WHO-EM/HEC/043/E

Report on the

Regional meeting on strengthening the implementation of social health insurance schemes for universal health coverage

Amman, Jordan
1–4 June 2014

World Health Organization
Regional Office for the Eastern Mediterranean

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1. INTRODUCTION

The achievement of universal health coverage is one of the most important commitments of countries, both globally and in the World Health Organization (WHO) Eastern Mediterranean Region. Achieving universal health coverage requires a portfolio of policy measures. It is not an easy goal. In a recent study of 194 countries, Feigle and Ding (2013) estimated that only 51 of 74 countries that had legislatively approved universal health care coverage had actually achieved it.

One of the important tools used by many countries, including in the Eastern Mediterranean Region, in the pursuit of universal health coverage is social health insurance. Several countries in the Region have national social health insurance schemes and there is increasing interest in social health insurance in the other countries. Most Eastern Mediterranean Region countries with social health insurance have coverage for the formal (employed) sector and there is also increasing interest in subsidizing coverage for the informal sector, especially in Group 1 countries. Morocco, Pakistan and Tunisia have social health insurance for the formal sector with separate subsidized schemes for the poor/informal sector. Egypt, Islamic Republic of Iran and Sudan have social health insurance for the formal sector and have a subsidized scheme within the social health insurance programme for the poor/informal sector. Djibouti and Lebanon have social health insurance schemes for the formal sector. Jordan and occupied Palestinian territory have social health insurance schemes managed by their ministries of health.

There is increased interest in implementing social health insurance, with some countries having passed social health insurance laws (Libya, Yemen). Some countries with a national health service are considering introducing social health insurance (Bahrain). Afghanistan and Somalia are both currently in the process of evaluating the potential for using social health insurance within their health systems. There are, however, continuing concerns about the appropriateness of social health insurance as a tool in many countries, ranging from the appropriateness of social health insurance versus other financing mechanisms to the challenges of extending coverage to the informal sector. Clearly, social health insurance is only one among many potential mechanisms available to policy-makers in the pursuit of universal health coverage. It is, however, a particularly useful policy tool in certain situations. Like any tool, its success depends largely on the details, not only of specific policies, but also of implementation. This was the rationale for the meeting.

The regional meeting was held in Amman, Jordan from 1 June to 4 June. It was attended by participants from 14 countries of the Region, selected experts, staff from Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) and United Nations Children's Fund (UNICEF) Middle East and North Africa Regional Office, as well as WHO staff from country and regional level. It focused on the practical challenges of implementing social health insurance in pursuit of universal health coverage. The intention was to provide a forum for honest discourse around real situations and practical concerns. The meeting was designed to focus on six key elements of social health insurance implementation: 1) fund management; 2) information management; 3) governance; 4) provider management; 5) membership management; and 6) benefit design. Inputs from technical experts as well as

presentations from countries provided a background for discussion. Each topic included discussion with a panel of resource persons.

The meeting began with a discussion of the current situation, with updates and key opportunities and challenges concerning universal health coverage around the Region. The meeting ended with feedback from each country covering insights, country challenges, potential applications of inputs from the meeting and suggestions for next steps, especially for working with WHO towards advancing the pursuit of universal health coverage using social health insurance. Discussion over the course of the meeting focused primarily around four key concerns: ensuring sustainability; addressing multiple programmes; challenges of addressing providers; and challenges of managing patient behaviour and expectations.

This report does not summarize specific technical or country inputs, but rather provides an overview of the discussions and potential future actions.

2. UNIVERSAL HEALTH COVERAGE AND SOCIAL HEALTH INSURANCE

Using the WHO framework, there are three dimensions for achieving universal health coverage: the proportion of the population that is covered, the services or benefit items that are covered, and how much financial support is provided.

A formal definition of universal health coverage was developed at the 2010 Global Symposium on Health Research. This definition has two critical components: (a) a legislative mandate to provide a health plan with a clearly specified package of services and with a specific year for implementation; and (b) at least 90% population access to skilled attendance at birth and health care insurance. This definition is similar to the universal health coverage determinants used by Feigle and Ding (2013), which uses three components: a legislated framework; at least 90% population access to skilled birth attendance; and at least 85% population access to formal coverage.

In discussion, it was pointed out that, in reality, there are variations in services covered and financial protection offered between the different populations covered. The differing needs and situation of different segments of the population naturally result in programmes designed specifically to meet the situation. This is the reality that any health policy or scheme, including social health insurance, needs to take into account. This was a critical juncture in discussions and was referred to multiple times during the rest of the four days of the meeting as key implementation challenges arose from this observation, not only in terms of priority setting but also in terms of practical realities.

It was further pointed out that universal health coverage has a clear financial objective, that of preventing impoverishment as a result of a disability or other health event. Moreover, the WHO universal health coverage framework specifically refers to pooled funds anchoring health coverage. This explains why financing is such an important building block for attaining universal health coverage. Particular attention needs to be paid to overreliance on out-of-pocket expenditures as a source of health care financing as this is indicative of the potential for health-induced impoverishment.

In the Eastern Mediterranean Region in 2011, about 46% of total health expenditures were financed through out-of-pocket expenditures, 48% from general government expenditures, 7% from social health insurance and 3% from private insurance. By contrast, of total world health expenditure, only 18% is financed out-of-pocket, with 23% from general government expenditures, 37% from social health insurance and 16% from private insurance. Social health insurance is present today in over 60 countries, and 27 countries have achieved universal health coverage through social health insurance. While it was acknowledged that, historically, social health insurance became prevalent primarily in OECD countries, there is increasing use of social health insurance in developing countries.

Within financing, the three key components that need to be addressed are: collection, pooling and purchasing. In the pursuit of universal health coverage, whether or not social health insurance is considered, all of these three aspects of financing must be considered.

It is important to remember that there are many possible approaches to implementing social health insurance and an understanding of the modern evolution of social health insurance is important when using it as a tool for universal health coverage. A practical understanding of the definition of social health insurance can be developed by remembering some common features or elements:

(a) social health insurance has a foundation of social solidarity;

(b) social health insurance relies on a publicly-mandated membership for a designated segment of the population;

(c) social health insurance is typically reliant, at least partially, on compulsory payroll contributions (with possible subsidization from government and donors);

(d) there is a clear linkage between contributions and a set of defined rights for the insured population;

(e) the social health insurance system is anchored by an independent or quasi-independent system of funds;

(f) the social health insurance system is managed with some degree of autonomy;

(g) nobody from the publicly-mandated population can be denied coverage (open enrolment).

Given this practical definition, it is clear that there are many elements of social health insurance that make it attractive as a tool for achieving universal health coverage.

It was pointed out in discussion that there is evidence pointing to social health insurance having improved efficiency compared to tax-based financing systems (in Jamaica, Kenya and Malaysia). It was also pointed out that there are some factors that lead to social health insurance being an effective mechanism for raising additional resources for health: individuals are more willing to be taxed if those taxes are associated with specific entitlements (a benefit tax); mandated contributions are not subject to annual budget negotiations; and unutilized funds are retained within the system.

The legislative mandate that is the foundation of social health insurance provides a strong basis for patient rights to services. When the legislative mandate covers the entire population, then this becomes the legislative foundation for universal health coverage. It can also be argued that a social health insurance scheme, especially when implemented within a mixed provider system, provides a stronger foundation for contestability in health care services.

In a national health service, the typical legislative foundation is focused on infrastructure and other assets. There is often less clarity concerning the entitlements of citizens to services. The availability of funds for a national health service is typically part of the annual budget process, and is usually reliant on general revenue. In a national health service system, the focus is on building supply. The challenge tends to be in ensuring that the supply thus built provides the appropriate services to the correct population (for instance, in the correct locations) with the appropriate quality and efficiency. As building this supply requires both operating expenses as well as significant capital investments, there is also the challenge of long-term financial sustainability,

By contrast, the essence of the legislative foundation for social health insurance is the definition of the covered population, the benefit entitlements of the covered population, the required contributions and the disposition of funds. Hence, a social health insurance scheme addresses two critical aspects of universal health coverage: the rights of patients to care; and a clear financing mechanism.

In a way, a social health insurance scheme is essentially a demand intervention. It provides the covered population with the right to demand specific services from specific providers. This is significantly different from the entitlements under a national health service scheme in a very important way. The demand for services under a social health insurance scheme is based on the promise of a payment resulting from the patient's membership in the social health insurance and the patient's use of (or enrolment for use of) services. By contrast, the funding in a national health service system flows primarily from the state and is often seen by providers as having only a tenuous relationship to individual demands for services. Hence, a social health insurance scheme typically has a significant influence on both patient and provider behaviour.

A social health insurance law also provides a legal foundation for the obligation of specific providers to provide such services. Where a national health service system puts the ministry of health in the position of managing and potentially speaking for providers in disputes between patients and providers, a social health insurance system puts the ministry of health in the position of a purchaser of services articulating the rights of the patients (covered population) to its providers. This can be a particularly powerful perspective and would affect state behaviour both in activities involving influencing provider behaviour as well as in activities involving patient behaviour.

In the area of financing, a social health insurance law typically specifically articulates all three aspects of financing: (a) collection through explicit provisions concerning contributions; (b) pooling through explicit provisions concerning funds and fund management, as well as provisions concerning equity; and (c) purchasing through specific provisions concerning providers.

3. UNIVERSAL HEALTH COVERAGE IN THE EASTERN MEDITERRANEAN REGION

In the Eastern Mediterranean Region, as in other regions, there are countries that lean more towards social health insurance and countries that lean more towards a national health system. However, as elsewhere, many countries rely on mixed systems.

It was pointed in discussion out that there is no one solution for all countries, and not even one single solution for one country. Social health insurance is a financing mechanism and statistics around the globe show that no country relies on a single financing mechanism. What is critical, though, is to avoid an overreliance on out-of-pocket payments as this is the financing source that potentially leads to impoverishment.

There is a wide range of situations in the countries of the Region, both in terms of financial resources ad in the current state of the health system. Participants pointed out both general as well as country-specific concerns and challenges, as follows.

(a) Stability is a critical concern for social health insurance. General revenues provide stability that contributions may not.

(b) Changes in government can endanger the effectiveness and stability of social health insurance, especially in the early years.

(c) Since social health insurance explicitly articulates benefit entitlements, it creates expectations among the covered population. These expectations need to be met over the long term. Hence, financial sustainability is a critical concern. Inflation in health care costs is an important consideration.

(d) Articulated benefit entitlements also pose sustainability concerns when policy decisions are made without adequate analysis or evidence.

(e) Mixed provider systems pose a particular challenge for social health insurance. General perceptions of relative quality between public and private providers affect the utilization of services by the covered population. This poses concerns over the appropriate use of resources.

(f) Affordability is a key concern for developing countries. Programmes for the formal population are typically easiest to establish and maintain. Typically, employee contributions are withheld by employers at source and employer contributions are a matter of compliance. The informal sector is much less tractable. For those with means in the informal sector, there is often no single convenient mechanism for collection. For those with no means (the poor), a sustainable source of funds is critical.

(g) In addition to the nature of the economy, the expectations of the covered population are important. As an example, long-term financial sustainability would be difficult to achieve if a significant portion of services are purchased from out-of-country. In cases where there are historical reasons for these expectations, there must be programmes designed both to ensure the availability of quality care locally as well as to influence patient expectations and perceptions.

(h) In transition economies, challenges exist in many areas, but particularly in terms of two aspects: the infrastructure of governance and provider resources. In these countries, there is often a need for capacity-building for health policy administrators, and, in certain cases, even health policy-makers. Many segments of the health provider system also often require renewed investment. In many transition economies, not only are there not enough health care workers, there is often a great incentive for local health care workers to move to more advanced economies.

(i) Where private insurance schemes exist, their effect on the social health insurance scheme and the behaviour of patients and providers, particularly private providers, could be either beneficial or inimical.

(j) In some countries, social health insurance schemes are not managed by a clearly autonomous entity. In these cases, the effective and efficient implementation of social health insurance is particularly threatened both by uncertainty in financial resourcing as well as potential instability as a result of changes in government.

(k) In countries with more developed systems, the concerns include ensuring more responsive benefits, potentially integrating multiple systems to more efficiently achieve social solidarity and long-term sustainability, and appropriate use of technology both to provide increased service as well as to minimize waste (including fraud).

It was also pointed out that social health insurance is only one tool for achieving universal health coverage. Providing funding via the social health insurance tool in its simplest individual-based benefit entitlement mechanism form is particularly efficient in areas where there is a large enough population to provide a potentially viable and competitive market. There are clearly exceptions and two are particularly obvious and important. These exist at both ends of the spectrum.

The first exception is health care services that are relatively inexpensive and need to be administered to the general population (for example, vaccinations). While these could be administered through a typical social health insurance system, they are typically more efficiently managed through the more typical public health approach. Of course, it is important to point out that, even in these cases, the ministry of health can simply be steward and purchaser as opposed to provider.

The second important exception is segments of the population that are small and isolated. These could be isolated as a result of geography or isolated as a result of epidemiology (such as those with a rare disease), or even isolated as a result of demography (such as a small segment of the population who are particularly prone to specific illnesses). Specific policies need to be created in all these cases. For those isolated due to geography, supply side interventions may be necessary. For the latter two, the basic packages in a social health insurance may not be the best means of addressing these isolated populations. Other mechanisms may need to be developed.

In addition to general concerns about social health insurance schemes, there are concerns about specific challenges in implementing and managing them. These were addressed within the six elements covered in the four-day programme.

4. SOCIAL HEALTH INSURANCE IN THE EASTERN MEDITERRANEAN REGION

Many countries in the Region have some form of social health insurance. The long-standing programmes began with social health insurance for the formal sector. Currently, the effort in these countries is to extend the scheme to the rest of the population. Typically, the approach after covering the formal sector is to cover the poor and other vulnerable segments of the population. These programmes for the poor and vulnerable are typically subsidized.

4.1 Extending coverage to vulnerable populations

Morocco and Tunisia have formal sector social health insurance schemes with separate, subsidized social health insurance schemes for the poor and vulnerable populations. Pakistan has already announced a government-subsidized social health insurance scheme for the poor. Both Djibouti and Lebanon are in the process of designing separate social health insurance arrangements for the poor to complement long standing formal sector social health insurance programmes.

Morocco's programme, Le Regime d'Assistance Medicale is currently being expanded to cover the poor and near poor populations. Poor families will be provided with a 3-year card providing zero co-payment access to government hospitals. Near-poor families may purchase these cards by paying 120 dirhams per person annually.

Tunisia's programme, Assistance Medicale Gratuite (AMG) aims to cover the poor and near poor, with the focus being on families who are provided with Progamme National d'Aide Aux Families Necessiteuses cash transfers. AMG beneficiary families are to be provided with a five-year card providing access to government hospitals with zero co-payment for the poor and 20% co-payment for the near poor.

Pakistan aims to implement a social health insurance scheme for the poor, which is to be jointly managed by the federal and provincial governments. The programme is expected to eventually incorporate similar programmes under the Benazir Income Support Programme.

4.2 Rapid increase in reach through social health insurance for the poor

Three countries in the Region, Egypt, Islamic Republic of Iran and Sudan, are in the process of consolidating formal sector social health insurance schemes with schemes for the poor and vulnerable populations. In these countries, government subsidy provided a means for rapid increase in insurance reach.

In Egypt, the Health Insurance Organization covers 57% of the population. Of this covered population, 40% are accounted for by partially subsidized primary and secondary

students, and 32% are the fully subsidized “under six” population. A proposed law calling for mandatory health insurance coverage is currently being drafted.

In the Islamic Republic of Iran, the fully subsidized rural health insurance covers nearly 23 million rural Iranians while the recently launched Health Evolution Plan is expanding insurance coverage to millions of urban poor. In Sudan, the National Health Insurance Fund has been working with the Ministry of Welfare and the Zakat charities in the Social Initiative Project to subsidize nearly 400 000 Zakat community-identified poor families.

In both Jordan and occupied Palestinian territory, formal sector programmes are also consolidated with government subsidized programmes. However, in these countries, there is no separate entity managing the social health insurance scheme. Rather, the schemes are managed by their ministries of health. In these countries, the ministry of health-managed hospitals and other health facilities function much like health facilities that are directly owned by an insurer, with no reimbursements or payments for care.

In Jordan, the covered population of the Civil Insurance Programme increased from 26% to 41% of the total population when all children under the age of six were added as insured members. In occupied Palestinian territory, the fully subsidized Al Aqsa scheme for Palestinians who have lost their jobs had covered around 177 000 people by 2013.

4.3 New social health insurance programmes

Libya and Yemen have both passed laws for establishing social health insurance schemes. Yemen has already a social health insurance authority. Libya is in the process of establishing social health insurance. One of its most important challenges is how social health insurance can help rationalize its programme of paying for overseas care of its citizens.

4.4 Possible shifts to social health insurance

Among Gulf Cooperation Council countries, Bahrain and Saudi Arabia are both considering transforming their national health services systems into social health insurance arrangements similar to the shift from national health service to social health insurance by Qatar and the Abu Dhabi and Dubai emirates of the United Arab Emirates.

Finally, Afghanistan, Iraq and Somalia are currently evaluating the advantages and feasibility of setting up social health insurance arrangements.

5. SUSTAINABILITY AND IMPLEMENTATION CHALLENGES

As countries in the Region progress on the path towards universal health coverage, there is growing recognition that the key to success lies in addressing certain legacy concerns and in the details of implementation.

In achieving universal health coverage through social health insurance, long-term sustainability is not merely a function of economics, it is also a function of politics and social support. This is true of all government social services programmes.

Socio-political support is a function of both real and perceived relevance. In social health insurance, it is important to be able to clearly identify population segments and the benefits (including level of financial protection) provided. Achieving real relevance requires the ability to generate information concerning actual health status and needs of the differing segments of the population. Achieving perceived relevance involves effective communication.

Along the three dimensions of universal health coverage, the typical first target is to extend the dimension of population coverage. Once breadth is achieved in terms of population coverage, then increases in financial support and services covered can be aimed for. However, the regional experience shows that providing subsidized coverage for vulnerable populations can provide rapid increases in the covered population.

It became clear in discussion that policy-makers are aware that achieving universal health coverage does not mean paying everything for everyone. Rather, it is about developing a system of priorities that provides a basic level of services that addresses the needs of the population.

The aim of preventing health-induced impoverishment clearly means that equity in social health insurance is not a matter of equality. In fact, the concept of social solidarity also points to this. For policy-makers, providing a high level of protection via social health insurance for the indigent population is rational as this is the population that is most vulnerable. Policies that ensure that the non-indigent population has access to care (such as through savings or supplemental insurance) could then be used to augment social health insurance.

While this nuanced benefit-setting policy is rational and would be expected to generate support from the poor, it is not guaranteed to generate political support from all. This needs to be taken into account both in policy setting as well as in communications. Also, it is important that policy setting and communications in social health insurance be aligned with general ministry of health and government policies and communication.

Economic or financial sustainability involves three general aspects of social health insurance management. The first is the general concern: achieving a long-term balance between benefit entitlements and contribution levels. Clearly, this involves judicious definition of services covered and target financial support. In addition, this also covers the development of a sustainable mix of financing sources. In terms of sources of financing for social health insurance, the general sources are member contributions, employer contributions, subsidies from donors and subsidies from government.

In general, some form of cross-subsidization from those with higher income to those with lower income is designed into the contribution schedules. However, evidence from developing nations shows that financial sustainability of coverage for the informal sector, particularly the poor, is unlikely to be sustainable without some form of government or donor subsidy. The reason for this is that the informal sector are generally either unwilling or unable to bear contributions, and contributions from the formal sector are generally not enough to provide cover to both the formal sector as well as all of the informal sector.

In terms of subsidies, donor funding is clearly not a permanent solution. Generally, donor funding can be utilized to jump start a programme. Eventually, a more permanent source of funding must be developed. Government subsidies are a more permanent source of financing. The two potential sources are general revenue or specific (hypothecated) taxes. Subsidies coming from general revenue become subject to annual budget negotiations and can become unstable. A potential treatment for this is to establish a relatively long target buffer amount for the fund. Specific taxes (e.g. sin taxes or some portion of value added taxes) are insulated from the annual budget process. However, care must be taken to ensure that the hypothecated tax revenue is enough to cover expected required subsidies.

The next two aspects of financial sustainability support the first: (a) strategic analytics, appropriate policies, and rational decision-making; and (b) efficient management of the social health insurance system.

Policy-setting requires accurate analyses concerning the population, likely costs of benefits and likely contributions, and developing policies that take these into account in a rational manner. Clearly this also requires that the social health insurance system is able to capture timely, accurate and complete information. The most important policies have to do with benefit entitlements, contribution levels, provider responsibilities and payments, and fund management.

Efficient management in social health insurance involves: (a) efficient administration of databases, especially with regard to members and providers; (b) efficient collection of contributions; (c) timely and accurate payment of benefits; and (d) prudent management of funds.

Effective and transparent governance policies, structures and mechanisms are critical to effective management. In managing the behaviour of all parties, payors, members and providers, it is important for the social health insurance system to understand and manage the resulting system of risks, incentives and costs.

While inflation is a critical ingredient in making long-term projections for social health insurance funds, other trends and changes are also important. It is extremely important to take into account the changing pattern not only in patterns of disease but also of population demographics. Historical evidence shows that the inevitable results of advances in medicine and improving economies, is longer life expectancies and smaller family sizes. These in turn result in aging populations and increased per capita costs of care. It is important for policy-makers to take a very long-term view when asking for analytics to support policy-setting.

Both in the area of communicating with its publics as well as in the area of laying the foundation for rational policy, information system management is a critical function. Information systems must capture information relevant to the four key users of information: policy-makers, payers, providers and patients.

6. SUSTAINABILITY AND THE SIX ELEMENTS OF SOCIAL HEALTH INSURANCE IMPLEMENTATION

Each of the six elements of social health insurance implementation discussed in the meeting addressed at least one of these factors of sustainability.

6.1 Fund management

At the core of a social health insurance scheme is an independent fund. This fund is an important element of a pragmatic social health insurance system.

The fund is at the heart of the many decisions made for social health insurance: decisions concerning benefits, contributions, subsidies, and even administrative decisions that affect expenses. There are also decisions that affect the fund itself.

The social health insurance fund can be understood first by understanding its constituents. It is increased by contributions and investment income, and is decreased by benefits and expenses.

One of the more important policies affecting fund management has to do with developing contribution schedules. For the formal sector and the non-poor informal sector, one key concern is balancing the desired level of progressiveness in contributions with the practical acceptability of high rates of contribution. For poor and near poor populations, the typical concern is the development of a sustainable source of subsidies. While general revenue is certainly an option, a hypothecated tax is less likely to be affected by budgetary negotiations.

A critical balance needs to be achieved between providing benefits significant enough to be relevant and to gain substantial social support, while ensuring that contributions are both acceptable as well as enough to sustain benefits. In schemes that are meant to support universal health coverage, it is particularly important to take note of long-term trends, not only in epidemiology and treatment, but also in medical inflation and national demographics.

With respect to expenses, most social health insurance schemes have spending caps for both operating expenses as well as capital expenditures. These are typically embedded in the social health insurance law and are expressed as a percentage of benefits, or funds, or contributions or some combination of these.

A very important policy for any social health insurance institution is the funding target. Technically, the funding policy can lie anywhere in the spectrum of pay-as-you-go (virtually no funding) to fully-funded. Many funds lie in between, being partially funded. For these funds, the fund financial reporting focuses on estimating a fund lifetime.

In reality, most social health insurance agencies, even those who subscribe to a pay-as-you-go policy maintain at least a buffer fund, ensuring that the fund can continue to provide benefits even in a year of unusual requirements.

Another policy that needs to be developed is how many different internal funds are to be maintained within the social health insurance scheme. For example, a separate fund could be maintained for coverage for retirees of the formal sector, especially if the intention is for the fund for this is to be developed during the working lifetime of the employee.

For countries moving towards universal health coverage, which means including the old and infirm, it is extremely important to be able to take into account the long-term effects of decisions. This requires actuarial analyses. These analyses must take into account short term and long-term effects of decisions. These analyses in aid of decision-making supplement the regular actuarial analyses.

6.2 Information management

Information management has always been a critical factor in health systems. Public health policy requires information concerning citizens and their health status, information concerning health providers, information concerning disease, treatments, and many other things. Similarly, insurance systems are data-driven.

In examining the three dimensions of universal health coverage, it is clear that each dimension requires the collection of data and the development of information. In order for the information to be able to drive effective policy and decision-making, a certain commonality of standards needs to exist between health information systems and health insurance information systems. More importantly, a certain commonality of standards needs to exist between the different entities involved in capturing and using the data.

In health systems, there are four groups of stakeholders: patients, providers, payors and policy-makers.

In Asia, the WHO created the Asia eHealth Information Network, a group composed of over 400 members in 20 countries. It is an informal network of ehealth advocates concerned with national scale health information systems, with a special focus on standards and interoperability.

As the health system is complex and is influenced by many players with differing points of views and objectives, information is a key element in ensuring that conversations concerning health policies are rational.

The Open Health Information Exchange Framework is one approach to developing such a set of shared standards.

Within this framework, certain critical components aid in attaining interoperability: (a) master registries for the population and for providers with a single ID for each individual in the population registry and a single identify for each health provider and each health facility; (b) a common set of terms and code sets such as the WHO ICD (International Classification of Diseases) and a standard nomenclature for medicines; and (c) shared health records.

Key challenges in information management involve capturing the data, ensuring that the data is organized into databases that are well-managed, and ensuring that the data is used well.

International standards exist for many code sets and it was pointed out in discussion that it is important to use such standards when they are available. Many other specific practical concerns were also pointed out. Data hosting is a concern as it is important to balance both the safety of the data through some form of back-up as well as to maintain privacy. Access to a single, shared database would be a challenge in many places where access to the internet is difficult or even non-existent. It was pointed out that the readiness and maturity of countries varies.

For many countries, developing integrated registries will involve migration from old, legacy systems. It is important that this change be well-managed.

6.3 Governance

A social health insurance scheme exists within a larger system. When social health insurance governance is developed and evaluated, it must be viewed within the context of at least two other governance mechanisms: the entire health system and that of the health markets. It is important to understand who the key players are within the health system, what their roles and responsibilities are, what their powers and authorities, and finally, what the legal bases of these roles, responsibilities, powers and authorities are.

Within the social health insurance system itself, a key question is whether there exists a single, separate legal entity or agency to manage the social health insurance scheme or schemes. The character of this agency is also important. In studies of health systems, especially those moving towards stewardship and those using social health insurance, one strong recommendation is to separate the function of purchasing health care form the function of providing health care.

The first, most important element of social health insurance governance is the legal foundation. This provides a touchstone for policy setting and typically also provides the legal basis for the existence of a social health insurance agency as well as its charter.

Ideally, the law establishing the social health insurance also includes provisions concerning governance: the composition of the Board, mechanisms for representation of key stakeholders, responsibilities and authorities of the board and key officers, required reports to the public and other key stakeholders, provisions concerning benefit targets and financial sustainability.

In discussion, concerns were expressed over the particular objectives and situations in some countries. These related to: (a) implementing a legal charter that turns out to be impractical, such as attempting to collect from the informal sector; (b) multiple agencies or entities; (c) multiple schemes under separate organizations; (d) achieving flexibility in order to address local challenges; and (e) decisions concerning outsourcing certain functions.

6.4 Provider management

A social health insurance scheme can deal with both public and private providers. While some social health insurance schemes decide to deal only with public providers, one of the strengths of a social health insurance scheme is its ability to channel financing to both public and private providers in order to promote market competition, which can lead to improved care for citizens.

In managing providers, a social health insurance scheme must work within the regulatory provisions of the country. In countries where the licensing of medical professionals and health facilities is well established, the social health insurance agency can use the government licensing system as a foundation for its own contracting.

It is important to remember that the essence of the relationship between the social health insurance agency and the provider is a contract. This contract allows the separation of the function of purchasing care from the function of providing care. This essential separation is lost when the social health insurance agency essentially owns the public providers.

In managing providers, there are four primary functions: (a) contracting, which may include accreditation-like activities; (b) payment; (c) performance evaluation; and (d) data collection. The contract must cover the details of the other three functions.

It is important to choose a payment scheme that takes into account the current situation, addresses key objectives and is practical. In general, each payment scheme creates certain incentives and disincentives. It is important for the social health insurance agency to understand this bundle of incentives and disincentives, and to balance them in the other areas of its contract and evaluation.

It was pointed out that the body of data pointing to the effectiveness of performance-based (also called value-based or risk-based) payments to providers is now mounting and there seems to be cause to consider these types of schemes where providers are well established.

Practical considerations concerning payments include: addressing global budget concerns; national payment rates versus localized payment rates; addressing pockets of low provider supply through financial incentives; and managing perverse results.

The experience in the Republic of Korea seems to indicate that certain payment mechanisms turn out to be less practical for certain types of expenses – for example, case rates are difficult to develop for very specialized services or conditions, while capitation seems easiest to adopt for primary care.

The management of providers also involves the ability to detect provider fraud in claims settlement.

6.5 Membership management

Membership management involves the important functions of: (a) enrolment; (b) collection; (c) benefit management; and (d) maintenance.

Enrolment within a national social health insurance usually involves classification. This is especially important when subsidies are available. Typically, there is a method of eligibility testing such as a means test.

Enrolment very often requires more than simply announcements. In the case of the informal sector, more direct face-to-face means are often necessary. This can be expensive if created from scratch. Hence, a social health insurance agency is often best served by evaluating existing government infrastructures and exploiting these. For example, if there already exists a system of village health officers or social welfare representatives, this can be used to approach potential members. On-site evaluation at health facilities is also a possibility.

Once members are enrolled, they must then be made aware of their benefits and the procedure for availing of these benefits. In many places, this involves receiving an ID and understanding what services are available and where these services can be accessed.

One of the barriers to the use of social health insurance benefits is often the paperwork involved in accessing them. The easier benefits are to access, the more effective coverage becomes. This leads to improved member satisfaction and higher rates of renewal of membership, as well as higher levels of compliance with mandatory contributions and membership.

Membership management also involves the ability to detect member abuse of services, including fraud (such as allowing non-members to use an ID).

6.6 Benefit design

Benefit design is essentially a matter of prioritization. In order to prioritize, any system must first decide on its basis for prioritization. Typically, this includes identification of critical health metrics and outcomes (for example, incidence of certain morbidities, life expectancy and quality-adjusted life years).

Benefits can be defined implicitly or explicitly and can include both a positive list (what is covered) and a negative list (what is excluded or not covered). Defining a benefit involves defining who is eligible for the benefit, what conditions are covered, what treatments are covered for that condition, which providers are allowed for these treatments, and finally what financial protection or benefit limit is provided.

Coverage decisions involve many factors, including burden of disease, treatment effectiveness and economics. In deciding on covering new treatments, countries are increasingly relying on incremental cost-effectiveness ratios. A possible four-step process for prioritizing benefits was proposed. This includes: (1) identifying major health needs; (2)

identifying constraints – money, people, population beliefs, infrastructure; (3) identifying the cost-effectiveness of options for addressing needs; and (4) discussion on other criteria.

7. CHALLENGES AND OPPORTUNITIES

There was a great willingness to share and learn among participants attending the meeting. Certain specific matters were identified as critical concerns.

In countries where there is still a legacy of point-of-care financing (subsidy at the point-of-care) as opposed to financing for protection (which the social health insurance mechanism facilitates), the point-of-care subsidies can undermine the pre-payment schemes. These legacy schemes include: Lebanon's Ministry of Public Health scheme, Jordan's Royal Court medical services, Pakistan's Bait-ul-Mal and Egypt's Programme of Treatment at the Expense of the State. All these schemes are designed to pay for hospital services for the non-insured who are poor. They are, however, subject to abuse and account for significant increases in government health spending. It may make sense to shift the funding for the point of care schemes towards expanding government subsidies for insuring the informal sector.

In certain countries, the social health insurance organizations continue to operate facilities. This means that the purchasing and providing function are not separated. This is true in: Islamic Republic of Iran's Social Security Organization, Egypt's Health Insurance Organization, Sudan's National Health Insurance Fund and Pakistan's provincial employee social security institutes. For these organizations, it may make sense to revisit their role and charter. Typically, this would mean focusing on improving their purchasing capacities and transferring the health service delivery function to a separate entity (such as the hospital authority).

Consolidation of multiple social health insurance schemes needs to be considered in many countries (such as Morocco and Tunisia). This is especially critical in countries where multiple social health insurance schemes result in significant differences in provider payments. In these cases, consolidation of social health insurance schemes would also lead to the rationalization of payments to providers. As an example, although 70% of the insured select the government provider track from the three benefit streams in Tunisia, only 56% of the total insurance payment is paid to this population cohort with a per member payment of 379 Tunisian pounds compared to 728 Tunisian dinars per member for the other two tracks which allow access to private providers.

National consolidated social health insurance schemes would also ease the availability of national level information.

Most importantly, not all countries have explicitly stated that they will cover all their citizens. Countries that have this explicit government commitment include: Morocco, Islamic Republic of Iran, Qatar and United Arab Emirates. These express declarations are needed to sustain the expansion of social health insurance in Region.

8. NEXT STEPS

Clearly, social health insurance is not a policy tool that is right for all countries. Even in countries which plan to utilize social health insurance as a key element of the national health system, it needs to be complemented by other structures. However, social health insurance is clearly an important and useful tool.

It can be an effective tool in raising resources for the health system. With adequately managed benefits, contributions and funds, it can also be an effective tool in creating a buffer mechanism to manage variability in available funds. Social health insurance is also a powerful mechanism in providing benefit entitlements for citizens. Likewise, it can be a powerful tool for states that hope to make the transition away from health care provider towards health care steward. This is particularly important in countries that work within a mixed provider mechanism. When used judiciously with other policy tools in a mixed financing (with private health insurance and other forms of financing such as mandatory health savings accounts) and mixed provider system, social health insurance can provide an opportunity for more targeted management of universal health coverage benefits and financial protection.

Participants generally provided positive feedback for the sessions and many requested additional meetings or specific technical support from WHO. There was support for the possibility of building a regional network for information sharing, and technical support and capacity-building for the use of social health insurance schemes for the achievement of universal health coverage.

Countries will require different levels of implementation support.

- Countries still deciding to use social health insurance in building up their health system need to focus on establishing an independent fund (such as Afghanistan and Somalia).
- (Countries still deciding to shift from a national health service to social health insurance system need to further study the value of a purchasing agency (such as Bahrain).
- Countries with a “still to be implemented” social health insurance law need support on moving forward with the implementation process, including implementation rules (such as Libya and Yemen).
- Countries with ministry of health-managed social health insurance arrangements need to be to be provided with templates for governance systems, including draft laws (such as Jordan and occupied Palestinian territory).
- Countries with formal sector social health insurance schemes need assistance in designing schemes to cover the poor/informal sector (such as Djibouti, Lebanon and Pakistan).
- Countries with formal sector social health insurance and subsidized arrangements for the poor/informal sector within the social health insurance scheme, need support on how to further expand the subsidized schemes to cover the entire informal sector (such as Egypt, Islamic Republic of Iran and Sudan).
- Countries with formal social health insurance arrangements and a separate subsidized scheme for the poor/informal sector need assistance on expanding the subsidized schemes to cover the entire informal sector and on converging the schemes (such as Morocco and Tunisia).

Regionally, the following activities along the lines of the six implementation functions can be considered:

- Fund management: Region-wide capacity in fund management and actuarial work.
- Information management: common it standards.
- Governance: sharing of governance systems.
- Membership management: sharing of lessons in dealing with the informal sector, compliance of the formal sector.
- Benefit design: cost-effectiveness/costing work, health intervention assessment, provider payment tool-kit.
- Provider management: accreditation, contracting tool-kit.

In order to aid WHO in assisting countries, it is recommended that an information matrix of countries, including the state of the health system, universal health coverage and social health insurance in the countries, be developed. This would provide both a method for monitoring status and progress, as well as being a quick reference tool for other countries in determining which country they could most learn from. A starting point for this would be information already available to WHO, including the presentations made by the countries which attended the meeting.

This information matrix could be organized as follows:

- context of health systems (to provide general country context and where we can include type of economy and situation of the state);
- current situation, including context of health policy;
- key indicators;
- characteristics of current health system, including. governance, providers, financing
- current policy direction (including the current reform agenda);
- key programmes;
- key objectives;
- key challenges and opportunities;
- overview of health financing in the country;
- health insurance in the country; and
- social health insurance in the country: history, current situation, future plans and key objectives and challenges.

Finally, a regional network for social health insurance for universal health coverage to be called the Social Health Insurance Network for the Eastern Mediterranean Region (SHINE) can be organized to follow-up on the above activities.

Annex 1

PROGRAMME

Sunday, 1 June 2014

08:00–08:30	Registration	
08:30–08:40	Message from Dr Ala Alwan, Regional Director for the Eastern Mediterranean	*Dr Basel Al-Yousfi*
08:40–08:50	Address by H.E. Dr Ali Hyasat, Minister of Health, Jordan	*Dr Hani Amin Brosk Kurdi, Secretary General, High Health Council*
08:50–09:00	Objectives of the meeting	*Dr Eduardo Banzon*
09:00–09:15	Introduction of participants	
09:15–09:35	Health care financing for universal coverage and the role of social health insurance	*Dr Awad Mataria*
09:35–10:00	General overview of social health insurance in the Eastern Mediterranean Region – social health insurance elements and implementation functions	*Dr Eduardo Banzon*
10:00–11:00	Panel discussion	

Session 1: Fund management

11:00–11:50	Fund management in social health insurance Role of actuarial studies in fund management	*Dr M. Elena Herrera*
11:50–13:30	Discussion	

Session 2: Information management and social health insurance governance

13:30–14:15	Emerging models in electronic membership, claims processing and provider management systems Coding systems (ICD-10, CPT and other coding schemes)	*Dr Alvin Marcelo (via Skype)*
14:15–14:45	Global experiences in social health insurance governance – Germany, Indonesia, Bangladesh	*Dr Paul Rueckert*
14:45–15:30	Discussion	
15:30–17:00	Panel discussion on social health insurance governance mechanisms and fund management in the Eastern Mediterranean countries (The panel would be participants from Morocco, Sudan, Jordan, Yemen and Islamic Republic of Iran)	*Dr Paul Rueckert*

Monday, 2 June 2015

08:45–09:00	Recap of day 1	*Mr Adem Althor*

Session 3: Membership management (formal sector)

09:00–10:00	Country presentations on formal sector membership registration, premium collection and data management	*Dr Awad Mataria*

	CNSS, Djibouti CIF, Jordan HIO, Egypt CNAM, Tunisia NHIF, Sudan	
10:00–10:20	Role of complementary and supplementary health insurance: global experiences	*Dr M. Elena Herrera*
10:20–11:00	Discussion	
Membership management (informal sector)		
11:00–11:25	Expanding health insurance coverage to the poor and vulnerable: lessons from RAMED	*Dr Hazim Jilali*
11:25–11:55	India's RSBY experience: operational issues in covering the below the poverty line (BPL) population of India	*Dr Nishant Jain*
11:55–12:20	Providing health insurance to the poor and other informal sector population: experiences from Europe	*Mr Riku Eloviono*
12:20–14:00	Discussion	
14:00–15:20	Country presentations on covering the poor and other informal sector population Iranian health insurance for the poor/rural health insurance, Islamic Republic of Iran Special hardship cases/Al Aqsa (occupied Palestinian territory) Ministry of Health as insurer of last resort, Lebanon AMG, Tunisia School health insurance, Egypt Waseela El-Sehat, Pakistan	*Mr Riku Eloviono*
15:20–16:10	Universal health coverage in the Eastern Mediterranean Region: Sudan	*Dr Mustaf Salih Mustafa*
Membership management (GCC)		
16:10–16:35	Implementation issues in covering the expatriate population in the GCC	*Dr Abdullah Al Sharif*
16:35–16:55	Social health insurance in GCC countries	*Mr Adem Althor*
16:55–17:10	Discussions	
Tuesday, 3 June 2015		
08:45–09:00	Recap of day 2	*Mr Adem Althor*
Session 4: Benefits design		
09:00–09:30	Tools for prioritization of social health insurance benefits: Burden of disease studies Cost effectiveness analysis	*Dr Awad Mataria*
09:30–10:10	Health technology assessment for social health insurance	*Dr Adham Ismail (via Skype)*

10:10–10:25	Costing benefit packages for social health insurance	*Dr Awad Mataria*
10:25–11:00	Discussion	
11:00–12:15	Panel discussion: covering all needed services in designing health insurance benefits-“who pays what?” Dr Mariam Atbhi Al-Jalahma Dr Abdullah Al Sharif Dr Paul Rueckert Mr Hazem Jilali Dr Ali Hegazi Dr Anoushirvan Mohseni Bandpei	*Dr Nishant Jain,* *Dr M. Elena Herrera*
12:15–14:00	Universal health coverage in the Eastern Mediterranean Region: Islamic Republic of Iran	*Mr Amirhossein Takian*
14:00–14:30	Health financing and social health insurance in Jordan	*Dr Khalid Abu Hudeib*
14:30–15:00	Health financing and social health insurance in Libya	*Dr Arbi Gomati*
15:00–16:00	Discussion	
16:00–17:30	Provider payment mechanisms (PPM) Types of PPM Design issues in global budget, capitation and DRGs Designing pay for performance and other results based payment methods	*Prof Soonman Kown*

Wednesday, 4 June 2015

Session 5: Provider management

09:00–09:30	Accreditation: The Saudi Arabian and other country experiences	*Dr Abdullah Al Sharif*
09:30–10:00	Contracting: global experiences	*Dr M. Elena Herrera*
10:00–10:25	Fraud and abuse control/cost containment	*Dr Nishant Jain*
10:25–11:00	Discussion	
11:00–11:30	Claims processing/claims review, Republic of Korea Closing session	*Prof Soonman Kown*

Annex 2

LIST OF PARTICIPANTS

AFGHANISTAN
Dr Ahmad Shah Salehi
Director
Health Economics and Financing Department
Ministry of Public Health
Kabul

BAHRAIN
Dr Mariam Athbi Al-Jalahma
Assistant Undersecretary for Primary Care and Public Health
Ministry of Health
Manama

Mr Mohamed Ahmed Al Atawi
Director of Financial Resources
Ministry of Health
Manama

DJIBOUTI
Mr Ali Sillaye Abdallah
Secretary General
Ministry of Health
Djibouti

Mr Ahmed Saad Sultan
Director of Administration and Finance
The National Social Security Fund
Djibouti

EGYPT
Dr Ali Hegazy
Chairman
Health Insurance Organization (HIO)
Cairo

Dr Mohsen George
Vice President
Health Insurance Organization (HIO)
Cairo

Dr Hala Massekh
Head of Technical Support Central Administration
Ministry of Health and Population
Cairo

ISLAMIC REPUBLIC OF IRAN
Dr Amirhossein Takian
Deputy Director General
International Relations Department
Ministry of Health and Medical Education
Teheran

Dr Anoushiravan Mohseni Bandpei
Director General
Iranian Health Insurance
Teheran

Ms Shadrokh Sirous
National Professional Officer
WHO Representative Office
Teheran

JORDAN
Dr Ahmad Basel Al Yosfi
Acting WHO Representative
Amman

Dr Hani Amin Brosk Kurdi
Secretary General
High Health Council
Amman

Dr Khaled Abu Hudeib
Director of Health Insurance
Ministry of Health
Amman

Dr Elham Khreisat
Director of Technical Affairs
Health Insurance Directorate
Ministry of Health
Amman

Ms Mayor Hatokai
Head of Quality Assurance Unit
Ministry of Health
Amman

LIBYA
Dr Khaled Masoud Etaleb
Director of International Cooperation
Ministry of Health
Tripoli

Prof Dr Samir Sagar
Chair of Steering Committe
Libya Health System Strengthening Programme
Tripoli

Dr Arbi Gomati
Director
Directorate of Health Financing Affairs
Ministry of Health
Tripoli

MOROCCO
Dr Hazim Jilali
Director General
l'Agence Nationale de l'Assurance Maladie (ANAM)
Rabat

Mr Abderrahmane Alaoui
Director of Planning and Financial Resources
Ministry of Health
Rabat

PAKISTAN
Dr Tayyeb Masud
Senior Health Specialist
The World Bank
Islamabad

PALESTINE
Dr Anan Al Masri
Deputy Minister
Ministry of Health
West Bank

Mr Nizar Masalmeh
Director General of Health Insurance
Ministry of Health
West Bank

Mr Ali Helo
Director General of Engineering and Information Technology
Health Information System
Ministry of Health
West Bank

SOMALIA
Dr Abdihamid Ibrahim Ahmed
Director of Policy and Planning
Ministry of Health and Human Services
Federal Government of Somalia
Mogadishu

SUDAN
Dr Mustafa Salih Mustafa
Director General
National Health Insurance Fund
Khartoum

Dr Bashir Mohamed Almahi
Director, Population Coverage Department
National Health Insurance Fund
Khartoum

Dr Abdallah Seid Ahmed
Director, Public Health Institute
Federal Ministry of Health
Khartoum

TUNISIA
Mr Mahmoud Hannechi
General Director Assistant
National Fund for Health Insurance
Tunis

Mr Slim Ben Yahmed
Head
National Fund Regional Centre
Sousse

Dr Riadh Ben Abbes
Ministry of Health
Tunis

YEMEN
Dr Nasser Baoom
Deputy Minister
Ministry of Public Health and Population
Sana'a

Dr Jamal Thabet Nasher
Deputy Minister for Planning
Ministry of Public Health and Population
Sana'a

Professor Dr Ahmed Al Khorasani
Chairman
General Authority of Social Health Insurance
Sana'a

TEMPORARY ADVISERS

Dr Abdullah Al Sharif
Secretary General
Council of Cooperative Health Insurance
Riyadh
SAUDI ARABIA

Professor Maria Elena Herrera
Asian Institute of Management (AIM)
Manila
PHILIPPINES

Dr Soonman Kwon
Dean, School of Public Health
Seoul National University
Seoul
REPUBLIC OF KOREA

OTHER ORGANIZATIONS

United Nations Children's Fund
Dr S.M. Moazzem Hossain
Regional Adviser Health
Middle East and North Africa Regional Office
Amman
JORDAN

Deutsche Gesellschaft fuer Internationale Zusammenarbeit (GIZ)
Dr Nishant Jain
Deputy Programme Director
Indo-German Social Security Programme
New Delhi
INDIA

Ms Alexandra Plüschke
Programme Manager
Health System Strengthening Programme
Sana'a
YEMEN

Dr Isaac El-Mankabadi *
Team Leader-Health Economist
Libya Health System Strengthening – LHSS
Tripoli
LIBYA

Dr Paul Rueckert
Principal Adviser (Health)
Dhaka
BANGLADESH

WHO SECRETARIAT

Dr Eduardo Banzon, Regional Advisor, Health Ecnomics and Financing, WHO Regional Office for the Eastern Mediterranean
Dr Awad Mataria, Health Economist, Health Economics and Financing, WHO Regional Office for the Eastern Mediterranean
Mr Riku Edward Elovainio, WHO Representative's Office, Egypt,
Dr Alissar Rady, National Professional Officer, WHO Representative's Office, Lebanon
Mr Ahmed Chahir, Project Coordinator, WHO Representative's Office, Morocco,
Mr Adem Althor, Rapporteur, WHO Regional Office for the Eastern Mediterranean
Ms Mona El Masry, Programme Assistant, WHO Regional Office for the Eastern Mediterranean
Ms Rita Meimari, Assistant to Director, WHO Regional Office for the Eastern Mediterranean

World Health Organization
Regional Office for the Eastern Mediterranean
P.O. Box 7608, Nasr City 11371
Cairo, Egypt
www.emro.who.int