the gathering of financial contributions for participation in the health insurance scheme. It is a critical function that can be difficult to manage in low-resource settings. This issue was addressed to some extent in Element 2, which looked at financing mechanisms. Depending on the insurance model being used, premium contributions can be collected through general taxes (sales, income, real estate, import/export, and other taxes), payroll deductions, or directly from individuals enrolling in the scheme. Tax-based and payroll-based insurance financing depend on a reasonably well-functioning tax system and a substantial formal sector that is willing to contribute.

In countries with a small formal sector (few registered companies) or effective tax system, contributions must be collected directly from beneficiaries. Reaching beneficiaries in dispersed, rural areas presents logistical challenges. For example, this is done door-to-door in rural Rwanda. Many subsistence farmers have cash income only in certain seasons and will not be able to contribute except around harvest time. Families living close to health facilities are far more likely to be willing to pay than those living farther away, although the most remote inhabitants often have the greatest need for health care services.

Typically, it makes sense to collect financial contributions at the same time as enrolment. It may be administratively easier and more cost-effective to collect annually for a one-year subscription to the health insurance scheme, and this may work well in farming communities if contributions can be collected at harvest times when families are most likely to have cash. However, in many resource-poor communities, paying for a year of health insurance in one lump sum may be cost-prohibitive and discourage families from enrolling. Some countries have been able to link health insurance collections to microfinance organizations, allowing families to access credit to cover their health insurance contributions and manage smaller payments on a regular basis. The fact that there is already a mechanism in place for debt payments facilitates this process. Overall, strong communications plans are critical to ensure that the population fully understands what they are paying for.

Claims Administration

Claims administration refers to the process of receiving, reviewing, adjudicating, and paying claims. In many health insurance schemes, the payer is not in a position to manage the claims process, so it is essential that another entity is hired to administer the claims (as addressed above under contract management). Claims administration also varies under different insurance models and provider payment systems.

In insurance schemes in which claims have to be processed, the responsibility for filing claims can fall on either the patient or the provider. In a cashless system, the beneficiary receives a covered service from a provider and does not pay the provider (other than a possible copayment or for items that the scheme does not cover). The provider then submits a claim for that service to the claims administrator for payment. In a reimbursable arrangement, the beneficiary seeks services and pays the provider out-of-pocket. The beneficiary then submits the receipt(s) and a claim for that payment to the claims administrator for reimbursement.

Beneficiaries generally prefer the former (cashless) option because the reimbursement option does not remove the financial barrier to accessing care and requires careful tracking of paperwork. Providers prefer the reimbursable arrangement because it reduces their administrative burden and allows them to be paid immediately (instead of waiting for reimbursement from a third party, which can take time). However, reimbursement is much less feasible in resource-constrained settings where the ability to pay up front and submit a claim to an insurer may present logistical challenges. Weighing the advantages and disadvantages of each option is essential to deciding on and developing your insurance scheme design.

Whichever submission option is selected, the claims administrator must determine if the claim is an eligible expense under the health insurance policy. This is an area of potential fraudulent behavior. Therefore, the claims administrator must have clear guidelines on which claims are allowable. Further, the claims administrator often needs to employ physicians or health care professionals to determine if a service was medically necessary and identify mutually exclusive claims. For example, a claim submitted for payment for both a normal, institutional delivery and for post-abortion care for the same individual should raise a red flag, because one person does not need both services for the pregnancy. The claims administrator must investigate to ensure that the right claim was submitted and that fraudulent activity did not occur. Claims investigation is the process of obtaining all the information necessary to determine the appropriate amount to pay on a given claim.

Depending on the insurance model, the payer and providers generally agree upon a *rate schedule*. This is the set of fees determined by an insurer or payer to be acceptable for a procedure or service, which the physician agrees to accept as payment in full (this takes into consideration any copayments, coinsurance, or deductible that may be applied). Sometimes the rate schedule includes individual rates per each service. In other cases, there are fixed, packaged (or case-based) payment rates (such as DRGs) that “prepackage” services. For example, for a woman delivering by cesarean section, the fixed package rate includes all the services needed to perform that procedure (blood, surgery, anesthesia and other drugs, etc.). Packaged payments require more sophisticated actuarial, accounting, and payment systems but are often preferred for cost-containment purposes.

To minimize the number of claims that must be investigated, some insurers require pre-authorization for each service. The provider must solicit the insurer’s authorization to deliver the service to a beneficiary and will be guaranteed payment, assuming no other questions arise.²⁹

Further, to facilitate claims administration, it is necessary to establish a coding system by which the provider labels health care services with a numerical identifier that that will be recognized by the payer or insurer. There are many different coding systems. Regardless of the system chosen, providers need training in filling out the claims paperwork to ensure accuracy and efficiency.

Information Systems and Monitoring

Continuous monitoring of insurance scheme performance against planned tasks is a key responsibility of the managing entity. Monitoring is critical to every design element discussed above.³⁰ It must be undertaken routinely throughout the life of the scheme. Key

areas for monitoring are both outcomes (i.e., number of individuals enrolled, utilization rates, claims ratios, etc.) and operational processes to ensure the program is running smoothly (Element 8).

A functioning management information system (MIS) is necessary for monitoring and eventually evaluating an insurance program. The MIS consists of a series of tools, procedures, and information flows and can be either manual or electronic depending on the technology available at different levels of the scheme. Some schemes use existing software programs to manage data at both local and central levels. In other schemes, data collection at the local level is done on paper, and the data then must be entered into a software program at the central level. Ideally, one centralized, electronic information system will collect and monitor data from all levels, but this may not be feasible in all settings.

The basic MIS administrative and technical monitoring tools and procedures are as follows:

- Enrolment and financial contribution data
- Coordination of benefits and claims
- Financial monitoring.

A membership database is needed to record information about members and dependents and the payments they have made. An individual or family membership card should be issued with an identification number, and the name, gender, and date of birth of each beneficiary. Other important information, such as beneficiary address, relationship to the household head, and occupation of each beneficiary should be collected and entered in the membership database. Accurate premium payment information should be recorded and made rapidly available to providers. Some basic monitoring tools and documents used in enrolment monitoring are as follows:

- Membership card listing dates of coverage
- Up-to-date registers of members
- Up-to-date registers of premium payment
- Renewal information.

COORDINATION OF BENEFITS AND MONITORING CLAIMS

An MIS that monitors the claims administration process will ensure accurate and timely payment of claims. It will also be able to produce disaggregated data on utilization and cost by age, gender, membership status, disease diagnosis, service type, and provider type that can guide management decision making. Basic tools (forms, guidelines, or procedures) for the claims processing monitoring include the following:

- Payment procedure
- Health care provider invoice register
- Claims register
- Claims listings by provider type
- Utilization and cost of service monitoring sheet
- Average claims cost monitoring sheet.

FINANCIAL MANAGEMENT

Like any business, whether nonprofit or for-profit, insurance schemes use standard financial management systems and practices, such as budgeting, accounting and payroll systems, cash management, and issuance of auditable financial statements (income and expenditure statement and balance sheet).

Steps to Address This Element

Financial Systems

1. Identify the different actors from which you need to collect financial data. For instance:
 - Who collects premiums from beneficiaries? How are this process and the resources managed?
 - Who manages claims processing?
 - What is the process for submitting claims and receiving payment?
 - What is process for paying providers?

Contract Management

1. Determine the current capacities of the managing entity to perform the functions needed to implement health insurance. What functions may need to be contracted out? Why?
2. To which agencies or entities could these specific functions be contracted out? What are the advantages and disadvantages of each choice?

Marketing/Communication

1. Determine the objectives of marketing and communication in your health insurance scheme.
2. Identify which entities will do the marketing and communication.
3. Determine the guidelines that the managing entity would like to define to ensure accuracy of information. What are the standards for educating beneficiaries on health insurance?
4. Determine how beneficiaries will be educated about the health insurance product.

Enrolment and Collection

1. Determine how the current enrolment process is working. From the beneficiaries perspective? From the payer's perspective? How can the enrolment process be improved?
2. Determine who will be responsible for beneficiary enrolment.
3. Determine how eligible beneficiaries will be identified. How will those exempt from payment be identified?
4. Determine how financial contributions will be collected.
5. Determine the steps that will be done to maintain the integrity of funds collected.
6. Decide how health care providers will confirm enrolment to provide benefits.

Claims Administration

1. How is the current claims administration system working/not working? From the beneficiary's perspective? From the provider's perspective? From the payer's perspective?
2. Describe the current or proposed mechanism for administering claims (if applicable).
3. Identify possible entities in the country that have or can develop the capability to serve as a claims administrator.
4. What is the current mode of coding claims (if applicable)? Do providers code effectively? Identify activities that might be necessary to improve the coding and claims administration process.
5. Identify specific options that you have within the country to strengthen the claims administration process.

9. Design Element 8: Monitoring and Evaluation of Health Insurance Schemes

By the end of this session, you will be able to do the following:

- Be familiar with indicators that scheme operators, managers, and evaluators can use to assess the performance of an insurance scheme to evaluate the achievement of its desired objectives
- Understand sources of data for monitoring and evaluating (M&E) of insurance schemes
- Know how to use information to make evidence-based decisions to improve the performance of a health insurance scheme.

Key Concepts

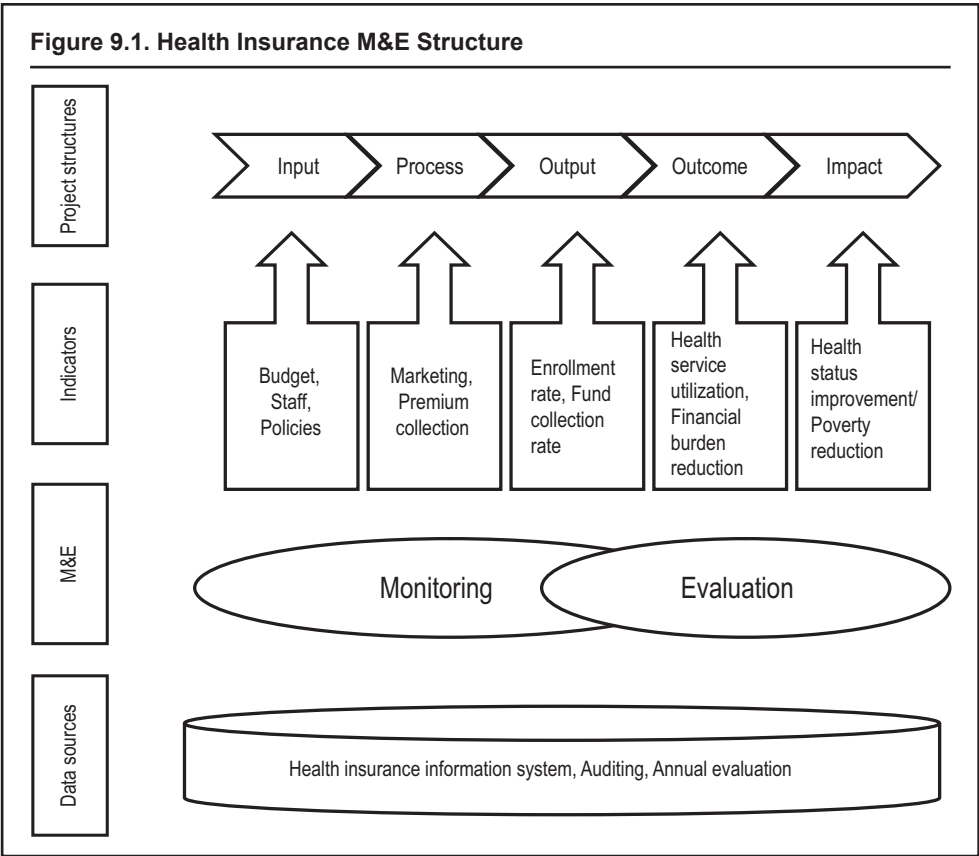
Evaluation is usually a periodic activity. It is the systematic and objective assessment of ongoing or completed activities in terms of their design, implementation, and results. Evaluation determines whether the scheme's objectives have been fully or partially achieved.

Monitoring is an ongoing activity to track progress against planned tasks. Monitoring involves continuously overseeing the proper execution of planned scheme procedures and providing timely information to improve management.

Important Considerations

Overview

M&E are two complementary but separate functions, which often serve distinct purposes. Figure 9.1 displays the structure of an M&E system's major components.



Source: Authors.

Inputs are the resources invested in an activity—here, a health insurance scheme—so that it can deliver its planned activities. Inputs include time, money, human resources, and physical infrastructure.

Processes are the planned and carefully coordinated activities carried out to achieve the outputs and outcomes.

Outputs are the tangible results of the activities.

Outcomes are all the results of the efforts and usually directly benefit the consumers.

Impacts are the broader, longer-term effects resulting from an activity and generally relate to the overall goals. The health insurance scheme contributes to the impacts, but impacts also are affected by other efforts/factors. Impacts can be difficult to assess in the short term.

Monitoring

Monitoring shows how the health insurance scheme is doing on an ongoing basis by tracking inputs and outputs to assess whether the scheme is performing according to plan. A functional MIS is essential for effective monitoring.³¹ Used daily, it facilitates

regular follow-up of activities and finances during implementation. The MIS data can also be used to evaluate the performance of the health insurance scheme by the management team as well as through internal and external audits.

Evaluation

Evaluation shows what the scheme has achieved by assessing its outcomes and impacts. Evaluation is important for ensuring that the scheme is having its intended effects: Is it increasing access to health care? Has coverage of health services increased? Are the right beneficiaries being targeted? Have out-of-pocket expenditures been reduced? Positive evaluation results can increase political buy-in for a scheme as it scales up and consumer demand for enrolment. Negative evaluation results can help policy makers revise scheme design or operations so that desired results are achieved. Evaluation results are also important for determining whether the most cost-effective approaches are being used.

Policy makers should consider from the outset how to evaluate the impact and cost-effectiveness of any proposed insurance scheme. Introducing the scheme in a way that facilitates evaluation will ensure more rapidly available, robust, compelling, and policy-relevant results. This can be done, for instance, by piloting the scheme in a randomly selected set of districts that have been matched to control districts—if a universal insurance scheme is introduced, it is much more difficult to design a robust evaluation retroactively. The results from an evaluation in pilot areas can also be used to modify the scheme's design prior to national scale-up, as well as work out solutions to any operational challenges that arise.

The following evaluation approaches have been used to assess health insurance schemes:

- An experimental evaluation design is used to test the efficacy or effectiveness of health care services or technologies. An experiment involves the random allocation of different interventions (treatments or conditions) to subjects. Due to the general difficulty of randomization, it is rarely used for health system or health insurance evaluation. Two exceptions include an evaluation of a Nicaragua insurance program by the Private Sector Partnerships-One project (Hatt et al. 2009) and the RAND Health Insurance Experiment.³²
- A quasi-experimental evaluation design resembles an experimental evaluation and shares characteristics of evaluations of interventions or treatments. The key difference in this approach is the lack of random assignment.
- Pre-post evaluation design is often used in project evaluation. It compares the selected indicators before and after the intervention to observe the changes that might be attributable to the intervention.
- Case-control comparison evaluation design is used to identify factors that may contribute to the effects by comparing subjects who are in the intervention group (the “cases”) with those who do not participate in the intervention but are otherwise similar (the “controls”).
- Cross-sectional evaluation design involves simultaneous observation of a sample, with groups compared across different independent variables. Cross-sectional design takes a “slice” of its target group and bases its overall finding on the views or behaviors of those targeted, assuming them to be typical of the whole group.

Key Indicators for M&E Systems

Key M&E indicators can be classified into three categories: management performance, financial performance, and impact. Below are examples of key performance indicators with a definition or illustration, and potential sources of the data that can be retrieved from the MIS. Not all relevant performance indicators are listed; the insurance scheme management should develop performance indicators that suit their needs.

MANAGEMENT PERFORMANCE INDICATORS

Management indicators provide information on the vitality of the scheme. Table 9.1 lists examples of basic management performance indicators.

Table 9.1. Management Performance Indicators

Indicators	Illustration/formula	
	Enrolment	Sources
Population coverage rate	Number of total members as percentage of target population	Member register
Membership growth rate	New member registration as percentage of total members during given period	Member register
Adverse selection	Identify adverse selection through a comparison of health status of insured and noninsured populations	Member register Household survey
Government contribution rate to the poor	Percentage of total costs incurred by population in poorest quintile that are subsidized by government, or percentage of poor individuals receiving premium exemptions	Member and premium register
Renewal rate	Number of renewals/number of potential renewals	Member register Renewal sheet
Drop-out rate	Number of drop-outs/number of potential renewals	Member register
Premium collection rate	Amount of premiums received as percentage of premiums due	Member and premium register
Reimbursement		
Average period for payment of providers	Time elapsed between the date of issuance of accurate invoices by providers for payment and the date on which payment is made	Balance sheet Income and expense statement
Average period for reimbursement of members	Time elapsed between the date of members' claims for reimbursement (assuming accurate) and the date on which payment is made.	Balance sheet Income and expense statement
Monthly claims and seasonal change	Set of indicators summarizing service utilization and costs and their trends (these can be disaggregated by type of service).	Health care provider invoices Claim register Claims listings by provider type

Source: Authors.

FINANCIAL PERFORMANCE INDICATORS

Financial indicators are used to evaluate the ability of the insurance scheme to rely on its income to cover expenses over the long term.

Table 9.2 lists examples of financial performance indicators.

IMPACT INDICATORS

Evaluating impacts of a health insurance scheme in terms of equity, efficiency, and effectiveness requires the use of analytical methodology that cannot be fully summarized in this short document. Briefly, a complete picture of the scheme's impact can be obtained by measuring changes in health status, financial risk protection, access to health care, service delivery efficiency, and quality of care. Public satisfaction is another important

Table 9.2. Financial Performance Indicators

Indicators	Illustration/formula	Sources
Solvency ratio	Solvency ratio = Assets/liabilities. Measurement of scheme's financial strength and its ability to pay its obligations in the short, medium, and long term.	Balance sheet
Liquidity ratio	Liquidity ratio = Current assets/current liabilities. Measurement of amount of available cash to meet short-term obligations of insurance scheme.	Balance sheet
Incurred claims ratio	Incurred claims for period given as percentage of earned premiums in same period. This period can be for a fiscal year or any other accounting period.	Income and expense statement
Incurred expense ratio	Incurred expenses for a period are divided by earned premiums in the same period.	Income and expense statement
Ratio of operating costs to income	Operating cost given as a percentage of total income.	Income and expense statement
Ratio of coverage of expenses	Ratio of coverage of expenses = Reserves/Monthly expenses. The accumulated reserves should cover the average claims for 3-6 months.	Income and expense statement

Source: Authors.

dimension. A comprehensive evaluation of an insurance scheme cannot be conducted in a short time frame because some impacts, such as changes in health status, will be observed only in the long term.

1. Examples of indicators by type of impact are listed below:
 - Health status change
 - Self-assessed health status
2. Days of work lost (productivity measure).
 - Financial risk protection
 - Annual out-of-pocket payments, by socioeconomic status and enrolment status
 - Out-of-pocket payments as a percentage of household income, by socioeconomic status and enrolment
 - Percentage of reimbursement of total medical expenditures, by socioeconomic status and enrolment
 - Poverty due to illness, i.e., medical expenditures that cause the household to fall below some poverty line.
3. Public satisfaction
 - Changes in worries or anxiety about becoming ill
 - Satisfaction with health services (including access to and quality of services)
 - Satisfaction with insurance management.
4. Change in access barriers
 - Change in outpatient and inpatient utilization rates
 - Percentage of sick persons reporting that they failed to seek care for financial reasons
 - Percentage of sick persons reporting that they failed to seek care because of distance from health facility
 - Percentage of sick persons reporting that they failed to seek care for technical reasons (such as health facility's lack of drug, equipment, or staff)
 - Preventable hospitalizations.

5. Efficiency gains or losses in service delivery

- Number of drugs used per visit or intravenous injections given per visit for some selected common illness such as flu
- Charges per outpatient visit or charges per inpatient day with same diagnosis or treatment
- Provider cost per day at health centers and district hospitals
- Number of patients treated per practitioner at health facilities
- Charges per visit comparing insured and noninsured.

6. Quality of services

- Prescription/medical record checks
- Practice guidelines.

Country Examples: China and Rwanda

Mutual Health Care in Rural China

An evaluation of a quasi-experimental rural mutual health care (RMHC) insurance in China showed increased use of outpatient care and a reduction of self-treatment and hospital care. In addition, reported health status improved and reported mobility problems, pain, anxiety, and depression were lower after the introduction of the insurance. Overall, there was a reduction in catastrophic health expenditures and a reduction of impoverishment (table 9.3).

Table 9.3. China: Changes in Health Care Utilization, Reported Health Status, and Health Care Expenditure under RMHC

Indicators	Baseline	Impact estimates	Percent change
Utilization			
Visit an outpatient provider in the last 2 weeks (1/0)	0.173	0.120**	69.36
Number of outpatient visits in the last 2 weeks	0.352	0.148**	42.05
Self-treat in the last 2 weeks? (1/0)	0.056	-0.039**	-69.64
Hospitalized in the last year? (1/0)	0.033	-0.011	-33.33
Health Status			
Any of the 5 dimensions with problem	0.49	-0.238**	-48.57
Mobility (1 = problem, 0 = no problem)	0.08	-0.022	-27.50
Self-care	0.05	0.001	2.00
Usual activity	0.11	-0.018	-16.36
Pain/discomfort	0.31	-0.117**	-37.74
Anxiety/depression	0.4	-0.217**	-54.25
Catastrophic Expenditure			
Out-of-pocket health expenditure >10% income net of expenditure	0.285	-0.091**	-31.93
>20%	0.197	-0.054*	-27.41
>30%	0.153	-0.062**	-40.52
Impoverishment			
% below \$1/day: full sample	0.201	-0.023	-11.44
% below \$1/day: lowest 25% income sample	0.621	-0.099*	-15.94

Source: Adapted from Yip, Wang, Gao et al. 2008.

Note: *Significant at 5%; **Significant at 1%.

Mutuelles and Health Financing in Rwanda

Table 9.4 summarizes quantitative evidence of the economic, health system, and political impacts of the mutuelle pilot experiment in Rwanda. These results are derived from statistical analysis of household survey and patient exit data that were built into the quasi-experimental pilot design. The data revealed that several objectives were met, such as for financial access, use, and social inclusion. These data also suggest that there was room for improvement in attaining some objectives.

Table 9.4. Rwanda: Economic Impacts of Financial Access

Income protection	
Out-of-pocket payment per visit	• Nonmembers spent 4 to 12 times more than members, per visit • Poorest members spent 10 times less per episode than poorest nonmembers • Members consumed fewer drugs/visit than nonmembers • Nonmembers spent 5 times more on home and traditional care
Affordability of membership	• Difficulties cited with paying premiums all at once on annual basis • Premiums for single people considered high
Periodicity of premium payment	• Annual
Premium as percentage of household income	• Including the premium payment, (1) lowest-income members spent 20% of household income on health care vs. 5% for nonmembers; (2) highest-income members spent 9% vs. 6% for nonmembers
Health system impacts: Consumer behavior	
<i>Use of health care services</i>	
Annual per capita visits	• 1.1 to 1.6 visits by nonmembers vs. 1 to 3 visits for members
Use of priority outpatient services	• Members use health center and preventive services at a rate several times higher than nonmembers
Use of hospital inpatient services	• Members deliver in health centers, and have caesarian births at a rate several times higher than nonmembers
Political impacts: Equity and social inclusion	
Overall percentage of population enrolled	• 6-10 % of the population of pilot districts
Percentage of members by socioeconomic group	• Percentages of members from lowest and highest socioeconomic-status level were approximately equal. • Wealth/economic level was not significant in determining membership. • Education of household head, family size are significant • Low- and high-income members use services at same rate.
Percentage of members by demographic/health status group	• 25% of member patients were from female-headed households; about equal numbers of women and men were member patients; children and elderly were well represented among members.
Percentage of members who are subsidized	• 3,000 widows and orphans subsidized by church in one pilot district

Source: Diop, Leighton, and Butera 2007.

Steps to Address This Element

- Understand the purposes of conducting health insurance M&E activities: What do you want to find out through evaluation?
- Identify the minimal indicators that you need to have in your M&E system.
- Develop methods to measure these indicators in your M&E system.
- Identify the sources of information for the measurement of these indicators.

- Develop an implementation plan for M&E activities (when, where, what, who, how).
- Recruit qualified people for M&E activities.
- Estimate and allocate appropriate funds for M&E activities.
- Use M&E results for evidence-based decision making.

Notes

1. These are the three classic health financing functions: revenue collection, pooling, and purchasing (WHO 2000).
2. Summarized from Njeru, Arasa, and Nguli. (2004); Carrin, Guy et al., "Health Financing Reform in Kenya: Assessing the Social Health Insurance Proposal," *South African Medical Journal* 97: 130–35. http://findarticles.com/p/articles/mi_6869/is_2_97/ai_n28448859/; accessed Sep 11, 2009.
3. Carrin, Guy et al., "Health Financing Reform in Kenya: Assessing the Social Health Insurance Proposal," *South African Medical Journal* 97: 130–35. http://findarticles.com/p/articles/mi_6869/is_2_97/ai_n28448859/; accessed Sep 11, 2009.
4. <http://www.imf.org/external/pubs/ft/fandd/2005/06/basics.htm>.
5. Definition adapted from: Gottret and Schieber (2006).
6. Carrin, G., O. Doetinchem, J. Kirigia, I. Mathauer, and L. Musango. 2009. "Social Health Insurance: How feasible is its expansion in the African region?" <http://www.iss.nl/DevISSues/Articles/Social-health-insurance-how-feasible-is-its-expansion-in-the-African-region>.
7. http://www.sis.gob.pe/a_produ_minim.html.
8. <http://www.paho.org/english/sha/prflper.htm>.
9. <http://www.sis.gob.pe>.
10. How it performs relative to means testing will depend on the goodness-of-fit and out-of-sample predictive properties of the statistical or calibration model. This can be improved by estimating or calibrating on the poorest half of the population, by specific region, and urban and rural areas separately.
11. Insurance schemes that include such noninsurable risks are technically referred to as prepayment schemes because the beneficiary pays in advance for a service likely to be utilized.
12. See <http://www.who.int/choice/results/en/> and <http://www.dcp2.org/page/main/BrowseInterventions.html>.
13. For an extended discussion of whether health insurance should focus on basic health care services or catastrophic expenditures such as inpatient services and AIDS treatment, see appendix A, this volume, "Health Insurance and Priority Services: How Do We Make It Work?"
14. <http://www.ilo.org/public/english/bureau/inf/magazine/44/socialre.htm>.
15. http://saludpublica.bvsp.org.bo/ass/analisis_situacion/bolivia/perfil-bolivia-2004.pdf.
16. <http://www.sns.gov.bo/direcciones/seguros/seguero/PRESENTACION%20SUMI.pdf>.
17. Mathematica Inc. http://www.mass.gov/Eeohhs2/docs/dhcfp/pc/2009_03_13_Global_Budgets_final-C5.pdf.
18. Summarized from: Zhang et al. Forthcoming.
19. World Bank and MOH ,Rwanda Ministry of Health, "Rwanda: A Country Status Report on Poverty and Health, forthcoming.
20. Government of Ghana, Act 650, http://www.nhis.gov.gh/_Uploads/dbsAttachedFiles/Act650original2.pdf.
21. http://www.moh.gov.rw/index.php?option=com_docman&task=cat_view&gid=59&Itemid=14.
22. http://www.msal.gov.ar/hm/site_viejo/plan_nacer/index.asp.
23. <http://www.ans.gov.br>.
24. Normand, C., and A. Weber. 1994. Normand, Charles, and Axel Weber. 1994. "Social Health Insurance: A Guidebook for Planning." Unpublished. World Health Organization. WHO/SHS/NHP/94.3, <http://whqlibdoc.who.int/publications/50786.pdf>.
25. National Health Insurance Act, http://www.nhis.gov.gh/_Uploads/dbsAttachedFiles/Act650original2.pdf.
26. In the interest of space, we do not attempt to describe all possible organizational structures for the different types of financing mechanisms. However, we do try to introduce critical concepts that must be considered when determining the most appropriate organizational structure.
27. <http://www.ans.gov.br>.
28. See the Peru case in Element 3.
29. Insurance plans need to distinguish planned admission versus accidents. Often unscheduled

services, such as trauma, can be dealt with through negotiated discounts in advance.

30. Monitoring of the insurance scheme is discussed here, separately from evaluation of the scheme and as an aspect of scheme information systems, because it is a critical operational function that must be managed throughout the design and implementation process. Evaluation is addressed in Element 8.

31. The MIS is presented in Element 7.

32. http://www.rand.org/pubs/research_briefs/RB9174/index1.html.

Appendixes

- A. Health Insurance and Priority Services: How to Make It Work?**
- B. Sample Benefits Packages**
- C. Current and Future Benefits Package**
- D. Additional Reading**

Appendix A. Health Insurance and Priority Services: How Do We Make It Work?

Increasing access to and use of priority¹ and preventive health care services is critical to improve health outcomes and reach the Millennium Development Goals (MDGs). For example, high fertility leads to increased risk of maternal mortality and poverty, and high maternal mortality leads to increased risk of infant mortality. In most countries, there is a political desire to improve access to and use of priority services to reduce fertility, improve maternal health outcomes, and improve child health outcomes. Financing these priority and preventive health care services, however, often proves difficult because of the limited tax revenues, inefficient use of funds, and poverty.

National Health Accounts (NHA) data show that household out-of-pocket spending for priority services is much higher than governments or donors realize. Though not the only factor that influences the use of these essential services, the cost of health care, particularly out-of-pocket expenses, does constitute a significant barrier to accessing the services, particularly among the poor. This barrier then affects the demand for and use of services. High out-of-pocket expenses also make people financially vulnerable to catastrophic events and increasing poverty.

Health insurance mechanisms pool risks for health care costs and have the potential to reduce or eliminate point-of-service costs. They are increasingly being created and expanded in developing countries to help achieve a variety of objectives. Some countries implement health insurance to reduce the risk of people's falling into poverty from high out-of-pocket health care costs. Others want to protect and improve health by increasing use of services, including priority services.

The purpose of this brief is to discuss the concepts of health insurance, the practice of designing and implementing health insurance, and whether priority services "fit" within a health insurance scheme. It also provides examples of countries that have tried to include priority services in the insurance benefits package and discusses critical success factors that have affected the outcomes of these schemes.

The country examples that are highlighted demonstrate that under the right circumstances, and if done correctly, health insurance programs can successfully cover priority health care services and can effect change in use of these services, in turn improving the health status of covered population.

Health Insurance Risks: What Are They?

Health insurance is the collection and management of financial resources so that large, unpredictable, and unforeseeable events or financial risks of each individual become predictable at the group level and are distributed across a diverse group. In other words, certain health events that are unknown and generate unpredictable expenditure are the best fit as insurance-targeted goods and services and qualify as "insurable risks" and are

1. Priority services are considered the most important and critical services that target specific health conditions or a specific target group. Priority services include: maternal and child health, reproductive health/family planning, and communicable disease prevention. They also include preventive services, or services that are intended to prevent a health condition from escalating into a catastrophic case. *Catastrophic* is defined as a health care cost that is severe enough to affect a person's financial stability and/or socioeconomic status.

therefore “insurable.” Health services that fall under this definition generally include catastrophic care, or high-cost care that is needed because of an unforeseen occurrence.

Substantial empirical evidence exists regarding the economic and social impacts of adverse health shocks and the need for policies to provide everyone, but particularly the poor, with financial protection against large, unpredictable costs (Wagstaff 2005). Therefore, the attention that health insurance has received in recent years in developing countries is understood and necessary.

Less empirically clear is the effect on health shocks of policies to provide everyone with financial protection against known, high-frequency, health care services, such as priority health care services. This is an important consideration, as many countries introduce health insurance not only to reduce the risk of catastrophic health care costs, but also to improve population health through increasing use of health care services across the board, including priority health care services.

Should Priority Services Be Insured?

Given the above, what does this mean for priority health care services, such as reproductive, maternal, and child health? Technically speaking and according to the definition, most priority health care services (such as family planning, prenatal care, and immunizations) do not fit under the pure definition of health insurance mainly due to their predictability.

However, for many countries, the objective of establishing health insurance includes protecting health and reducing the risk of requiring catastrophic, inpatient care. To achieve these objectives, it may necessary to consider including these “noninsurable” services within the benefits package. While many people refer to an expanded benefits package that includes known, frequent, low-cost services as health insurance, it is in fact a form of “prepayment” scheme. Prepayment schemes have benefits packages that include what is traditionally considered noninsurable services, such as priority services. Prepayment schemes may also include an insurance portion, which covers catastrophic, insurable risks. Many people use the term “health insurance” to refer to both true health insurance schemes and prepayment schemes.

If priority services are included, careful consideration to some key issues is required.² The determination of a benefits package will depend on the structure of revenues (sources of funds), payment mechanisms (e.g., capitation, fee schedules), and delivery structure (e.g., gatekeepers, primary care groups, utilization review) that may be implemented as part of the insurance scheme. All of these characteristics affect the cost of the expanded benefits package, as well as the feasibility and ease with which the expanded benefits package can be executed.

2. Calling a scheme that includes noninsurance risks “insurance” may be somewhat of a misnomer given the definition of insurance. Many schemes are in fact social security schemes, or simply prepayment schemes. They may have an “insurance” component to them, which pools risks to cover unpredicted health costs. Further, it is possible to create a benefits package that is purely primary health care, to include preventive care. The drawback to this approach is that it does not serve the basic function of health insurance, to protect individuals from unexpected, unpredictable high costs associated with disease or injury by spreading the risk for those costs across a large group of individuals.

There are advantages and disadvantages to including priority services in the benefits package. Operationally, it is much more difficult to include low-cost, high-frequency services since these will require a more extensive review and billing process, a much more frequent information exchange, and much higher administrative costs. Therefore, expanding a benefits package to include priority services may require a phased approach to ensure that the system operationally can handle the increased capacity. As the operation of insurance becomes more efficient and the sources of funding are more closely aligned with the expected system costs, a more generous benefits package may become possible.

Despite some of these operational considerations, there are many reasons to believe a relationship exists between health insurance enrolment and the use of priority health care services. The first is that health insurance can increase the service use. Health insurance can reduce financial barriers to accessing health care services because it reduces the point-of-service costs, which are often too high for individuals to cover when needed. Long-term methods of family planning, considered priority services, have high up-front costs, which can limit access to care (Stover and Heaton 1999). Because insurance is a prepayment scheme³ that reduces or eliminates costs at the time of service, people are more inclined to utilize health services than they would be if they had to pay at the time of care (Eklund and Stavem 1990; Schneider, Diop, and Bucyana 2000).

Second, health insurance can make services more available. If priority services are not covered by the insurance scheme, and the individual is less willing and less able to pay, providers will be less willing to provide these priority services. Insurance plans have the potential to assist governments and donors in organizing the funds, purchasing these services from providers, and ensuring the quality of services. Because the insurance scheme pays for these services, they will be more available to the enrolled population.

Third, if preventive measures are taken (as is the case with priority health care services), the long-term costs of health care should go down. For example, if a woman can prevent an unplanned pregnancy—and thus avoid the cost of abortion, the costs of delivery, the infant and child costs, and the longer term societal costs—the overall cost could go down. Further, if antenatal care is provided to pregnant women, the risks and costs associated with complicated delivery and emergency care are greatly reduced.

There are many reasons to justify the inclusion of priority services in a benefits package. Many countries have incorporated priority services in the benefits package and have valuable lessons that can be shared with others that are going down that path as well.

Experiences of Including Priority Health Services in Benefits Package

The case studies below present experiences from countries that have incorporated priority health care services in their health insurance/prepayment benefits package. Each country has included priority services with different objectives in mind. Some of them did so expressly to increase use of priority services to help achieve the MDGs. In other countries, the objective was to offer comprehensive health care to the population and address equity and accessibility issues.

3. Prepayment refers to insurance members paying for average expected costs (among the risk pool) in advance, relieving them of uncertainty and ensuring compensation should a health risk occur (Gottret and Scheiber 2006).

Some countries have had great success achieving their objectives, whether in increasing use or creating a more equitable health financing scheme. Other countries have not had the same success.

Each country case provides some background on the insurance/prepayment scheme, as well as a brief presentation of the priority services included in the benefits package. The impacts of including those services, in light of the original objectives of the scheme, are also discussed. After the case examples, key lessons are presented to help other countries incorporate priority services into their insurance/prepayment packages. Critical success factors that may have contributed to the success of the schemes in achieving the intended objectives are also highlighted.

Ghana

Prior to 2003, Ghana financed its health care through tax revenues and user fees paid by patients at the time of service. There were some exemptions to the user fees, but experience showed that user fees substantially decreased access to health care services, particularly among the poor. Evaluations determined that the exemptions were being applied unevenly and that the poor still faced financial barriers to obtaining needed services.

To help overcome the financial barriers, community-based health insurance programs (CBHI) began appearing throughout the country and increased substantially between 2001 and 2003 (47 CBHI programs in 2001 and 168 in 2003). While CBHIs covered only about 1 percent of the population in 2003, it was clear there was a need and demand for a formal health-financing mechanism to spread the costs of health care across a group of people.

This demand prompted the government to explore abolishing user fees and implementing a national health insurance scheme. In 2003, the government began introducing policies to exempt women from delivery fees in public, private, and mission facilities. Along with this change, the government passed the National Health Insurance Act, which aimed to provide universal coverage to all Ghanaians within five years. The scheme was to be nationally mandated in all districts. By 2007, approximately 42 percent of the population was covered by the insurance scheme.

BENEFITS PACKAGE

The National Health Insurance Scheme (NHIS) now covers basic health care services, including outpatient consultations, essential drugs, inpatient care and shared accommodation, maternity care (normal and cesarean), eye care, dental care, and emergency care.

Initially, certain public health services were excluded from the benefits package because they were considered “essential public goods” and were provided free by the government. These services include family planning and immunizations.⁴ In July 2008, all pregnant women became eligible and exempt from premium contributions. In September 2008, all children under 18 became eligible regardless of whether their parents were enrolled. Women are entitled to free prenatal care, free delivery care (both normal and cesarean delivery), as well as free care for their babies up to one year of age. Women are able to also receive family planning services at the same clinic, but must pay out-of-pocket.

4. In reality, constrained budgets are failing to cover all the operational costs of facilities, so nearly all public and private facilities charge fees for family planning products.

Recently, the government and other stakeholders have considered the costs of including family planning in the benefits package, including long-term and permanent family planning methods as well as injectables. A cost-benefit study found that, if family planning were covered in 2009, by 2011 NHIS would save almost \$11 million that year alone and up to \$17 million by 2017 (cost savings would come from decreased fertility, averted births, and lower costs associated with birth [Smith and Fairbanks 2008]).

OUTCOMES/IMPACT

An evaluation of NHIS was done in two of the districts, Nkoranza and Offinso.⁵ It was found that the proportion of women with delivery in the past 12 months who were insured at time of delivery increased from 30 percent in 2004 (baseline) to 45 percent in 2007. This in essence means that the number of people covered by insurance increased between the two years. Further analysis found that women of reproductive age from wealthier households enrolled in NHIS at higher rates than did women from poorer households: 16 percent of women from the poorest quintile were enrolled, compared with 48 percent of women from the richest quintile.

Despite an expanded enrolment in the scheme, the analysis showed no significant change in the proportion of women receiving prenatal care between baseline and end-line, indicating that NHIS did not increase use of prenatal care. Prenatal care in Ghana was already high at baseline (96 percent in 2004), which may be one of the reasons for the lack of change.

The proportion of women delivering in a facility also did not change significantly during the first few years of the insurance scheme (from 54.5 percent to 54.9 percent). Further, multivariate analysis (controlling for socioeconomic characteristics known to be associated with maternal health-seeking behavior) suggests that the NHIS is not associated with change in the likelihood that a woman delivered in a health facility. Also the distribution of deliveries that took place in the private, public, or mission facilities did not change.

Although reducing financial barriers to care through the NHIS does not appear to have had an impact on the use of maternity care in this case, it was found that, since the initiation of NHIS, out-of-pocket expenditures decreased by approximately one-third, a significant change in household expenditures. Further, average expenditures on prenatal care also declined (not statistically significant). Also, the proportion of women who did not have to pay anything for their prenatal care increased from 8 percent to 43 percent.

Colombia

The government of Colombia transformed its health care system in 1993 with the enactment of a law that provided for a transition from a supply-based health care model to a managed care insurance model. To facilitate universal health care for all Colombians, two health insurance schemes evolved, a contributory insurance scheme and a subsidized insurance scheme.⁵

5. Prior to the reforms, the general Social Security System (ISS) guaranteed universal emergency care and general health services including family planning, prenatal, and delivery care services for workers, their spouses, and children under one year of age.

The former system, called the Health Promotion Company (EPS), covers those with the ability to contribute. It is financed through employer and employee contributions through a tax of 12 percent of income. The scheme includes the formal and informal sector: anyone who chooses to participate may, as long as they can pay the contribution. One-twelfth of these funds are used to finance the subsidized scheme, called the Subsidized System Administrator (ARS). ARS funding is supplemented by the decentralized political entities, such as departments (responsible for hospital services), municipalities (responsible for primary care), and Ministry of Health. Members of the ARS also contribute resources on a sliding scale based on income. Some beneficiaries contribute nothing.

Members of ARS are generally poorer than EPS members. Anyone, however, can join EPS, as long as they are able to pay to participate. EPS enrolment entitles members to a wider range of services at notionally higher quality. The ARS benefits package is more limited, but still covers prevention and primary health care (including family planning and maternal health services).

BENEFITS

In addition to catastrophic care, both EPS and ARS provide coverage for family planning services and maternity care, including prenatal services, delivery and puerperal care, and nutritional assistance to mothers. Coverage is provided for everyone including pregnant and nursing women and their children up to one year of age (even the poor who may not be contributing to the scheme).

EPS members receive services in "higher quality" government facilities and private facilities. ARS members receive services in the government-owned public facilities.

OUTCOMES/IMPACT

Generally speaking, the introduction of universal health insurance appears to have contributed positively to the improvement of reproductive health services. For example, there were increases in physician-assisted deliveries (66 percent), deliveries in health facilities (18 percent) and use of prenatal care among rural women (49 percent) (all from Demographic and Health Survey data: 1986, 1990, 1995, 2000).

In general, there was not a large variation in the proportion of women who used modern family planning methods⁶ across the two insurance types. The women enrolled in EPS were slightly more likely to use modern methods of family planning than those without insurance, but the difference was nominal. One note is that in Colombia, access to high-quality, inexpensive family planning services already existed from the NGO, Profamilia. This may explain why insurance does not seem to have played a role in increasing family planning use. ARS did not seem to have an effect on modern family planning use.

Women who were EPS members were more likely to receive prenatal care and give birth in a facility than those without insurance. Those with ARS were only slightly more likely to receive prenatal care and deliver in a facility. This may be the result of ARS members' having access only to public facilities, rather than the higher-quality private facilities.

6. Modern methods are those that require supplies or clinical services. They include: contraceptive sterilization, intrauterine devices, hormonal methods, oral pills, condoms, and vaginal barrier methods.

Bolivia

Bolivia began implementing a public health insurance scheme in 1996 with what started as the National Maternal and Child Insurance program (*Seguro Nacional de Maternidad y Niñez, SMNM*).⁷ To counter Bolivia high maternal and infant mortality, the insurance program was to increase coverage of health care services for women and children, improve service quality and equity, and increase efficiency and effectiveness of the health care delivery system (Maceira 2007).

Shortly after the launch of the SMNM, the scheme was expanded to cover more services and renamed the Basic Health Insurance Scheme (*Seguro Básico de Salud, SBS*). In 2002, the government further expanded the package of benefits and services. The name was then changed to the Universal Mother and Child Insurance Scheme (*Seguro Universal Materno Infantil, SUMI*).

Technically, SUMI is not an insurance scheme, but rather a health financing mechanism that offers a package of free services available to everyone through all public health service providers throughout the country. Patients register at first contact and receive an identification card. All types of providers are able to participate, including faith-based organizations and other types of NGO.

SUMI pools resources from three different sources: municipality (local government), departments, and national government. Ten percent of local revenue (from municipalities) is allocated to pay for SUMI services. Departmental funds pay for health service personnel. The National Solidarity Fund (financed through debt relief) helps strengthen SUMI financing. If the municipality has funds remaining, they are used for social investments, including infrastructure or other activities related to maternal and child health. In 2006, municipalities received \$22 million for payment of SUMI services. This national policy commitment and financial support have ensured the economic sustainability of the program.

BENEFITS

The focus of SUMI is to increase access to services among the more vulnerable population groups, specifically women and children. As such, the services offered are in line with maternal, reproductive, and child health care.

Initially, SMNM included 32 health issues, including maternity care (cesarean and normal deliveries) and pediatric care for diarrhea and respiratory infections. Under SBS, the benefits package was expanded to cover 92 health issues. In addition to the previous 32 issues, SBS covered obstetric emergency transport, newborn care, child nutrition, development screening, vaccination, and care for infectious diseases other than diarrhea and pneumonia, such as sepsis and meningitis (Bohrt and Holst 2002).

When SBS was expanded to SUMI, the coverage increased to 547 health issues, including those that affect pregnant women (starting at beginning of pregnancy to six months after childbirth and covering children from birth to 5 years of age). In 2006, services were further expanded to incorporate 27 additional sexual and reproductive health service packages, including family planning and cervical cancer screening, protecting women up to 60 years of age.

7. Much of the data in this case are from Pooley, Ramirez, and de Hilari (2008).

OUTCOMES/IMPACT

Through SUMI, Bolivia was able to meet some tremendous targets set by the government in cooperation with the World Bank (which helped finance the management of the scheme). By 2007, they had met four of the eight projected indicators: Early neonatal mortality reduction, uptake of iron supplementation, and coverage of pneumonia cases and immunizations.

Further coverage of four prenatal care visits and institutional delivery was greatly improved under SUMI (compared with two previous programs). However, it was SNMN that saw the greatest improvement in these indicators. Since then, the indicators have steadily improved and are now reaching a plateau. So far, there are no data to show the impact of the sexual and reproductive health services that were added in 2007.

Although access to services increased, they did not extend to the poorest segments of the population, especially in rural areas. Only one-third of pregnant women from rural areas completed four prenatal care visits, while 70 percent of urban women did. Further, neonatal coverage (well-baby check-up before one month of life) was only 6 percent in rural areas, but close to 94 percent in urban areas. However, the coverage of under five years (measured as one doctor's visit per year) was 10 percent higher in rural areas than in urban areas (56 percent vs. 44 percent) (Pooley et al. 2008). There was no change in cesarean rates rural areas since the beginning of the scheme.

Economic barriers have been mitigated through SUMI, but challenges continue in equity and social exclusion because of geographic inaccessibility, insufficient human and technical resources mostly in rural areas, and cultural aspects of community and providers.

Critical Success Factors for Including Priority Services in Benefits Packages

Health insurance/prepayment schemes can be effective in reducing financial barriers to accessing priority services, such as family planning, immunizations, and maternal and child health services. However, reducing financial barriers to accessing priority services does not automatically translate directly into increased use of those services or more equitable access to them. Some experiences demonstrate success in increasing use and access to priority services through health insurance/prepayment, although often equity issues persisted.

What is important to gain from these experiences, however, are the processes by which the country was able to include the priority services, as well as some of the lessons learned that contributed to the success of the schemes to improve utilization and health outcomes. With each of these examples, there are lessons learned of how to facilitate successful implementation of an expanded health insurance/prepayment package that includes priority services.

The following are some "critical success factors" for including priority services in health insurance/prepayment:

- Factors that encouraged countries to include priority services in the benefits package
- Factors that contributed to whether inclusion of priority services affected uptake or use of services
- Factors that contributed to the impacts realized by including priority services in the benefits package.

Design and Type of Insurance/Prepayment

The type of health insurance/prepayment model applied has implications for coverage with priority health services. Among other things, the source of funding affects the decision-making process for choosing in the benefits to be included in the insurance/prepayment scheme. For example, with a privately financed insurance/prepayment model, it is important that the payers (employees in an employer-based scheme, communities in a microinsurance scheme) demand priority services and be willing to pay for them if those services are included in the benefits package. For publicly funded programs and social insurance programs, the policy makers must be convinced of the value of adding priority services to the benefits package design and motivated to take on the necessary actions to make it happen.

The types of providers who participate in the model also make a difference in whether priority services coverage is feasible or not. The closer the providers are to the covered population and the more service delivery points there are, the greater the impact will be on access to services. The type of provider payment mechanism also makes a difference and can help facilitate the provision of priority services, such as family planning. For example, in Nigeria, a project funded by USAID formed a strategy to expand and improve the delivery of family planning and reproductive health products and services in the private health sector. The introduction of the National Health Insurance Scheme (NHIS) presented an opportunity to address the needs of private providers participating in the scheme and to encourage them to promote the use of family planning and other priority services included in the scheme. The NHIS used a preferred provider model, in which beneficiaries choose their primary care providers who receive a fixed monthly capitation fee for basic services. This gives providers an incentive to keep their patients healthy and to manage their costs effectively.

Box A.1. Including Priority Services in Health Insurance: The Case of Family Planning

Globally, an estimated 210 million pregnancies occur each year. Of these, 60 million end in abortion or with the death of the mother or baby. More than 500,000 maternal deaths and 4 million neonatal deaths occur annually. More than 54 million women suffer diseases or complications due to pregnancy and childbirth. The need for family planning (FP) is of great importance, but it is not being met around the world. In sub-Saharan Africa, an estimated 19.4 percent of women would like to avoid becoming pregnant but are not using contraception (Levine et al. 2006).

Given these staggering statistics, it is important to increase access to and use of FP services. One way is through health insurance / prepayment mechanisms.

Why include FP in insurance benefits package? It makes sense for the following reasons:

- **Cost-effectiveness.** FP is cost-effective (Levine et al. 2006; Stover, et al. 1996; Mauldin and Miller 1994; Pritchett 1994; Hughes and McGuire 1996). An averted pregnancy can prevent health care costs associated with other conditions or ailments. Inclusion of FP in insurance is important from a cost perspective because averting a birth also reduces future fertility, and DALYs saved can exceed the gains possible from the health benefits to just one generation.

(Box continues on next page)

Box A.1 (continued)

- *Improvement of knowledge and social acceptance.* Inclusion of FP in health insurance can provide a platform for educating and counseling beneficiaries on the use of FP. Its inclusion in health insurance benefits packages can also improve social acceptance of FP.^a
- *Fulfillment of beneficiaries' health needs.* When a health insurance benefits package is based on beneficiary needs, there is a greater chance for the success of the insurance scheme because of beneficiary compliance and increased demand and renewal rates of the insurance policy (in voluntary schemes). The high rate of unmet need for FP is a red flag that barriers to FP access exist. Inclusion of FP, a desired product, could increase the attractiveness of health insurance, making the insurance scheme more feasible to implement and sustain.
- *Promotion of merit good.* Although FP services are consumed by private individuals, the services have profound externalities (external benefits and/or costs) and are therefore often considered merit goods. These are the health needs defined by the experts and society that everyone should have regardless of willingness and ability to pay. Putting these types of services into a health insurance benefits package can ensure their availability and promote their use.
- *Efficiency of delivery.* If the FP services are included in the health insurance package, they can be organized and delivered through the existing health insurance provider networks, which will make the service delivery more efficient.

Cost-Benefit Analysis of Family Planning

Banking on Health^a conducted a cost-benefit analysis of adding coverage of long-term and permanent FP methods and injectable contraceptives to the Ghana NHIS benefits package. The analysis revealed that including FP would cause a decrease in fertility and would avert births that otherwise would have cost NHIS considerable expenditures. According to the assumptions, if FP is covered in 2009, by 2011 NHIS will realize almost \$111 million in net savings in that year alone.

Source: Private Sector Partnerships (PSP)-One. 2008. *Banking on Health Explores Adding Family Planning Services to the Ghana National Health Insurance Scheme*. <http://psp-one.com/content/announcements/detail/5215/>.

Specific Complexities of Including FP in Health Insurance

- *Politics.* The politics of FP has been contentious for decades; this has affected its sustainability and funding. Health insurance is not immune to FP politics. Prioritizing services to be included in health insurance can come under great scrutiny, which opens the door for political adversaries to voice opinions of whether to include (and promote) FP through health insurance.
- *Funding gaps.* Because FP is considered a merit good, which is often defined by need rather than by demand, consumers' willingness to pay may not be sufficient to cover the services defined in the benefits package. If insurance relies on the premium contribution from the enrollee, funding gaps may stand in the way of including FP. Further, many countries omit FP as a benefit in health insurance, indicating that the public health care system will provide it free of charge to all in need. For example, in Ghana, FP was determined to be an "essential public good" and would be offered "free" through the Ghana Health Service. However, because constrained budgets failed to cover all basic operational costs at facility level, almost every public facility and all private facilities charged fees for FP products (PSP-One 2008).
- *Opportunities to include FP in health insurance benefits packages.* Despite the difficulties, there are very important reasons to include FP in health insurance benefits packages. Below we present a few ways in which stakeholders can help get FP covered:

(Box continues on next page)

Box A.1 (continued)

- *Service bundling.* FP does not have to be a stand-alone service that is provided to all beneficiaries. For example, to alleviate some of the political challenges that can surface, some countries have bundled FP services into other packages of services, such as postpartum services. Preventing pregnancy immediately following birth is an important public health consideration that generally has public and medical support. Counseling women at this time about the use of FP can be an effective way to include FP in the benefits package.
- *Advocacy.* Generating demand for FP coverage can be one of the most effective ways to get FP covered by health insurance. Depending on the model of health insurance, different stakeholders may be involved in determining the benefits package so it is important to target messages to the appropriate audience (e.g., Ministry of Health, employers, insurance agency).
- *Funding guideline.* In decentralized settings, resource decisions belong to local governments, which can result in FP not being adequately addressed. In Bolivia, where decision making has been decentralized to 311 municipalities, the central government has developed guidelines to ensure that funds are allocated in accordance with national priorities. Based on these guidelines, for example, local governments have to allocate a specific percentage of revenue to the universal health insurance program for mothers and children. Without such guidance, programs such as FP might be underfunded.^b

a. Casterline and Sinding (2000) identified social disapproval and lack of knowledge of FP to being two of the main reasons for unmet need.

b. T. Egan, Family Planning Challenges and Decentralization of Health Services in Latin America. Population Reference Bureau 2008, <http://www.prb.org/Articles/2008/familyplanning-latinamerica.aspx>.

Information Dissemination/Outreach

Information dissemination and outreach is a critical component of successful health insurance/prepayment. While this is true for all health insurance/prepayment models and benefits packages, it is particularly important when the packages include priority health care services, as one of the objectives is to increase use of priority services. Beneficiaries must understand what services their health insurance/prepayment scheme covers and where they can obtain them. They must also understand the fee structure in before using the services (e.g., if there is a copayment).

Effective information dissemination also allows the scheme to expand and attract new members, which creates a large pool of persons among whom to spread the costs and risks. For example, in Peru, a USAID-funded project called Apoyo a Programas de Población was implemented to expand family planning programs in the private sector and increase the number of insurance companies and employers offering family planning services. The project was unsuccessful in attracting new users to the insurance scheme primarily because of ineffective communication and information dissemination practices. Therefore the effect of health insurance coverage on family planning use could not be determined (Lambert et al. 1994).

Content of Benefits Package

There is no gold standard when it comes to developing a health insurance/prepayment benefits package; however, what is known is that the benefits package must meet the people's needs to be perceived as useful. This is particularly true when beneficiaries are expected to contribute to the scheme.

In addition, an expensive component of health insurance/prepayment is the operational costs to educate and enroll beneficiaries. If beneficiaries, particularly the poor, do not see a value added to participating in a scheme, people are likely to drop out of the scheme and not renew their membership. This may be the case with a benefits package that covers only catastrophic care, as the chance of experiencing a catastrophic health condition is rare. In contrast, a benefits package that provides coverage for services that beneficiaries often need provides a greater incentive to renew membership.

Discontinuing health insurance membership can put considerable strain on a health insurance/prepayment scheme's viability, so maximizing renewal rates is a serious consideration. Ensuring the benefits package includes services that are demanded and needed by the beneficiary population will help them realize the value-added of the scheme and increase the likelihood of renewal.

Quality of Services and Provider Capacities

A health insurance/prepayment scheme is only as good as the quality and accessibility of health care services to the beneficiary population. If the quality of services provided by the insurance scheme is poor, beneficiaries will not use them, regardless of whether they are free or not. This is evidenced by the fact that even in systems where services are provided free of charge in public facilities, the poor often pay for services in the private sector to obtain superior quality.

Quality depends on many variables—too many to address all of them here. A critical variable, however, is the provider's ability to take on the demand for services, both in number and in type. For example, if an insurance/prepayment benefits package is expanded to include clinical methods of family planning, but the local participating provider does not have the ability to deliver these services, including that service in the insurance/prepayment package is not effective. Effective planning can help counter this by ensuring that the participating providers can offer the priority services within the benefits package.

Ghana is currently trying to include family planning in its national health insurance scheme but seems to have a shortage of qualified potential providers to meet what is expected to be increased demand. Further, commodity security would need to be strengthened to ensure that supplies meet the new demand. Jumping too quickly into including family planning in Ghana, might compromise service quality. Effective planning to ensure that providers have the capacity necessary to meet the increased demand and that supplies are available would help Ghana make the transition to include this important service.

Facilitating Delivery of Drugs and Consumables at Provider Level

It is necessary to have a national and local supply system that allows health personnel to get the drugs and consumables needed to deliver the priority services, such as commodities for family planning and obstetric and neonatal emergencies. If a participating provider does not have access to commodities needed to deliver services included in the benefits package, there is no benefit from including them. Most countries struggle with delivering commodities and supplies to all providers, particularly those in more remote locations. Stock-outs and other logistical challenges could compromise the expansion of service use that would have been observed otherwise.

Availability of Free Services in Public Facilities through Donor Funds

Expanding health insurance/prepayment benefits can sometimes be costly, given all the administrative duties necessary to manage a successful insurance/prepayment scheme. While the cost of including new, low-cost services is nominal, the costs to ensure that the system can respond to the added service (such as logistics supply and provider capacity) might not outweigh the benefits. This is especially true when donors finance priority services provision free of charge or at a very low cost, such as is the case with family planning services.

Further, a country where many priority services are offered free of charge may see only a marginal increase in use of services through the insurance/prepayment scheme. This is not to suggest that in situations where donor support is significant for the provision of priority services that the country does not find alternative means to finance priority services. However, it is important to recognize this and understand that, if the impact observed is marginal, there might be a good reason for it.

Monitoring Systems

A results-driven approach and focus on accountability can help facilitate project implementation and follow-up. This is especially true at lower levels of the health care system, where priority services are often delivered. Improvement in information systems is essential to enable monitoring of indicators and assess whether insurance policy is reaching the poor. Further, standardized indicators are needed to facilitate compatibility of information systems at different levels of system.

Conclusion

Health insurance/prepayment is a mechanism that can help facilitate the provision of priority health care services. However, empirical evidence to show whether including priority services in benefits package increases use is limited. Insurance/prepayment is a way to help finance the provision of priority health care services in a sustainable manner and to better integrate the provision of care, which is more efficient and cost-effective.

Including priority services in health insurance/prepayment is not, however, a quick fix to addressing use and equity issues. The important considerations and variables, presented above, need to be addressed to maximize effectiveness.

Appendix B. Sample Benefits Packages

Ghana¹

National Health Insurance Scheme: Benefits Package

- Outpatient Services
 - General and specialist consultations reviews
 - General and specialist diagnostic testing including, laboratory investigation, X-rays, ultrasound scanning
 - Medicines on the NHIS Medicines list
 - Surgical peration such as hernia repair
 - Physiotherapy
- Inpatient Services
 - General and specialist 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
 - Feeding (where available)
- Oral Health
 - Pain relief (tooth extraction, temporary incision and drainage)
 - Dental restoration (simple amalgam filling, temporary dressing)
- Maternity Care
 - Prenatal care
 - Deliveries (normal and assisted)
 - Caesarean section
 - Postnatal care
- Emergencies

These refer to crises in health situations that demand urgent attention such as:

 - Medical emergencies
 - Surgical emergencies
 - Pediatric emergencies
 - Obstetric and gynecological emergencies
 - Road traffic accident

Note: The material in this appendix was reproduced verbatim from the official sites referenced in the notes.

1. National Health Insurance Authority, "NHIS Benefits Package," Ghana, <http://www.nhis.gov.gh/?CategoryID=158&ArticleID=120>.

EXCLUSION LIST

The following health procedures are excluded from the NHIS Benefits List:

- Appliance and prostheses including optical aids, heart aids, orthopaedic aids, dentures, etc.
- Cosmetic surgeries and aesthetic treatment
- HIV retroviral drugs
- Assisted reproduction (e.g., artificial insemination) and gynecological hormone replacement therapy
- Echocardiography
- Photography
- Angiography
- Dialysis for chronic renal failure
- Organ transplantation
- 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 (e.g., Visa application, education, institutional, driving license etc)
- VIP ward (accommodation)

NATIONAL HEALTH INSURANCE MEDICINES LIST 2007²

Therapeutic Class	Name of Drug, Dosage Form and Strength
1. Anaesthetic Agents	
1.1 General Anaesthetics	• Halothane Inhalation • Isoflurane Inhalation • Ketamine Injection, 10mg/ml in 20ml • Ketamine Injection, 50mg/ml in 10ml • Nitrous Oxide Inhalation • Oxygen (Medicinal Gas) Inhalation • Propofol Injection, 10mg/ml • Thiopentone Sodium Injection, 1gm • Thiopentone Sodium Injection, 500mg
1.2 Local Anaesthetics	• Bupivacaine + Glucose Injection, (5mg+80mg)/ml • Bupivacaine Injection, 2.5mg/ml • Bupivacaine Injection, 5mg/ml • Lidocaine Cream, 2 - 4% • Lidocaine Gel, 4% • Lidocaine Injection, 1% • Lidocaine Injection, 2% in 20mls • Lidocaine Injection, 20mg/ml • Lidocaine Spray, 10% • Lidocaine+Adrenaline Injection, 10mg/ml+5mcg/ml • Lidocaine+Adrenaline Injection, 20mg/ml+5mcg/ml • Prilocaine Injection, 10mg/ml
2. Pre-Operative Medications and Sedation for Short-Term Procedures	
Pre-Anaesthetics	• Atropine Injection, 0.6mg/ml • Doxapram Injection, 20mg/ml in 5mls • Ephedrine HCl Injection, 30mg/ml • Glycopyrronium Injection, 200microgram • Lorazepam Inj 4mg/ml • Midazolam Injection, 1mg/ml • Midazolam Injection, 2mg/ml • Midazolam Injection, 5mg/ml • Midazolam Tablet, 15mg
3. Analgesics, Antipyretics, Nsaids and Drugs Used in Gout	
3.1 Non-Opioid Non-Steroidal Analgesics	• Acetylsalicylic Acid Tablet, 300 mg • Allopurinol Tablet, 100 mg • Allopurinol Tablet, 300 mg • Diclofenac Capsule, 75mg • Diclofenac Injection, 25 mg/ml • Diclofenac Suppository, 100 mg • Diclofenac Suppository, 50 mg • Diclofenac Tablet, 25 mg • Diclofenac Tablet, 50 mg • Ibuprofen Suspension, 100 mg/5 ml • Ibuprofen Syrup, 100 mg/5ml • Ibuprofen Tablet, 200 mg • Ibuprofen Tablet, 400 mg • Mefenamic Acid Capsule, 250mg • Mefenamic Acid Tablet, 500mg

2. www.ghana.gh/ghana/health_insurance_scheme_implement_new_medicine_list.jsp.

Therapeutic Class	Name of Drug, Dosage Form and Strength
3.1 Non-Opiod Non-Steroidal Analgesics	• Paracetamol Suppository, 125 mg • Paracetamol Suppository, 250 mg • Paracetamol Suppository, 500 mg • Paracetamol Suspension, 120 mg/5 ml • Paracetamol Syrup, 120 mg/5 ml • Paracetamol Suspension, 250 mg/5 ml • Paracetamol Syrup, 250 mg/5 ml • Paracetamol Tablet, 500 mg • Piroxicam Capsule, 10mg • Piroxicam Capsule, 20mg
3.2 Opiod Analgesics	• Fentanyl Citrate Injection, 50 microgram/ml • Morphine Injection, 10 mg/ml • Morphine Injection, 10 mg/ml (Preservative Free) • Morphine Sulphate Tablet, 10 mg (Slow release) • Morphine Sulphate Tablet, 30 mg (Slow release) • Pethidine Injection, 50 mg/ml in 2 ml
4. Anti-Allergic Drugs	
	• Adrenaline Injection, (1:1000) 1 mg/ml • Cetirizine Tablet, 10 mg • Chlorphenamine Syrup, 2 mg/5 ml • Chlorphenamine Tablet, 4 mg • Dexamethasone Injection, 4 mg/ml • Dexamethasone Injection, 8 mg/2ml • Dexamethasone Tablet, 500 microgram • Diphenhydramine Tablet, 25 mg • Hydrocortisone Sodium Succinate Injection, 100 mg • Prednisolone Tablet, 5 mg • Promethazine Elixir, 5 mg/5 ml • Promethazine Injection, 25 mg/ml in 2 ml • Promethazine Tablet, 25 mg
5. Antidotes and Other Substances Used in Poisoning	
5.1 Non-Specific Antidotes	• Activated Charcoal Powder, 50 g • Ipecacuanha Emetic Mixture BP
5.2 Specific Antidotes	• Acetylcysteine Injection, 200 mg/ml • Atropine Injection, 0.6 mg/ml • Benzatropine Injection, 1 mg/ml • Naloxone Injection, 400 microgram/ml • Polystyrene Sulphonate Resins Powder, 300 g • Protamine Sulphate Injection, 10 mg/ml
6. Anticonvulsants	
Anticonvulsants	• Carbamazepine Tablet, 100 mg • Carbamazepine Tablet, 200 mg • Carbamazepine Sustained-Release Tablet, 200 mg • Carbamazepine Sustained-Release Tablet, 400 mg • Diazepam Injection, 5 mg/ml in 2 ml • Diazepam Rectal Tubes, 2 mg/ml • Ethosuximide Syrup, 250 mg/5 ml • Ethosuximide Tablet, 250 mg • Magnesium Sulphate Injection, 20%

Therapeutic Class	Name of Drug, Dosage Form and Strength
Anticonvulsants	• Magnesium Sulphate Injection, 25% • Magnesium Sulphate Injection, 50% • Phenobarbital Elixir, 15 mg/5 ml • Phenobarbital Injection, 200 mg/ml • Phenobarbital Tablet, 30 mg • Phenobarbital Tablet, 60 mg • Phenytoin Injection, 50 mg/ml • Phenytoin Sodium Capsule, 50 mg • Phenytoin Sodium Capsule, 100 mg • Phenytoin Sodium Tablet, 100 mg • Piracetam Tablet, 800 mg • Primidone Tablet, 250 mg • Sodium Valproate Capsule, 200 mg • Sodium Valproate Capsule (Slow Release), 500 mg • Sodium Valproate Syrup, 200 mg/5 ml
7. Anti-Infective Drugs	
7.1 Anthelmintic Drugs	
7.1.1 Intestinal Anthelmintic Drugs	• Albendazole Syrup, 100 mg/5 ml • Albendazole Tablet, 200 mg • Mebendazole Suspension, 100 mg/5 ml • Mebendazole Tablet, 100 mg • Mebendazole Tablet, 500 mg • Niclosamide Tablet, 500 mg • Tiabendazole Suspension, 50 mg/ml • Tiabendazole Tablet, 500 mg
7.1.2 Antifilarial Drugs	• Diethylcarbamazine Tablet, 50 mg • Ivermectin Tablet, 6 mg
7.1.3 Antischistosomal Drugs	• Praziquantel Tablet, 600 mg
7.2 Antibacterial Drugs	
7.2.1 Penicillins	• Amoxicillin + Clavulanic Acid Injection, 500 mg + 100 mg • Amoxicillin + Clavulanic Acid Suspension, 250 mg + 62 mg • Amoxicillin + Clavulanic Acid Suspension, 400 mg + 57 mg • Amoxicillin + Clavulanic Acid Tablet, 500 mg + 125 mg • Amoxicillin Capsule, 250 mg Amoxicillin Capsule, 500 mg • Amoxicillin Suspension, 125 mg/5 ml • Amoxicillin Suspension, 250 mg/5ml • Ampicillin Injection, 500mg • Benzathine Benzylpenicillin Injection, 1.2 MU • Benzathine Benzylpenicillin Injection, 2.4 MU • Benzylpenicillin Injection, 1 MU • Benzylpenicillin Injection, 5 MU • Cloxacillin Injection, 250 mg • Cloxacillin Injection, 500 mg • Flucloxacillin Capsule, 250 mg • Flucloxacillin Injection, 250 mg • Flucloxacillin Injection, 500 mg • Flucloxacillin Suspension 125 mg/5 ml • Phenoxymethyl Penicillin Tablet, 250 mg • Procaine Benzylpenicillin Injection, 4 MU

Therapeutic Class	Name of Drug, Dosage Form and Strength
7.2.2 Other Antibacterial Drugs	• Azithromycin Capsule, 250 mg • Azithromycin Suspension, 200 mg/5 ml • Cefaclor Capsule, 250mg • Cefaclor Capsule, 500mg • Cefaclor Suspension, 250 mg/5ml • Cefaclor Suspension, 125 mg/5ml • Cefotaxime Injection, 1 g • Cefotaxime Injection, 500 mg • Ceftriazone Injection, 1 g vial • Ceftriazone Injection, 250 mg vial • Cefuroxime Injection, 1.5 g vial • Cefuroxime Injection, 750 mg vial • Cefuroxime Suspension, 125 mg/5ml • Cefuroxime Tablet, 125 mg • Cefuroxime Tablet, 250 mg • Chloramphenicol Capsule, 250 mg • Chloramphenicol Injection, 1 g • Chloramphenicol Suspension, 250 mg/5 ml • Ciprofloxacin Infusion, 2 mg/ml in 100 ml • Ciprofloxacin Tablet, 250 mg • Ciprofloxacin Tablet, 500 mg • Clarithromycin Tablet, 250 mg • Clarithromycin Tablet, 500 mg • Clarithromycin Paediatric Suspension, 125 mg/5 ml • Clindamycin Capsule, 150 mg • Clindamycin Injection, 150 mg/ml in 2ml • Clindamycin Suspension, 75mg/5ml • Cotrimoxazole Suspension, (200+40) mg/5 ml • Cotrimoxazole Tablet, (400+80) mg • Doxycycline Capsule, 100 mg • Erythromycin Injection, 1 g • Erythromycin Injection, 500 mg • Erythromycin Syrup, 125 mg/5 ml • Erythromycin Tablet, 250 mg • Gentamicin Injection, 40 mg/ml in 2 ml • Nalidixic Acid Tablet, 500 mg • Neomycin Tablet, 500 mg • Nitrofurantoin Tablet, 100 mg • Secnidazole Tablet, 500 mg • Tetracycline Capsule, 250 mg • Tinidazole Capsule, 500mg
7.3 Antifungal Drugs for Systemic Use	• Fluconazole Capsule, 150 mg • Fluconazole Capsule, 200 mg • Fluconazole Suspension, 50 mg/5ml • Griseofulvin Suspension, 125 mg/5 ml • Griseofulvin Tablet, 125 mg • Griseofulvin Tablet, 500 mg • Itraconazole Capsule, 100 mg • Itraconazole Suspension, 10 mg/ml • Ketoconazole Tablet, 200 mg • Miconazole Oral Gel, 25 mg/ml • Nystatin Pastilles, 100,000 IU • Nystatin Suspension, 100,000 IU/ml • Nystatin Tablet, 500,000 IU • Terbinafine HCl Tablet, 250 mg

Therapeutic Class	Name of Drug, Dosage Form and Strength
7.4 Antiprotozoal Drugs	
7.4.1 Anti-Amoebic Drugs	• Metronidazole Injection, 5 mg/ml in 100 ml • Metronidazole Suppository, 500 mg • Metronidazole Suppository, 1000 mg • Metronidazole Suspension, 100 mg/5 ml (as benzoate) • Metronidazole Suspension, 200 mg/5 ml (as benzoate) • Metronidazole Tablet, 200 mg • Metronidazole Tablet, 400 mg
7.4.2 Antileishmaniasis Drugs	• Pentamidine Isetionate Injection, 300 mg vial
7.4.3 Antimalarial Drugs	• Amodiaquine Tablet, 75 mg • Amodiaquine Tablet, 150 mg • ³Amodiaquine + Artesunate Tablet, 150 mg + 50 mg • Amodiaquine + Artesunate Tablet, 75 mg + 25 mg • Artemeter + Lumefantrine Suspension, 20 mg + 120 mg/5 ml • Artemeter + Lumefantrine Tablet, 20 mg + 120 mg • Artesunate Suppository, 50 mg • Artesunate Suppository, 200 mg • Artesunate Tablet, 25 mg • Artesunate Tablet, 50 mg⁴ • Dihydroartemisin + Piperaquine Capsule, 40 mg + 320 mg • Dihydroartemisin + Piperaquine Granules, 15 mg + 120 mg • Dihydroartemisin + Piperaquine Tablet, 40 mg + 320 mg • Quinine Injection, 300 mg/ml in 2 ml • Quinine Tablet, 300 mg • Sulfadoxine + Pyrimethamine Tablet, 525 mg
7.4.4 Anti-tuberculosis Drugs	• Ethambutol Tablet, 400 mg • Isoniazid Tablet, 100 mg • Isoniazid Tablet, 300 mg • Isoniazid + Thiacetazone Tablet (300 mg + 150 mg) • Pyrazinamide Tablet, 400 mg - Category 3 • Pyrazinamide Tablet, 500 mg • Pyridoxine Tablet, 100 mg • Pyridoxine Tablet, 50 mg • RHZE(2)+ RH (4) Tablet, (900mg + 225 mg) - Category 1 • Rifampicin + Isoniazid Tablet, (150 mg + 75 mg) - Category 3 • Rifampicin + Isoniazid Tablet, (150 mg + 100 mg) • S + RHZE (2) + RHZE (1) + HRE (5) - Category 2 • Streptomycin Injection, 1 gm
7.5 Antiviral	• Aciclovir Injection, 250 mg vial • Aciclovir Suspension, 200 mg/5 ml • Aciclovir Tablet, 200 mg
8. Antimigraine Drugs	
	• Acetylsalicylic Acid Tablet, 300 mg • Ergotamine Tablet, 2 mg • Paracetamol Tablet, 500 mg • Propranolol Tablet, 40 mg
9. Antineoplastic and Immunosuppressive Drugs⁵	
9.1 Hormones and Antihormones	• Anastrozole Tablet, 1 mg • Diethylstilboestrol Tablet, 1 mg • Diethylstilboestrol Tablet, 5 mg • Prednisolone Tablet, 5 mg • Tamoxifen Tablet, 10 mg • Tamoxifen Tablet, 20 mg

3. Amodiaquine strength of 153 mg is acceptable.

4. This medication is yet to be confirmed for general use.

5. The medicines in this group are mainly for the management of breast cancer.

Therapeutic Class	Name of Drug, Dosage Form and Strength
9.2 Alkylating Drugs	• Cyclophosphamide Injection, 500 mg
9.3 Cytotoxic Antibiotics	• Adriamycin Injection, 50 mg
9.4 Taxanes	• Docetaxel Injection, 40 mg/ml • Paclitaxel Injection, 6 mg/ml
9.5 Anti-Metabolites	• 5-Fluorouracil Injection, 50 mg/ml (10 ml vial) • Capecitabine Tablet, 500 mg • Methotrexate Injection, 25 mg/ml (2ml vial) • Methotrexate Tablet, ⁶ 10 mg • Methotrexate Tablet, 2.5 mg
10. Antiparkinsonism Drugs	
	• Benztropine Injection, 1 mg/ml • Benztropine Tablet, 2 mg • Biperiden Injection, 5 mg/ml • Biperiden Tablet, 2 mg • Trihexyphenidyl Tablet, 2 mg • Trihexyphenidyl Tablet, 5 mg
11. Drugs Affecting The Blood	
11.1 Antianaemia Drugs	• Ferric Ammonium Citrate (FAC) • Ferrous Fumarate Tablet, 100 mg (elemental iron) • Ferrous Gluconate Tablet, 35 mg (elemental iron) • Ferrous Sulphate (BPC) Syrup, 60 mg/5 ml • Ferrous Sulphate + Folic Acid Tablet, 50 mg (elemental iron)+ 400 microgram • Ferrous Sulphate Tablet, 60 mg (elemental iron) • Folic Acid Tablet, 5 mg • Hydroxocobalamin Injection, 1 mg/ml • Iron (III) Polymaltose Complex Capsule • Iron (III) Polymaltose Complex Suspension • Iron Dextran Injection, 50 mg/ml • Iron Sucrose Injection, 20 mg/ml • Multivitamin Drops • Multivitamin Tablet
11.2 Anticoagulants And Antagonists	• Heparin Injection (Dalteparin) Injection, 5000 IU • Heparin Injection (Enoxaparin) Injection, 40 mg/0.4ml • Heparin Injection, 1000 units/ml • Heparin Injection, 5000 units/0.2 ml • Heparin Injection, 5000 units/ml • Phytomenadione Injection, 1 mg/ml • Phytomenadione Injection, 10 mg/ml • Protamine Sulphate Injection, 10 mg/ml • Warfarin Tablet, 1 mg • Warfarin Tablet, 3 mg • Warfarin Tablet, 5 mg(scored)
11.3 Anti-Fibrinolytic Drugs	• Tranexamic Acid Injection, 100 mg/ml • Tranexamic Acid Tablet, 500 mg
11.4 Fibrinolytic Drugs	• Alteplase Injection, 10 mg/vial • Streptokinase Injection, 100,000 unit-vail • Streptokinase Injection, 250,000 unit-vail • Streptokinase Injection, 750,000 unit-vail
11.5 Anti-Platelet Drugs	• Acetylsalicylic Acid Tablet (Dispersible), 75 mg • Eptifibatide Injection, 2 mg/ml • Eptifibatide Infusion, 750 micrograms/ml • Tirofiban Infusion, 250 micrograms/ml (concentrate) • Tirofiban Infusion, 50 micrograms/ml

6. Methotrexate Tablets may be used in the management of Rheumatoid Arthritis.

Therapeutic Class	Name of Drug, Dosage Form and Strength
12. Blood Products and Blood Substitutes	
	• Etherified Starch Infusion (Hexa-starch) • Gelatin Infusion (succinylated gelatin)
13. Cardiovascular Drugs	
13.1 Anti-Anginal Drugs	• Acetylsalicylic Acid Tablet (Dispersible), 75 mg • Atenolol Tablet, 25 mg • Atenolol Tablet, 50 mg • Atenolol Tablet, 100 mg • Glyceryl Trinitrate Sublingual Tablet, 500 microgram • Isosorbide Dinitrate Tablet, 10 mg • Nifedipine Tablet, 10 mg (slow release) • Nifedipine Tablet, 20 mg (slow release) • Nifedipine Tablet, 30 mg (GITS)
13.2 Antidysrhythmic Drugs	• Adrenaline Injection, 1:10,000 • Amiodarone Tablet, 200 mg • Atenolol Tablet, 25 mg • Atenolol Tablet, 50 mg • Atenolol Tablet, 100 mg • Disopyramide Capsule, 100 mg • Disopyramide Phosphate Injection, 10 mg/ml • Lidocaine Injection, 20 mg/ml in 5 ml • Verapamil Tablet, 40 mg • Verapamil Tablet, 80mg
13.3 Antihypertensive Drugs	• Amlodipine Tablet, 5 mg • Amlodipine Tablet, 10 mg • Atenolol + Hydrochlorthiazide Tablet, 100 mg + 25 mg • Atenolol + Hydrochlorthiazide Tablet, 50 mg + 25 mg • Atenolol Injection, 500 microgram/ml • Atenolol Tablet, 100 mg • Atenolol Tablet, 50 mg • Bendroflumethiazide Tablet, 2.5 mg • Bendroflumethiazide Tablet, 5 mg • Hydralazine Injection, 20 mg • Hydralazine Tablet, 25 mg • Labetalol Injection, 5 mg/ml • Labetalol Tablet, 100 mg • Labetalol Tablet, 200 mg • Lisinopril + Hydrochlorthiazide Tablet, 10 mg + 12.5 mg • Lisinopril + Hydrochlorthiazide Tablet, 20 mg + 12.5 mg • Lisinopril Tablet, 10 mg • Lisinopril Tablet, 2.5 mg • Lisinopril Tablet, 5 mg • Losartan Tablet, 25 mg • Losartan Tablet, 50 mg • Losartan Tablet, 100 mg • Methyldopa Tablet, 250 mg • Nifedipine Capsule, 10 mg • Nifedipine Tablet, 10 mg (slow release) • Nifedipine Tablet, 20 mg (slow release) • Nifedipine Tablet, 30 mg (GITS) • Prazosin Tablet, 500 microgram • Propranolol Injection, 1 mg/ml • Propranolol Tablet, 10 mg • Propranolol Tablet, 40 mg • Propranolol Tablet, 80 mg • Reserpine Injection, 1 mg/ml

Therapeutic Class	Name of Drug, Dosage Form and Strength
13.4 Cardiac Glycosides	• Digoxin Elixir, 50 microgram/ml • Digoxin Injection, 250 microgram/ml • Digoxin Tablet, 62.5 microgram • Digoxin Tablet, 125 microgram • Digoxin Tablet, 250 microgram
13.5 Lipid-Regulating Drugs	• Atorvastatin Tablet, 10 mg • Atorvastatin Tablet, 20 mg • Fluvastatin Capsules, 20 mg • Rosuvastatin Tablet, 10mg • Rosuvastatin Tablet, 5 mg • Simvastatin Tablet, 20 mg • Simvastatin Tablet, 40 mg
13.6 Drugs Used In Shock	• Adrenaline Injection, 1 mg/1ml (1:1000) • Dopamine Injection, 40 mg/ml in 5ml • Hydrocortisone Sodium Succinate Injection, 100 mg
14. Dermatological Preparations	
14.1 Antifungal Drugs	• Benzoic Acid + Salicylic Acid Ointment, 6%+3% • Clotrimazole + Hydrocortisone Cream, 1% + 1% • Clotrimazole Cream, 1% • Clotrimazole Pessary, 100 mg • Clotrimazole Pessary, 200 mg • Clotrimazole Pessary, 500 mg • Miconazole + Hydrocortisone Cream, 2% + 1% • Miconazole Cream, 2% • Miconazole Ovule, 400 mg • Povidone Iodine Solution • Selenium Sulphide Shampoo, 2.5%
14.2 Anti-Infective Drugs	• Aciclovir Cream, 5% • Cetrimide Solution • Chlorhexidine Cream, 1% • Chlorhexidine Solution, 2.5% • Silver Sulphadiazine Cream, 1%
14.3 Anti-Inflammatory and Antipruritic Drugs	• Betamethasone Cream, 0.05% • Betamethasone Cream, 0.1% • Calamine Lotion, 15% • Calamine Cream, 15% • Clobetasol Propionate Cream, 0.05% • Hydrocortisone Cream, 1%
14.4 Astringent Agents	• Salicylic Acid Ointment, 2%
14.5 Scabicides And Pediculocides	• Benzyl Benzoate Lotion, 25% • Lindane Lotion, 1%
14.6 Emollients And Vehicles	• Aqueous Cream BP
14.7 Others	• Benzoyl Peroxide Solution, 10% • Benzoyl Peroxide Solution, 5% • Clindamycin Solution, 1% • Mercurochrome Solution
15. Diuretics	
	• Bendroflumethiazide Tablet, 2.5 mg • Bendroflumethiazide Tablet, 5 mg • Furosemide Injection, 10 mg/ml in 2 ml • Furosemide Tablet, 40 mg • Mannitol Injection, 10% • Mannitol Injection, 20% • Metolazone Tablet, 5 mg • Spironolactone Tablet, 25 mg • Spironolactone Tablet, 50 mg

Therapeutic Class	Name of Drug, Dosage Form and Strength
16. Gastrointestinal Drugs	
16.1 Antacids and Other Antiulcer Drugs	• Aluminium Hydroxide Mixture • Aluminium Hydroxide Tablet, 500 mg • Esomeprazole Tablet, 20 mg • Esomeprazole Tablet, 40 mg • Magnesium Trisilicate + Aluminium Hydroxide Mixture • Magnesium Trisilicate + Aluminium Hydroxide Tablet • Magnesium Trisilicate Mixture • Magnesium Trisilicate Tablet, 500 mg • Omeprazole Capsule, 10 mg • Omeprazole Capsule, 20 mg • Omeprazole Injection, 40 mg • Rabeprazole Tablet, 20 mg • Ranitidine Tablet, 150 mg
16.2 Anti-Emetics	• Metoclopramide Injection, 5 mg/ml in 2 ml • Metoclopramide Tablet, 10 mg • Promethazine Hydrochloride Elixir, 5 mg/5 ml • Promethazine Hydrochloride Injection, 25 mg/ml • Promethazine Theoclate Tablet, 25 mg
16.2.1 Anti-emetics used in cancer chemotherapy	• Dexamethasone Injection, 4 mg/ml • Dexamethazone Tablet, 500 microgram • Domperidone Tablet, 10 mg • Granisetron Injection, 1 mg/1ml • Granisetron Tablet, 1 mg • Lorazepam Tablet, 1 mg • Lorazepam Tablet, 2 mg
16.3 Antihæmorrhoidal Drugs	• Ethanolamine Oleate Solution, 5% • Phenol 5% in Almond Oil Injection • Soothing Agent + Local Anaesthetic Ointment • Soothing Agent + Local Anaesthetic Suppository • Soothing Agent + Local Anaesthetic + Steroid Ointment • Soothing Agent + Local Anaesthetic + Steroid Suppository
16.4 Anti-Inflammatory Drugs	• Sulfasalazine Tablet, 500 mg
16.5 Antispasmodic Drugs	• Hyoscine Butylbromide Tablet, 10 mg • Hyoscine Butylbromide Injection, 20 mg/ml • Mebeverine Tablet, 135 mg
16.6 Cathartic Drugs	• Bisacodyl Tablet, 5 mg • Glycerol Suppository, 1 gm • Glycerol Suppository, 2 gm • Glycerol Suppository, 4 gm • Lactulose Liquid 3.1–3.7 g/5 ml • Magnesium Sulphate Salt • Paraffin Liquid Psyllium Powder • Senna Granules Senna Tablet, 7.5 mg • Sorbitol Liquid, 70%
16.7 Drugs Used In Diarrhoea	
16.7.1 Oral Replacement Solution	• Oral Rehydration Salts Powder
16.7.2 Antidiarrhoeal (Symptomatic) Drugs	• Codeine Tablet, 30 mg • Loperamide Capsule, 2 mg
17. Hormones and Other Endocrine Drugs	
17.1 Adrenal Hormones And Synthetic Substitutes	• Dexamethasone Injection, 4 mg/ml • Fludrocortisone Tablet, 100 microgram • Hydrocortisone Sodium Succinate Injection, 100 mg • Prednisolone Tablet, 5 mg

Therapeutic Class	Name of Drug, Dosage Form and Strength
17.2 Androgens	• Testosterone Enantate Injection, 250 mg in 1ml ampoule
17.3 Estrogens	• Conjugated Oestrogen Tablet, 625 microgram • Conjugated Oestrogen + Norgesterol Tablet, 625 microgram + 150 microgram • Conjugated Oestrogen Vaginal cream, 625 microgram/g
17.4 Insulins And Other Antidiabetic Drugs	• Glibenclamide Tablet, 5 mg • Glimepiride Tablet, 1mg • Glimepiride Tablet, 2mg • Glimepiride Tablet, 4 mg • Glucagon Injection, 1 mg • Insulin pre-mixed (30/70) HM Injection, 100 units/ml in 10 ml • Insulin Soluble HM, 100 units/ml in 10 ml • Isophane Insulin Injection (HM), 100 units/ml in 10 ml • Metformin Tablet, 500 mg • Pioglitazone Tablet, 15 mg • Pioglitazone Tablet, 30 mg • Rosiglitazone Tablet, 4 mg • Tolbutamide Tablet, 500 mg
17.5 Progestogens	• Medroxyprogesterone Acetate Tablet, 5 mg • Norethisterone Tablet, 5 mg
17.6 Thyroid Hormones and Antithyroid Drugs	• Carbimazole Tablet, 20 mg • Carbimazole Tablet, 5 mg • Levothyroxine Sodium Tablet, 100 microgram • Levothyroxine Sodium Tablet, 25 microgram • Levothyroxine Sodium Tablet, 50 microgram • Propylthiouracil Tablet, 50 mg
17.7 Other Endocrinological Drugs	• Bromocriptine Tablet, 2.5 mg
18. Immunologicals	
18.1 Sera and Immunoglobulins	• Anti D Rh Immune Globulin Injection • Anti-rabies Immunoglobulins Injection, 1000IU/5 ml • Anti-snake venom, Polyvalent Injection • Human Immune Tetanus globulins Injection, 250IU/ml
18.2 Vaccines	
18.2.1 For Childhood Immunisation	
18.2.2 For Specific Groups of Individuals	• Rabies Vaccine Injection • Tetanus Toxoid Injection, 0.5 ml • Tetanus Vaccine Injection, 40 IU/5 ml
19. Muscle Relaxants and Cholinesterase Inhibitors	
	• Atracurium Injection, 10mg/ml in 2.5ml • Neostigmine Injection, 2.5mg • Neostigmine Injection, 0.5mg • Rocuronium Injection, 10mg/ml • Suxamethonium Injection, 100mg/2ml • Vecuronium Bromide Injection, 10mg/vial
20. Ophthalmological Preparations	
20.1 Anti-Infective Agents	• Aciclovir Eye Ointment, 3% • Chloramphenicol Eye Drops, 0.5% • Chloramphenicol Eye Ointment, 1% • Ciprofloxacin Eye Drops, 0.3%

Therapeutic Class	Name of Drug, Dosage Form and Strength
20.1 Anti-Infective Agents	• Econazole Eye Drops, 1% • Erythromycin Eye Ointment, 0.5% • Gentamicin Eye Drops, 0.3% • Gentamicin Eye Ointment, 0.3% • Sulphacetamide Eye Drops, 10% • Sulphacetamide Eye Ointment, 10% • Tetracycline Eye Drops, 0.5% • Tetracycline Eye Ointment, 1%
20.2 Anti-Inflammatory Agents	• Corticosteroid + Antibiotic Eye Drops • Corticosteroid + Antibiotic Eye Ointment • Dexamethasone Eye Drops, 1% • Dexamethasone Eye Ointment, 1% • Hydrocortisone Eye Drops, 1% • Hydrocortisone Eye Ointment, 1% • Lodoxamide Eye Drops, 0.1% • Prednisolone Eye Drops, 0.5% • Prednisolone Eye Drops, 1%
20.3 Local Anaesthetics	• Tetracaine Eye Drops, 0.5%
20.4 Miotics and Drugs Used in Glaucoma	• Acetazolamide Injection, 500 mg • Acetazolamide Tablet, 250 mg • Adrenaline Eye Drops, 1% • Betaxolol HCl Eye Drops, 0.5% • Pilocarpine Eye Drops, 2% • Pilocarpine Eye Drops, 4% • Timolol Maleate Eye Drops, 0.5%
20.5 Mydriatics	• Atropine Eye Drops, 1% • Cyclopentolate Eye Drops, 1% • Homatropine Eye Drops, 2%
20.6 Others	• Methyl Cellulose Eye Drops, 0.3%
21. Oxytocics and Anti-Oxytocics	
21.1 Oxytocics	• Ergometrine Injection, 0.5 mg/ml • Ergometrine Tablet, 0.5 mg • Misoprostol Vaginal Tablet, 200microgram • Oxytocin Injection, 5 units/ml
21.2 Anti-Oxytocics	• Salbutamol Sulphate Injection, 500 microgram/ml • Salbutamol Tablet, 4 mg
22. Peritoneal Dialysis Solutions	
	• Intraperitoneal Dialysis Solution, Hypertonic • Intraperitoneal Dialysis Solution, Hypotonic
23. Psychotherapeutic Drugs	
	• Amitriptyline Tablet, 10 mg • Amitriptyline Tablet, 25 mg • Amitriptyline Tablet, 50 mg • Chlorpromazine Injection, 25 mg/ml in 2 ml • Chlorpromazine Tablet, 100 mg • Chlorpromazine Tablet, 25 mg • Chlorpromazine Tablet, 50 mg • Diazepam Injection, 5 mg/ml in 2 ml • Diazepam Tablet, 10 mg • Diazepam Tablet, 5 mg

Therapeutic Class	Name of Drug, Dosage Form and Strength
	• Fluoxetine Capsule, 20 mg • Flupentixol Tablet, 1mg • Flupentixol Tablet, 500 microgram • Fluphenazine Deconate Injection, 25 mg/ml • Haloperidol Injection, 5 mg/ml • Haloperidol Tablet, 10 mg • Haloperidol Tablet, 5 mg • Imipramine Tablet, 25 mg • Lorazepam Tablet, 2.5 mg • Risperidone Liquid, 1 mg/ml • Risperidone Tablet, 1 mg • Risperidone Tablet, 2 mg • Risperidone Tablet, 500 microgram • Sertraline Tablet, 100 mg • Sertraline Tablet, 50 mg • Trifluoperazine Tablet, 1 mg • Trifluoperazine Tablet, 5 mg
24. Drugs Acting on the Respiratory Tract	
24.1 Anti-Asthmatic Drugs	• Aminophylline Injection, 250 mg/10 ml • Beclometasone dipropionate Inhaler, 50 microgram/metered dose • Beclometasone dipropionate Inhaler, 100 microgram/metered dose • Budesonide + Formoterol Inhaler, 160 microgram + 4.5 microgram • Budesonide + Formoterol Inhaler, 80 microgram + 4.5 microgram • Budesonide Dry Powder Inhaler (DPI) (Turbohaler), 100 microgram • Budesonide DPI, 200 microgram Fluticasone + Salmeterol Inhaler, 250 microgram + 50 microgram • Fluticasone Metered Dose Inhaler (MDI), 125 microgram • Fluticasone MDI, 250 microgram • Fluticasone MDI, 50 microgram • Hydrocortisone Sodium Succinate Injection, 100 mg • Prednisolone Tablet, 5 mg • Salbutamol Inhaler, 100 microgram/metered dose, 200 doses • Salbutamol Nebulizer, 2.5 mg Nebules • Salbutamol Nebulizer, 5 mg Nebules • Salbutamol Syrup, 2 mg/5 ml • Salbutamol Tablet, 2 mg • Salbutamol Tablet, 4 mg • Theophylline Syrup, 60 mg/5 ml • Theophylline Tablet, 200 mg (slow release)
24.2 Antitussives	• Carbocisteine Capsule, 375 mg • Carbocisteine Syrup Paediatric, 125 mg/5ml • Carbocisteine Syrup, 250 mg/5ml • Dihydrocodeine Tablet, 30 mg • Simple Linctus (paediatric) BPC • Simple Linctus BPC
25. Solutions Correcting Water and Electrolyte Abnormalities	
25.1 Oral Preparations	• Oral Rehydration Salts Powder • Potassium Chloride Tablet, 600 mg (enteric coated)

Therapeutic Class	Name of Drug, Dosage Form and Strength
25.2 Parenteral Solutions	• Badoe's Solution Injection, 1000 ml • Cholera Replacement Fluid Injection, (5:4:1) • Darrow's Solution Injection, Half-Strength 250 ml • Dextrose in Sodium Chloride Intravenous Infusion, 4.3% in 0.18% (250 ml) • Dextrose in Sodium Chloride Intravenous Infusion, 5% in 0.9% (500 ml) • Dextrose⁷ in Sodium Chloride Intravenous Infusion, 10% in 0.18% (250 ml) • Dextrose Infusion, 5% (250 ml) • Dextrose Infusion, 5% (500 ml) • Dextrose Infusion, 10% (250 ml) • Dextrose Infusion, 10% (500 ml) • Dextrose Infusion, 20% (250 ml) • Dextrose Infusion, 50% (50 ml) • Potassium Chloride Injection, 20 mEq/10 ml • Ringer's Lactate Solution, 500 ml • Sodium Bicarbonate Injection, 8.4% in 10 ml Sodium Chloride + Potassium Chloride Injection, 0.9% + 20 mMol (500 ml) • Sodium Chloride Injection, 0.45% (250 ml) • Sodium Chloride Injection, 0.9% (250 ml) • Sodium Chloride Injection, 0.9% (500 ml)
25.3 Miscellaneous	• Water for Injection
26. Parenteral Nutrition	
	• Amino Acid Solution Injection, 10% • Amino Acid Solution Injection, 20% • Intralipid Solution (for TPN)
27. Vitamins and Minerals	
	• Calciferol Tablet, 10,000 units • Calcium Carbonate Tablet, 500 mg • Calcium with Vitamin D Tablet, (97 mg + 10 microgram) • Calcium Gluconate Injection, 100 mg/ml in 10 ml • Multivitamin Drops • Multivitamin Syrup • Multivitamin Tablet • Retinol Soft Capsule, 200,000IU • Retinol Soft Capsule, 100,000IU • Thiamine Injection, 100 mg • Thiamine Tablet, 25 mg
28. Other Drugs	
28.1 Drugs for Ear, Nose and Throat	• Adrenaline Injection, 1 mg/1ml (1:1000) • Ephedrine Nasal Drops, 0.5% • Ephedrine Nasal Drops, 1% • Sodium Chloride Nasal Drops, 0.9%
28.2 Drugs For Dentistry	• Chlorhexidine Mouthwash, 0.2% • Lidocaine + Adrenaline Cartridge, 20 mg/ml + [1:80,000/1:100,000] • Miconazole Oral Gel, 25 mg/ml • Nystatin Ointment, 100,000IU • Fluconazole Suspension, 10 mg/ml
28.3 Drugs For Urology	• Tamsulosin Capsule, 400 microgram • Terazosin Tablet, 2 mg • Terazosin Tablet, 5 mg • Finasteride Tablet, 5 mg • Potassium Citrate Mixture BP

7. Dextrose is used interchangeably with Glucose.

India⁸

UNITED INDIA INSURANCE COMPANY LIMITED
Reg. & Head Office: 24, Whites Road, Chennai-14.
PROSPECTUS
UNIVERSAL HEALTH INSURANCE SCHEME for BPL FAMILIES

SALIENT FEATURES OF THE POLICY

- (i) The UNIVERSAL HEALTH INSURANCE policy will be available to both Individuals as well as in Group.
- (ii) Each Insured should cover all eligible members (insured persons) under one group policy only. In other words different categories of eligible members shall not be allowed to be covered under different group policies. It is not permissible to issue any unnamed group policy.
- (iii) The Individual Policy will be issued in the name of the earning head of family with details of insured family members. The Group policy will be issued in the name of the Group/Association/Institution (called insured) with a schedule of names of the members including his/her eligible family members (called Insured persons) forming part of the policy.

COVERAGE**SECTION I. HOSPITALISATION EXPENSES**

The policy covers reimbursement of Hospitalisation expenses for illness/diseases suffered or injury sustained by the Insured Person. In the event of any claim becoming admissible under policy, the company through TPA will pay to the Hospital/Nursing Home or Insured Person the amount of such expenses subject to limits as would fall under different heads mentioned below, as are reasonably and necessarily incurred in respect thereof anywhere in India by or on behalf of such Insured Person but not exceeding Sum Insured (all claims in aggregate) for that person as stated in the schedule in any one period of insurance.

	Hospitalisation Benefits	Limits
A	Room, Boarding Expenses as provided by the Hospital/nursing home.	Up to 0.5% of Sum Insured per day
	If admitted in IC Unit	Up to 1% of Sum Insured per day
B	Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees, Nursing Expenses	Up to 15% of Sum Insured per illness/Injury
C	Anaesthesia, Blood, Oxygen, Operation Theatre Charges, surgical appliances, Medicines & Drugs, Diagnostic Materials and X-ray Dialysis, Chemotherapy, Radiotherapy Cost of Pacemaker, Artificial Limbs & Cost of organs and similar expenses.	Up to 15% of Sum Insured per illness/Injury
D	Maternity Benefit – ONE CHILD ONLY(with 12 months waiting period)	Rs.2,500/- for normal delivery and Rs.5,000/- for caesarean delivery.

N.B: a) Company's Liability in respect of all claims including Maternity Benefit admitted during the period of Insurance shall not exceed the Sum Insured of Rs.30,000/- per person or family as mentioned in the schedule).

b) Total expenses incurred for any one illness is limited to Rs.15000/- (other than Maternity Benefit).

8. United India Insurance Company, "Family Medicare Prospectus," India, http://www.uiic.co.in/uhi_bpl.jsp.

The Policy is extended to include one Maternity Benefit with liability under the Section being restricted to Rs.2,500/- for normal delivery and Rs.5,000/- for caesarean delivery. A waiting period of 12 months from inception of the policy is applicable. The above amount would also cover the medical expenses incurred in respect of new born child up to 3 months. However, this benefit is within the overall limit of Sum Insured of Rs.30,000/-.

This benefit is available only once to an insured person during the currency of the policy or its subsequent renewals, i.e., only once during the life time of insured person.

SECTION II

A. PERSONAL ACCIDENT COVER TO EARNING HEAD

If the Insured Person (earning head of the family) shall sustain any bodily injury resulting solely and directly from Accident caused by outward, violent and visible means, and if such injury shall within 6 calendar months (unless otherwise specified) of its occurrence lead to death then the Company shall pay to the Insured the sum as specified below:

Death of Insured Person (earning head of the family) solely due to accident: Rs.25,000/-

B. DISABILITY COMPENSATION FOR EARNING HEAD AND/OR SPOUSE OF THE FAMILY

If the Earning head of the family/spouse is hospitalized due to accident/disease /illness for which there is a valid claim admitted under Section I of the policy then after a waiting period of 3 days, the Company shall pay to the earning head of the family or spouse a compensation of Rs.50/- per day from the fourth day of hospitalization up to a maximum of 15 days per policy period.

Note: The maximum liability of the Company is limited to Rs.750/- in all during the policy period in respect of II (B) above.

SECTION III. DEFINITIONS

1.0 HOSPITAL/NURSING HOME means any institution in India established for indoor care and treatment of sickness and injuries and which:

has been registered as a Hospital or Nursing Home with the local authorities and is under the supervision of a registered and qualified Medical Practitioner.

Or

(a) Hospital /Nursing Home run by NGOs/Government

Or

(b) Should comply with minimum criteria as under:

- (i) It should have at least 15 inpatient beds.
- (ii) Fully equipped operation theatre of its own wherever surgical operations are carried out.
- (iii) Fully qualified Nursing Staff under its employment round the clock.
- (iv) Fully qualified Doctor (s) should be in-charge round the clock.

N.B: In class 'C' towns condition of number of beds be reduced to 10.

The term “Hospital/Nursing Home” shall not include an establishment which is a place of rest, a place for the aged, a place for drug-addicts or place of alcoholics a hotel or a similar place.

- 2.0 “SURGICAL OPERATION” means manual and/or operative procedures for correction of deformities and defects, repair of injuries, diagnosis and cure of diseases, relief of suffering and prolongation of life.
- 3.0 EXPENSES ON HOSPITALISATION for minimum period of 24 hours are admissible. However, this time limit is not applied to specific treatments, i.e., Dialysis, Chemotherapy, Radiotherapy; Eye Surgery, Dental Surgery, Lithotripsy (Kidney Stone removal), D&C, Tonsillectomy taken in the Hospital/Nursing Home and the Insured is discharged on the same day, such treatment will be considered to be taken under hospitalisation Benefit. This condition will also not apply in case of stay in Hospital of less than 24 hours provided:

The treatment is such that it necessitates hospitalisation and the procedure involves specialised infrastructural facilities available in hospitals.

Due to technological advances hospitalisation is required for less than 24 hours only.

Note: When treatment such as dialysis, Chemotherapy, Radiotherapy, etc., is taken in the hospital/nursing home and the insured is discharged on the same day the treatment will be considered to be taken under hospitalisation benefit section.

Liability of the company under this clause is restricted as stated in the Schedule attached hereto.

- 4.0 MATERNITY BENEFIT means expenses incurred in Hospital/Nursing Home arising from or traceable to Pregnancy, childbirth including normal Caesarean Section. This also includes medical expenses incurred in respect of new born child up to 3 months.
- 5.0 ANY ONE ILLNESS:
- Any one illness will be deemed to mean continuous period of illness and it includes relapse within 60 days from the date of discharge from the Hospital/Nursing Home from where treatment was taken. Occurrence of same illness after a lapse of 60 days as stated above will be considered as fresh illness for the purpose of this policy.
- 6.0 MEDICAL PRACTITIONER means a person who holds a degree/diploma of a recognised institution and is registered by Medical Council of respective State of India. The term Medical Practitioner would include Physician, Specialist and Surgeon.
- 7.0 QUALIFIED NURSE means a person who holds a certificate of a recognised Nursing Council and who is employed on recommendation of the attending Medical Practitioner.
- 8.0 TPA means a Third Party Administrator who, for the time being, is licensed by the Insurance Regulatory and Development Authority, and is engaged, for a fee or remuneration, by whatever name called as may be specified in the agreement with the company, for the provision of health services.

SECTION IV. EXCLUSIONS

Applicable to Section 1

The company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

- 4.1 Injury/disease directly or indirectly caused by or arising from or attributable to invasion, Act of Foreign enemy, War-like operations (whether war be declared or not)
- 4.2 Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an accident, vaccination or inoculation or change of life or cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.
- 4.3 Cost of spectacles and contact lenses, hearing aids.
- 4.4 Dental treatment or surgery of any kind unless requiring hospitalisation.
- 4.5 Convalescence, general debility; run-down condition or rest cure, Congenital external disease or defects or anomalies, Sterility, Venereal disease, intentional self injury and use of intoxication drugs/alcohol
- 4.6 All expenses arising out of any condition directly or indirectly caused to or associated with Human T-Cell Lymphotropic Virus Type III (HTLB-III) or lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variation Deficiency Syndrome or any syndrome or condition of a similar kind commonly referred to as AIDS.
- 4.7 Charges incurred at Hospital or Nursing Home primarily for diagnosis x-ray or Laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of positive existence of presence of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home.
- 4.8 Expenses on vitamins and tonics unless forming part of treatment for injury or diseases as certified by the attending physician
- 4.9 Injury or Disease directly or indirectly caused by or contributed to by nuclear weapon/materials
- 4.10 Naturopathy Treatment

Applicable to SECTION II

- 4.11 Payment or compensation in respect of death directly or indirectly arising out of or contributed to by or traceable to any disability already existing on the date of commencement of this policy.
- 4.12 Death injury or disablements arising directly or indirectly from or traceable to:
 - i. Intentional self injury, suicide or attempted suicide
 - ii. Pregnancy or in consequence thereof
 - iii. Whilst engaging in aviation or Ballooning, whilst mounting into, dismounting from, or travelling in any Balloon or aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world.

- iv. Whilst under the influence of intoxication, liquor or drugs
- v. Directly or indirectly caused by venereal diseases or insanity
- vi. Arising or resulting from the insured committing any breach of law with criminal intent
- vii War and war like perils, nuclear perils, radioactivity etc.

SECTION V. CONDITIONS APPLICABLE TO SECTIONS I & II

1. Every notice or communication to be given or made under this Policy shall be delivered in writing at the address of the TPA office as shown in the Schedule.
2. The premium payable under this Policy shall be paid in advance.
3. No receipt for Premium shall be valid except on the official form of the company signed by a duly authorised official of the company. The due payment of premium and the observance and fulfilment of the terms, provisions, conditions and endorsements of this Policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be a condition precedent to any liability of the Company to make any payment under this Policy. No waiver of any terms, provisions, conditions and endorsements of this policy shall be valid unless made in writing and signed by an authorised official of the Company.
4. Upon the happening of any event which may give rise to a claim under this Policy notice with full particulars shall be sent to the TPA named in the schedule immediately and in case of emergency within 24 hours of Hospitalisation.
5. All supporting documents relating to the claim must be filed with TPA within 7 days from the date of discharge from the hospital.

Note: Waiver of this Condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.

The Insured Person shall obtain and furnish the TPA with all original bills, receipts and other documents upon which a claim is based and shall also give the TPA/Company such additional information and assistance as the TPA/Company may require in dealing with the claim.

6. In case of death of earning member of the family due to accident a post-mortem report must be submitted along with other documents of proof of death.
7. Any medical practitioner authorised by the TPA/Company shall be allowed to examine the Insured Person in case of any alleged injury or disease requiring Hospitalisation when and so often as the same may reasonably be required on behalf of the Company.
8. The Company shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the Insured Person or by any other person acting on his behalf.

9. If at the time when any claim arises under this Policy, there is in existence any other insurance (other than Cancer Insurance Policy in collaboration with Indian Cancer Society), whether it be effected by or on behalf of any Insured Person in respect of whom the claim may have arisen covering the same loss, liability, compensation, costs or expenses, the Company shall not be liable to pay or contribute more than its rateable proportion of any loss, liability, compensation costs or expenses. The benefits under this Policy shall be in excess of the benefits available under Cancer Insurance Policy.
10. The policy may be renewed by mutual consent. The Company shall not however be bound to give notice that it is due for renewal. The Company may at any time cancel the Policy on grounds of misrepresentation, fraud, non-disclosure of material fact or non-cooperation by the insured by sending seven days notice in writing by Registered A/D to the insured at his last known address in which case the Company shall return to the insured a proportion of the last premium corresponding to the unexpired period of insurance if no claim has been paid under the policy. The insured may at any time cancel this policy and in such event the Company shall allow refund of premium at Company's short period rate table given below provided no claim has occurred up to the date of cancellation.

Period On Risk .	Rate of Premium To Be Charged
Up to one month	1/4 of the annual rate
Up to three months	1/2 of the annual rate
Up to six months	3/4 of the annual rate
Exceeding six months	Full annual rate

11. If any dispute or difference shall arise as to the quantum to be paid under the policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this policy that award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.

12. If the Company, as per terms and conditions of the policy, shall disclaim liability to the Insured for any claim hereunder and if the Insured shall not within 12 calendar months from the date or receipt of the notice of such disclaimer notify the Company in writing that he does not accept such disclaimer and intends to recover his claim from the Company then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

13. All medical/surgical treatments under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency. Payment of claim shall be made through TPA to the Hospital/Nursing Home or the Insured Person as the case may be.

SECTION VI. AGE LIMIT

This insurance is available to persons between the age of 5 to 70 years. Children between the age of 3 months and 5 years of age can be covered provided one or both parents are covered concurrently.

SECTION VII. NOTICE OF CLAIM

1. Preliminary notice of claim with particulars relating to policy numbers, Name of Insured Person in respect of whom claim is made, Nature of illness/Injury and Name and Address of the attending Medical Practitioner/Hospital/Nursing Home should be given by the insured person to the TPA immediately and in case of emergency hospitalisation within 24 hours from the date of Hospitalisation. In case of notice received beyond 24 hours from the time of hospitalisation etc., the matter may be referred to the insurer for considering waiver of the condition, wherever felt appropriate.
2. Final Claim along with receipted Bills/Cash Memos, claim form and list of documents as listed in the claim form, etc., should be submitted to the TPA within 7 days from the date of completion of treatment.

Note: Waiver of the Condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insurer was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit.

SECTION VIII. PAYMENT OF CLAIM

All claims under this policy shall be payable in Indian currency. All medical treatments for the purpose of this insurance will have to be taken in India only. Payment of claim shall be made by the TPA on behalf of the Company either to the Hospital/Nursing Home or the Insured Person as the case may be.

SECTION IX. DETAILS OF INSURED PERSON:

The insured shall be required to furnish a complete list of insured persons in the following format. Any additions and deletions during the currency of the policy should be intimated to the Company in the same format. However, such additions and deletions will be incorporated in the policy from the first day of the following months subject to pro-rata premium adjustment.

Sr. No.	Names of Insured Persons	Relation with Insured	Age	Sex
1				
2				
3				
4				

NOTE: No refund of premium will be allowed for deletion of Insured person in the event of Insured Person having made/recovered a claim under the policy.

SECTION X. SUM INSURED

Section I: Hospitalisation Benefit: Rs.30,000/- per family – per policy period (Rs.30,000/- is inclusive of Maternity benefit of Rs. 2500/- for normal and Rs.5000/- for caesarean delivery)

(Total expenses incurred for any one illness is limited to Rs.15,000/- (other than Maternity Benefit))

Section II: (A) Accidental death of earning head of the family Rs.25,000/-

Section II: (B) Disability compensation payable due to hospitalisation of earning head and or spouse at the rate of Rs.50/- per day up to maximum of period of 15 days in a policy year with a time excess of 3 days . Maximum compensation is restricted to Rs.750/- in one policy year.

XI. PAYMENT OF PREMIUM

Coverage	Premium	Insured's Share	GOI Subsidy
Individual	Rs.300/-	Rs.100/-	Rs.200/-
Family up to 5 Members	Rs.450/-	Rs.150/-	Rs.300/-
Family up to 7 Members	Rs.600/-	Rs.200/-	Rs.400/-

Family (not exceeding 5) consisting of Insured, spouse and first 3 dependent children Rs.450/-per annum.

Family (not exceeding 7) consisting of Insured, spouse, first 3 dependent children and parents Rs. 600/-per annum

SECTION XII. CLAIM MINIMISATION CLAUSE

The Insured will at all times cooperate with a TPA/Company to contain claims ratio by ensuring that the treatment charges and other expenses are reasonable.

SECTION XIII. BPL FAMILY

A certificate as proof thereof issued by an official not below the rank of B.D.O./Tehsildar of Revenue Department of the concerned State Government has to be attached.

SECTION XIV. PROTECTION OF POLICY HOLDERS' INTEREST

In compliance to IRDA (Protection of Policy Holders' Interest) Regulations, 2002, the Company has opened grievance cell at Regional Office as well as Head Office. The policy holder may submit his complaint/grievance to the said grievance cell of the Company for remedial action.

The prospectus shall form part of your proposal form hence please sign as you have noted the contents of this prospectus.

Signature

Name

Place

Date

New York⁹

**STATE CHILD HEALTH PLAN
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: New York State
 Organization: New York State Department of Health
 Address: Corning Tower, 14th Floor
 Empire State Plaza
 Albany, New York 12237-0001

Supervising Official: Dennis P. Whalen
 Executive Deputy Commissioner

As a condition for receipt of Federal funds under Title XXI of the Social Security Act,

(Signature of Governor of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Program and hereby agrees to administer the program in accordance with the provisions of the State Child Health Plan, the requirements of Title XXI and XIX of the Act and all applicable Federal regulations and other official issuances of the Department.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

9. <http://www.health.state.ny.us/nysdoh/child/chcont.htm>.

Appendix C. Current and Future Benefits Package

	Current coverage	Future coverage
Services Provided at Primary Health Facilities¹		
Outpatient Care		
General curative consultation		
Ancillary services		
Small surgical procedures		
Dental care		
Laboratory exams		
Brand Name Drugs		
Essential generic drugs		
Transport		
Ambulance		
Inpatient Care		
Hospital stay		
Imagery/Echography/X-rays		
Laboratory exams		
Brand Name Drugs		
Essential generic drugs		
Medical consumables		
Maternity Care		
Prenatal consultation		
Postnatal consultation		
Family planning		
Simple delivery		
Hospital stay		
Imagery/Echography		
Laboratory exams		
Brand Name Drugs		
Essential generic drugs		
Services Provided at Hospitals		
Outpatient Care		
General curative consultation		
Specialty consultation		
Ancillary care		
Small surgical procedures		
Dental care		
Laboratory exams		
Imagery/Echography/X-rays		
Brand Name Drugs		
Essential generic drugs		

Note: The material in this appendix was reproduced verbatim from the official sites referenced in the notes.

1. United India Insurance Company, "Family Medicare Prospectus," India, http://www.uiic.co.in/uhi_bpl.jsp.

	Current coverage	Future coverage
Transport		
Ambulance		
Inpatient Care		
Hospital stay		
Imagery/Echography/X-rays		
Laboratory exams		
Brand Name Drugs		
Essential generic drugs		
Medical consumables		
Surgical procedures		
Maternity Care		
Specialty and gynecological consultation		
Delivery with complications		
Caesarian Section		
Hospital stay		
Laboratory exams		
Imagery/Echography/X-rays		
Brand Name Drugs		
Essential generic drugs		
Exclusions		
Antiretroviral drugs		
Vision glasses		
Contact lenses		
Care outside of the country		
Others?		

Appendix D. Additional Reading

Section 2. Design Element 1: Feasibility of Health Insurance

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Recently Published

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**—Mrs. Roman Tesfay, Director General
Policy, Planning, and Finance Directorate
Federal Ministry of Health
Ethiopia**



ISBN 978-0-8213-8982-9



SKU 18982