DFID Health Systems Resource Centre

DFID Health Insurance Workshop

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CONTENTS

1 EXECUTIVE SUMMARY

The DFID Health and Population Department/Division hosted a two-day workshop on health insurance in sub-Saharan Africa (SSA) in April 2002. The initiative was in response to the increasing policy interest in health insurance (HI) in several SSA countries, and particularly in social health insurance schemes.

The workshop was attended by a mix of African government representatives, health insurance experts and DFID policy advisers. African governments participating were Ghana, South Africa, Kenya, Tanzania, Nigeria, Malawi and Uganda. A representative from the Zimbabwean private health insurance industry also attended.

At the workshop participants debated and discussed the merits of introducing or expanding a role for social health insurance (SHI) into countries in sub-Saharan Africa. Ghana, Zimbabwe, South Africa and Nigeria are developing these systems. Kenya introduced a National Health Insurance Fund in 1966. Tanzania began implementation of a national scheme in July 2001. SHI was placed in the broad context of strengthening health system performance in these countries, and the implications for the uninsured parts of the population.

The emphasis of the workshop was on the social health insurance schemes initiated by central government. The core pillar proposed in most countries is a payroll tax and benefits for the formal sector. This may also encompass existing private sector schemes in the formal sector and community health insurance initiatives. The acronym SHI is used throughout this report, as it was at the workshop, to represent government backed schemes that may include a variety of health insurance forms.

The two major objectives of the workshop were:

- To review the international evidence for how health insurance can make a useful contribution to country health systems development in sub-Saharan Africa (SSA) in terms of:
    - The policy objectives for introducing HI, such as revenue generation, risk sharing, or improving the health system through efficient 'purchasing'
    - Whether HI facilitates generation of additional resources for health and how to extend schemes to an increasing share of the population
    - Whether and how it can achieve better results in terms of efficient health service delivery and improved access, for the insured and for others (including the poor)
    - How to deal with HIV/AIDS.
- Through this process to identify areas of consensus, issues of relevance to countries and issues for further work.

The workshop identified a number of challenges, opportunities and knowledge gaps.

The major points emerging from the workshop are:

- These schemes have existed for a long time in parts of Europe and have been introduced with inconclusive results in Latin America and the Balkans. One clear criterion for positive results is a strong and improving economy.
- Experience from low income countries indicates that SHI appears to fail on the objectives of improving equity of access and in expanding coverage.

- The decision to introduce SHI, and the form it will take, must include consideration of the country's existing institutional and organizational arrangements, as well its macro-economic performance and structure.
- Experience suggests that achieving universal coverage is not feasible in the short to medium term through SHI, and the majority of workers in the informal sector will remain excluded.
- Health insurance schemes have a tendency to skew the allocation of human and financial resources in a health system towards the insured, better-off groups in the population. Hence, there is a need to protect the existing finance streams, infrastructure and clinical staff serving the excluded majority.
- Both the direct and the indirect impact on the poor must be assessed and measures put in place to ensure that healthcare access and existing resource allocations are safeguarded and improved.

Major challenges facing the introduction or expansion of SHI were seen as:

International concerns with SHI as a health care financing mechanism, in particular:

- Difficulty in containing health care costs, and need for capacity for strong purchasing and commissioning functions.
- Managing the ways in which inefficiencies can increase (causing cost escalation) such as through additional administrative demands, the potential to duplicate services, and the need for specialist skills, for example in contracting and fund management.
- Lack of evidence for ability of HI to raise additional finance for the health budget.
- The formal sector's dominance by the public sector, in low income countries, so that any insurance payments raised through individual and employer may represent a recycling of government funds rather than new finance.

Additional concerns that relate to the specific nature of the SSA context, such as:

- Negative growth in many economies of SSA.
- Resistance from powerful stakeholder groups hinders implementation.
- How much care under the scheme to provide for major diseases such as HIV/AIDS, and TB?

Challenges of improving health care for the poor, given:

- International evidence that SHI can reduce equity in service provision.
- Difficulty in identifying the poor.
- Overcoming the existing lack of political will to tackle this issue.
- The number of problems inherent in community health insurance schemes such as small size, low uptake and renewal rates, limited local understanding of the principles of insurance.
- Tendency of skilled staff and resources, including those in the public sector, to shift to providers offering care to the insured groups, and therefore reducing the benefit incidence of public funds to the poor.

The difficulty in raising additional revenue from SHI, given:

- Small formal sector tax base typical of SSA countries.
- Slow pace of increasing coverage.
- Difficulty reaching the informal sector, where estimates show 30 per cent of an SSA country's GDP may be generated.

Opportunities to strengthen the SHI model were identified as:

- Recognition that the informal sector is heterogeneous, and that multiple scheme designs may be required to reach this sector comprehensively.
- Recognition that marketing the scheme in the informal sector is vital to encourage people to see the advantages of joining.
- The need to build in a number of design features to the SHI model that can reduce problems associated with cost escalation, such as:
    - maintaining a system of co-payments;
    - moving away from fee-for-service payment mechanism to providers towards capitation based methods;
    - ensuring that reimbursements on drug expenditure are made on the basis of the national essential drug list;
    - ensuring that access to secondary level care is through a gatekeeper referral system at primary level.
- Develop a provider accreditation process and the use of contracts between purchaser and provider.
- Build in design elements to prevent increasing inequity in health care provision, such as:
    - the creation of 'health for the poor' or equity fund, to enable poor , uninsured patients to be exempted from health care charges;
    - a risk sharing mechanism to divert some revenue from the insured to the uninsured.

In the final session, participants identified the major areas where greater knowledge is needed to inform policy making and planning for health insurance.

Major gaps in knowledge were identified as:

- A better understanding of the incentive environment around both purchasers and providers, and the way that health insurance is likely to change their behaviour.
- A more systematic understanding of the scale and nature of the impact of SHI on health resources in SSA - perhaps using national health accounts and benefit incidence studies similar to the kind already undertaken in Latin America.
- Strategies to cover the excluded majority in the informal sector, particularly the poor, and to pool risks amongst these groups.
- How to link up community health schemes and develop risk equalization mechanisms so as to improve population risk sharing, in such a way that takes into account regional and other differences.
- Greater understanding of the target groups for extending SHI coverage, such as their purchasing capacity, or willingness to pay, their incentives to join and stay in a an SHI scheme.

In the context of strengthening health system performance in these countries, concern was expressed that SHI is being seen as a cure for a number of the existing system problems. Participants were reminded that as a financing mechanism, SHI may raise additional funds for the health sector, but cannot allocate, or redistribute health revenues in an equitable and efficient way without the accompanying political will to do so.

Discussion of SHI continually raised broader systems issues such the need to improve district level drug supply, primary care gatekeeper functions, and the

standardisation and improvement of care, especially in hospitals. The relevance of an SHI scheme aimed at formal sector workers for resolving these system failures was unclear. Fundamental health questions remain: what is the best use of $10 per capita on health care? How can the government provide catastrophic coverage to the population? Is it a question of enhancing the 'insurance function' of the government (defined as access to needed care without risk of financial impoverishment) without necessarily introducing an insurance scheme?

2 PURPOSE AND BACKGROUND TO WORKSHOP

The DFID Health and Population Department hosted a two-day workshop on health insurance in sub-Saharan Africa (SSA) in April 2002. The initiative was in response to the increasing policy interest in health insurance in several SSA countries, and particularly in social health insurance schemes. This includes the implementation last year of a National Health Insurance Fund in Tanzania, and proposals for similar schemes in Ghana, South Africa, Nigeria and Zimbabwe.

The two major objectives of the workshop were:

- To review and draw together the international evidence and experience of the extent to which health insurance can make a useful contribution to country health systems development in sub-Saharan Africa (SSA) in terms of:
    - the policy objectives for introducing HI, such as revenue generation; risk sharing, or improving the health system through efficient 'purchasing';
    - whether HI facilitates generation of additional resources for health and how to extend schemes to an increasing share of the population;
    - whether and how it can achieve better results in terms of efficient health service delivery and improved access, for the insured and for others (including the poor);
    - how to deal with HIV/AIDS.

- Through this process to identify areas of consensus, issues of relevance to countries and issues for further work.

The workshop was attended by a mix of African government representatives, health insurance experts and DFID policy advisors. African governments participating were Ghana, South Africa, Kenya, Tanzania, Nigeria, Malawi and Uganda. A representative from the Zimbabwean health insurance industry also attended. The participant list is in Annex 1.

The emphasis of the workshop was on social health insurance schemes initiated by central government. The core pillar proposed in most countries is a payroll tax and benefits for the formal sector, but may also encompass existing private sector schemes in the formal sector and community health insurance initiatives. The acronym SHI is used throughout this report, as it was at the workshop, as short hand for these large government backed schemes that may include a variety of health insurance forms. Please refer to the commissioned background papers of the workshop for a definition of social health insurance.

3 INTERNATIONAL OVERVIEW OF SOCIAL HEALTH INSURANCE

Workshop participants were invited to consider the lessons learned in using social health insurance from the experiences of Europe, the Balkans and Latin America. A brief summary of important points from these regions is presented below.

3.1 Europe

SHI has a long history in Europe and is one of the major revenue raising mechanisms in a number of countries. In Germany, for example, the first sickness funds started over 100 years ago when they covered 10 per cent of the population. From this point, they expanded to cover other employment groups and today 88 per cent of population are covered, of which 73 per cent have mandatory coverage through formal employment.

Typically, in European SHI systems, both employees and employers pay into the funds, and contributions for the unemployed from government or elsewhere are channelled through the sickness funds. There is normally more than one sickness fund in European countries with SHI, but the number and size of funds and the degree of competition between them varies between countries. Few European countries rely on SHI to entirely finance their health systems. At most SHI never accounts for more than 75 per cent of the total heath care expenditure.

There is evidence to suggest that European countries using the SHI model are able to raise more money for health care than countries relying on general taxation. At the same time, cost containment has been a greater problem in European countries with SHI. It is difficult to tell whether the use of SHI is directly associated with a higher quality, and a more efficient or equitable, service.

A few issues emerging from the European experience with SHI are:

- It takes a long time for SHI schemes to evolve.
- General taxation remains important even in countries that are officially financed by social insurance.
- With multiple funds, the equity of the SHI system has depended on the ability to successfully pool funds. This is turn, is not linked to the degree of competition between funds.
- The danger of inefficiency increases with the number of sickness funds, and the extent to which administrative systems of setting and collecting payments vary between them.

Further information about social health insurance financing in Europe can found in the chapter 3 by Charles Normand and Reinhard Busse on www.healthsystemsrc.org/hltinsurance2002/papers.htm.

3.2 The Balkans

The Balkan countries (Albania, Croatia, Macedonia, Bosnia & Herzegovina, Serbia and Slovenia) have recently developed SHI systems as part of their transition

towards market based economies. The schemes have in common a single health insurance fund, the collection of payroll contributions and the use of contracts with both public and private providers. In addition, health care packages to be covered by the scheme have been established and the countries are aiming for universal coverage provided for by newly established social heath insurance laws.

The Balkan countries are characterised by comprehensive health care and reasonable quality infrastructure (in terms of both facilities and human resources) as a result of their Soviet legacy. Most GDP per capita figures are around US$1,500 with the exception of Croatia (US$4,533) and Slovenia (US$10,000). Pension contributors in the workforce vary from 32 per cent in Albania to 86 per cent in Slovenia. Key findings that have emerged so far from the Balkans experience with SHI are:

- The SHI systems of the stronger economies (Croatia and Slovenia) have been more successful at raising revenue for health. However, the revenue raised from the systems is not enough to support the whole health system, and other mechanisms are still required.

- Most countries are struggling to raise enough revenue due to the narrow payroll base of the formal sector and the high levels of self employment in agricultural sectors. In Albania, expenditure from HI income accounts for only 4 per cent of total health expenditure.

- A major distortion is seen in Macedonia where high contributions paid by the employees (the highest in the region) seem to be one of the determining factors of the country's very high unemployment rates.

Further information about social health insurance in the Balkans can found in the workshop background paper prepared for DFID by João Costa on www.healthsystemsrc.org/hltinsurance2002/papers.htm.

3.3 Latin America

Many countries in Latin America have developed SHI as a means to raise revenue for health care alongside general taxation and earmarked taxes. Health care systems in LA have long segmented their health care to the population along income lines. Typically public providers provide services to low income groups, SHI affiliated providers to middle income groups and private providers to the rich.

Recently many countries in the region have sought to transform their SHI systems in order to extend financial protection to groups other than the urban middle income group. This has been carried out in a number of ways. Costa Rica and Colombia have both sought to include middle and low income groups in contributing to and benefiting from the scheme. Others, such as Chile, have tried to transfer SHI into the private sector in order to free up government resources for poorer groups.

Reforms in Colombia focused on reducing the substantial administrative inefficiency by replacing the vast number of SHI organisations (over a thousand) to two basic plans. One was financed by payroll contributions from formal sector workers and informal sector workers of a certain minimum income. The other was to cover the poor, estimated to be around 30 per cent of the population. A new law required the state to pay a premium for each member of this group, along with a 1 per cent cross-subsidy from the payroll fund, and other municipal funds, and special taxes. However

the complexity of the transition to a single SHI system, alongside financial and political challenges, has made the incorporation of the poor and the reallocation of public resources towards low income groups a slow process.

Chile sought to involve the private sector to act as third party insurance funds, as well as purchasers of health care. A number of these organisations (ISAPRES) were created with formal competition existing between them. However weak regulation has led to cream skimming with poor, chronically ill groups excluded from the system and relying instead on the public services (FONASA).

In general Latin America's attempts to introduce SHI have suffered from weak regulation, and an inability to create appropriate incentives in health institutions to make them behave in a more efficient way. As a result SHI has not so far solved any of the region's issues of cost control and inequity.

Further information about social health insurance in Latin America can found in the workshop background paper by Alejandra Rossetti on www.healthsystemsrc.org/hltinsurance2002/papers.htm.

4 SOCIAL HEALTH INSURANCE IN SUB-SAHARAN AFRICA

Several presentations described recent experience in the African context. Participants were introduced to the complex policy process for developing new schemes, such in Tanzania and Ghana, and the range of stakeholders with often conflicting interests. Kenyan delegates shared their thoughts on the challenges of reforming the National Hospital Insurance Fund,. A brief summary of the experiences in Ghana, Tanzania and Kenya is presented below.

4.1 Ghana case study

Ghana has a population of 18 million, and a GDP per capita of $400. The country is divided into 10 regions with 110 decentralized districts constituting the lower level of political administration. Each district has a district assembly, an autonomous agency responsible for the public service functions at the local level and who provide a civil society role. Historically Ghana has relied on a mix of tax revenue, external donor assistance, user fees ('cash and carry') and employer based schemes to finance the health system. Some community health insurance schemes already exist in places, and a number of private health insurance scheme have recently developed. Tax revenue and external donor assistance account for 70 per cent of funds for health care with the remaining 30 per cent generated by private out-of-pocket payments.

The objective of the proposed National Health Insurance Program (NHIP) is to assure equitable universal access for all residents of Ghana to an acceptable quality package of health services. It is based on a fundamental principle that inability to pay at the point of service should not prevent access to essential services. Under these proposals district level bodies, called Mutual Health Organizations (MHOs), will be set up to act as third party health care purchasers for the local population with all funds to pay for local health services for the local population channelled through this body. In addition to existing revenue sources, new money will be collected in the form of social health insurance. This will target formal sector workers who will contribute from payroll taxes, along with their employers. A newly created National Health Insurance Fund (NHIF) will collect the funds at the central level. At the same time, the government will continue to facilitate the development of community health insurance schemes that are targeted at people in the informal sector.

It is proposed to allocate the funds from the centralized NHIF to the district MHOs using a formula, still to be devised. Funds collected by the community health insurance schemes will be merged with NHIF funds at district level. A portion of the existing funds from central government and the donor community will be repackaged as an 'exemption fund' and channeled via the district body as earmarked funds for poor and vulnerable groups. The initially defined benefit package is to include inpatient hospital care, outpatient care at primary and secondary level, emergency and transfer services. However, the affordability of this package in relation to revenues expected under the scheme has still to be costed.

The scheme represents an ambitious reform of the health sector, rather than the creation of a new financing mechanism. A number of challenges remain for health planners in Ghana including how to set the appropriate level of contribution from payroll taxes; how to effectively merge the community health funds with the district funds; how to set up a regulatory framework, and how to determine an appropriate

payment mechanism to reimburse providers. Payment to provider issues are complicated by variable costs among providers for the same treatment, such as caesarian sections for example.

4.2 Tanzania case study

Tanzania has a population of 33 million and a GDP per capita of US$210. Until 2001, health care was financed through a combination of general taxation, formal sector employer schemes, user fees, external donor assistance and a number of small health insurance schemes, consisting of small private schemes and community pre-payment health insurance schemes. A survey carried out in 1990 found that formal sector employer based schemes, which are typically small and have low viability, were estimated to be costing larger employers around 11 per cent of their payroll.

Last year the country began implementation of a National Health Insurance Fund (NHIF) with a number of objectives:

- strengthen cost sharing in public services;
- provide health insurance cover to employees;
- provide free choice of providers to civil servants;
- enhance equity of health financing and provision among employees;
- create an environment for private sector participation.

The initial membership consists of 179,000 civil servants, but there is the intention to extend this to the rest of the formal sector. Funds are to be collected via a 6 per cent payroll tax split between employees and employers although at this stage, the government is the only involved employer. The benefit package includes inpatient and outpatient care up to a predetermined sum. Public health services covered by specific government programmes, such as TB and basic diagnostic tests are excluded, as well as maternal health care. All services for people with AIDS are also excluded.

The NHIF has been established as an executive agency of the government with board members appointed by the Ministry of Health, and under guidance from a range of professional disciplines including insurance industry experts and trade unions representatives. In choosing to locate the fund as an autonomous agency of the Ministry of Health, planners in Tanzania had already considered and rejected a number of other possibilities as unsuitable[1].

Rich detail emerged during the workshop on the practical implications of introducing an insurance scheme, such as the logistical difficulties of ensuring that appropriate administrative documents were in place across the country timed for the start of the insurance scheme, and producing enough ID cards and registration forms to start the scheme. Planners realised that insufficient attention was paid to advocacy and raising awareness of the scheme both amongst health care providers expected to become accredited to the scheme and amongst new members, some of whom were unaware of the scheme until deductions appeared on their pay slips.

Strong resistance towards the NHIF has been encountered prior to and from its introduction, partly among political leaders who felt their health care privileges

[1] For a more thorough explanation of this process see Mapunda, M., *Social health insurance issues of management body and legislation needs: the experience of Tanzania,* University of Cape Town, 2000 on www.healthsystemsrc.org/hltinsurance2002/Mapunda_Tanzania.pdf

threatened by the concept of the same benefits to all members. To ensure greater political 'buy in', three types of membership have been created, each with the same package of care, but with different abilities to leapfrog the referral system. A prior step of ensuring the right legislative frameworks were in place was considered important to avoid challenges to the scheme in court.

Since the scheme began there is evidence that the provider sector is changing, with some providers beginning to expand capacity. Planners and policy makers are now concerned with the issue of how to protect hospitals that cannot attract insured members from reducing capacity or closure. Another challenge for the scheme is how, in practice, to move from a fee-for-service payment mechanism for providers towards a capitation based system.

4.3 Kenya case study

The Kenya National Health Insurance Fund (NHIF) was launched in 1966, making it the oldest scheme of its kind in English speaking SSA countries. The scheme is compulsory for all Kenyans earning over a certain monthly wage. It was targeted initially at the formal sector, where revenue is collected through a payroll tax paid only by employees. It has since expanded to include parts of the informal sector. Only hospital benefits are included under the scheme, and only hospitals are eligible to receive reimbursements. The NHIF has undergone substantial reform during its lifetime, and has had considerable impact on hospital service delivery in particular by encouraging the growth of the private sector.

The scheme has learnt a number of valuable lessons since its inception. People are willing to pay for health care and demand for an insurance product in the health sector exists. In particular, the Kenyan experience provides evidence of the administrative challenges in introducing a national insurance scheme, and the way in which resources can become skewed towards certain population groups. Other key lessons learnt include:

- The importance of appropriate governance arrangements for an insurance fund. Early arrangements were for the Fund to be controlled by the Ministry of Health, with fund management expertise but limited membership representation on its board. As a result the Fund developed huge surpluses as the emphasis was placed on accumulating funds rather than developing health services. De-linking the fund from the Ministry, changing the skill set of the board and widening the net of accredited health providers were successful at reducing the size of the Fund.

- Fraud abuse can flourish as a result of poorly developed compliance and monitoring systems. One estimate determined that the NHIF received less than 70 per cent of its expected revenue.

- Certain private facilities were able to master the claiming process more effectively than facilities serving poorer population groups. This illustrates one way in which resources can become skewed in favour of the better off: one study found that private hospitals, nursing homes and maternity homes accounted for 26 per cent of approved facilities but received 58 per cent of total NHIF reimbursements. The inclusion of hospital based care, and not primary services in the insurance package, tends to act as an incentive to bypass first level providers.

- Extending coverage of the scheme to the informal sector is a slow process: thirty-five years on, the scheme covers around 25 per cent of the population. A vigorous marketing was considered a vital component in encouraging the informal sector to participate.

A consultative taskforce was set up in January 2002 to remodel the NHIF as a mandatory national social health insurance scheme, with a particular focus on targeting poor people, improving the drug supply and incorporating traditional medicine into the national health care system. A new revenue stream from a levy on sales of tobacco, alcohol and related products is being considered.

4.4 Summaries of national health insurance schemes in Kenya, Nigeria, South Africa, Tanzania, Zimbabwe and Ghana

The following table was compiled prior to and during the workshop, and describes the basic details of proposed and actual social health insurance schemes in SSA.

A more in-depth summary about social health insurance in SSA can be found in the workshop background paper by Ceri Thompson on www.healthsystemsrc.org/hltinsurance2002/papers.htm. A number of academic papers, grey literature and country policy documents about social health insurance were collated in preparation for this workshop. A list of these, with many available electronically, is on www.healthsystemsrc.org/hltinsurance2002/further.htm.

Table 1: Summary details of actual or proposed National Health Insurance Schemes in Kenya, Nigeria, South Africa, Tanzania, Zimbabwe and Ghana

	KENYA	TANZANIA	NIGERIA	SOUTH AFRICA	ZIMBABWE	GHANA
Date to introduce scheme	Launched in 1966	Started officially in July 2001	Launched October 1997, still unimplemented	Under discussion	Under discussion	Under discussion
Eligibility and basic structure	Eligible and compulsory for all earning over KSh 1000 per month Voluntary for non-salaried members	Universal eligibility Will be compulsory for formal sector Initial coverage 53,000 civil servants then will gradually expand to other formal sector employees	Universal eligibility First phase, compulsory for firms with 10 or more workers Coverage of informal sector and rural population to follow	Formal sector employees Two forms of membership – direct & indirect	Universal eligibility. Compulsory for workers in the formal sector, voluntary for informal sector workers	Universal eligibility
Type of contributions	Employee only premium deducted by employers through payroll. Contribution level depends on income - 2 per cent of salary up to a set maximum	6 per cent of employees through payroll deductions. Recommended that 3 per cent each paid by employers and employees. Fixed inpatient fee up to a maximum of 120 days per household – rate depending on classification of provider	5 per cent of employees salary matched by 10 per cent of salary paid by employer	Not determined	Employee and employer contributions. Payroll tax rate - not yet specified, but to be a proportion of member's earnings plus set rates for dependents.	Employee and employer payroll contributions, the level of which currently being discussed by parliament
Population cover of scheme	Estimated in 1992 to cover approx. 7 million people (including dependents). 25 per cent of the population	Will cover spouses and up to 4 other dependents. Entitlement stops 3 months after retirement	6 million people (7 per cent) of population in first phase . Dependents are covered	6.9 million Dependents are covered		Total population
Contribution for the disadvantaged groups (unemployed, disabled, elderly, etc)?	No contribution is made for these groups				Government will pay a contribution to the Fund to cover the disadvantaged groups.	Some Government and external donor funds to be repackaged as an exemption fund and channeled through the district level MHO for poor and vulnerable groups
How package of care is defined?	Only in-patient medical care. This does not include hotel services in hospitals.	Benefits include inpatient and outpatient care of a fixed, predetermined sum; payment of generic drugs on the national drug list; and basic diagnostic tests Services covered by specific government programmes are excluded such as for TB.	Personal preventive services including immunization, family planning, ante- and post-natal care Ambulatory and in-patient care services; Maternity and family planning; Diagnostic treatments; Drugs; Limited dental, optical, prostheses services	A 'minimum package' of essential hospital services	Basic package of health services at primary and secondary facilities – to be defined.	The initially defined benefit package is to include in-patient hospital care, out-patient care at primary and secondary level and emergency and transfer services

	KENYA	TANZANIA	NIGERIA	SOUTH AFRICA	ZIMBABWE	GHANA
Governance arrangements of the third party fund - accountable to MOH?	The NHIF is a n autonomous state corporation linked to the MoH. Its board members include representatives from major stakeholders, e.g. civil service, farmers, teachers union, Kenyan medical association etc.	Yes, NHIF established as an executive agency of the government. NHIF board members appointed by Minister of Health but under guidance to include an appropriate range of professional disciplines and stakeholder representatives such as from Trade Unions etc.	Major role planned for private sector HMOs to administer the funds. National Health Insurance Council (NHIC) will regulate at national level	A new SHI Fund will be established, controlled and managed by a new statutory SHI Authority (SHIA). This will be accountable to MoH and Parliament but located outside the civil service. Minister of Health will appoint Board members	Not clear. The NSSA will administrate the reimbursements to providers. A regulatory agency will be set up and will work with the Medical Aid Societies (MAS).	A national fund will be set up to collect the payroll tax contribution from the formal sector. Not clear yet, the extent that this will accountable to the MoH. These central funds will be allocated by formula to district level bodies that will act as a third party fund, called Mutual Health Organizations (MHOs).
Contracts with providers? What payment mechanisms?	Retrospective, fixed fee (per diem) reimbursement to either member of provider. Most members allow provider to claim on their behalf.	Providers must be accredited to the scheme. Initially, the insurance fund will pay providers on a fee for service basis. Members can only attend accredited providers. All providers can apply for accreditation.	Private sector HMOs will act as intermediaries between contributers to the fund and with providers. Way in which HMOs will organize providers is not yet clear. HMOs to pay a combination of capitation payment to primary providers, and fee for service reimbursement to individual private practitioners.	No information	Reimbursement on a capitation basis to providers for provision of basic package of benefits	The MHOs will manage the reimbursements to providers at district level, the mechanism that will be used has not been determined yet.
Do beneficiaries access separate facilities?	No, the scheme does not own facilities.	No, non beneficiaries may also access accredited providers.	No, non beneficiaries would be able to access same facilities. Beneficiaries can use public facilities, or private facilities for a 10 per cent co-payment.	No information	No, non beneficiaries would be able to access same facilities. Members of the scheme can choose to register with either public or private providers	The whole population are beneficiaries.
What is the extent of private insurance? Can people opt out of the scheme if privately insured?	A number of private sector insurance schemes exist covering in-patient care, including the AAR (60,000 members), Medi-plus and Avenue Health	Very limited – employers have prepaid schemes with certain providers to cover own employees. Workers covered by NHIF cannot opt out.	Private, for profit, health insurance is just developing. Four wholly private companies marketing HI plans exist. Each pool is small, the largest is 18000 people. An estimated 0.03 per cent of population covered by PHI as of July 1995.	Already 17 per cent of population covered by medical schemes, a further 3 per cent by private for profit insurance. Early indications are that people can opt out of SHI if already covered by these	There are a number of Medical Aid Societies (non profit). Government is considering either to allow members to opt out of NHIF if privately insured, or to reduce the contribution to it	There is limited private insurance, it is not clear whether people can opt out.

Collated from a range of sources including academic papers, discussion with workshop delegates, and various grey literature sources.

See web references: www.healthsystemsrc.org/hltinsurance2002/further.htm.

5 RATIONALE AND CHALLENGES TO SHI IN SSA

This section presents the major reasons for introducing SHI, as stated by workshop participants during working group sessions, along with the principal challenges to implementation and successful policy outcomes that emerged during discussion. It is evident in the following summary of issues that the challenges to meeting some objectives for SHI are significant. This is particularly the case where SHI is introduced with social objectives aimed at improving health care access for the whole population, such as improving equity or expanding coverage.

5.1 Rationale for introducing SHI in sub-Saharan Africa

Participants outlined the major objectives for introducing large health insurance schemes. Summary of major policy objectives for introducing some form of social health insurance from workshop discussion is in Table 2 below.

Table 2: Major country policy objectives for introducing SHI emerging from workshop discussion

Policy objective	Country
To formalise cost sharing in the informal sector	Tanzania
To increase revenue to the health sector	Tanzania, Nigeria, Kenya, South Africa, Uganda
To improve access to the health system	Tanzania, Nigeria, Kenya
To improve risk sharing	Malawi, Kenya
To improve equity in revenue collection	Malawi, Nigeria, Kenya, South Africa
To improve efficiency of revenue collection	Nigeria

The discussion recognised the danger of articulating multiple health sector objectives for SHI schemes that have still to display even financial viability.

In addition to the above, participants also discussed the following reasons as a motivating force behind an SHI scheme.

- To organise the extensive out-of-pocket expenditure into something more equitable for poorer people.
- To simplify, and improve efficiency, of the many small, schemes in the formal sector that have developed for middle and higher income groups.
- To improve efficiency of health care delivery through the creation of a strong purchasing function.

5.2 Challenges to introducing effective SHI in SSA

The effectiveness of a national health insurance scheme needs to be assessed in relation to the scheme's wider policy objectives. A country that intends to use health insurance simply as a way of raising additional revenue for its formal sector employees may not be concerned about the slow coverage of the informal sector. However, it may be concerned instead with the implications for efficiency of different provider payment mechanisms, and the potential negative impact on poor and vulnerable groups.

Resistance from powerful stakeholder groups can delay start-up of the scheme. Introducing a new tax is extremely difficult in any country and this is certainly the case in SSA. Ghana has been trying for 25 years to set up a health insurance system. The Tanzanian scheme has also been many years in preparation prior to its eventual implementation last year. The benefits of the schemes thus need to be weighed against the effort required to start them up. Country case studies identify the health providers, formal sector employers, and the scheme members, represented by trade unions, to be the three most powerful political groups.

5.2.1 Challenges to raising additional revenue

Formal sector tax base is small in SSA. The constraint in SSA countries is that only a small relatively percentage of the population are in the formal sector, and therefore likely to be reached through a payroll tax.

Increasing coverage is extremely slow, the political timeframe needs to understand the practical timeframe, and health plans should reflect the long term.

There are no easy answers to raising revenue from the informal sector. This is a critical issue if the scheme is to become universal. An important point is recognising the heterogeneity of the informal sector, with some quite rich groups and some very poor. Most schemes focusing on the informal sector have been voluntary as there are numerous practical difficulties to developing a compulsory scheme in the informal sector. Key challenges to setting up voluntary schemes is encouraging people to join in the first place, finding ways to retain members and encouraging workers to register their dependents.

5.2.2 Challenges to improving health care for the poor

Risk of reducing equity The workshop heard of evidence from a number of countries that rather than improving conditions for the poor, health insurance can actually skew resources towards high income groups. This occurs through a number of ways, including:

- creating additional administration costs that leave fewer resources available for health care general;
- the continued government subsidy to health care facilities and staff used by members of the insurance scheme;
- the ability of some providers to take advantage of the system, through opportunism or as a result of superior administrative capacity.

Who are the poor? The practical issue of identifying the poor was raised as a major consideration to reaching them, although it was recognised that this is true of any financing mechanism. Issues of health services for the poor are more related to community approaches than through large, compulsory payroll funded SHI schemes. Solutions to increasing informal sector coverage are there very pertinent to the equity issue.

Overcoming the lack of political will was raised as an issue for those countries hoping to use SHI to address inequity in health care delivery for poor and vulnerable groups. SHI is simply another financial mechanism for raising revenue, and not a substitute for political leadership to reallocate revenue to parts of the health sector that need it most. There is no reason to assume that fair and equitable allocation of resources will occur under an SHI system if it has not under a general taxation system.

Limited community understanding of insurance principles. The workshop heard how a lack of cultural experience of insurance could easily produce distrust of health insurance schemes. This is particularly relevant in discussion of voluntary schemes aimed at the informal sector: early mishandling of a scheme can cause the population to lose faith and stop participating. Take-up of schemes at local level is often low and the schemes are unsustainable.

International experience suggests that equity under SHI needs to be considered as a broader societal issue, and not just in relation to the very poorest. While an emphasis on the very poor is a major issue for African governments and development partners such as DFID, there is a need to consider equity more broadly across major occupational groups. Experience from Latin America reveals that SHI increases inequity of health care provision more occupational groups such as the formal and informal sectors, or between the rural and urban population.

5.2.3 Challenges to cost containment and efficiency

Cost escalation is a risk. There is evidence that health insurance schemes can exacerbate cost escalation in a number of ways, including: encouraging a large, unregulated private provider market; encouraging overuse of health services by the insured; and by increasing the administrative costs in the health sector. Design features that can help to limit cost escalation were discussed in the workshop and are presented in the next section.

HI can increase health system inefficiencies. As a financing mechanism, health insurance is administratively complex and its additional demands on a system unused to insurance schemes can be onerous. The costs of introducing the infrastructure of health insurance need to be weighed against the additional revenue that it will generate. Not only the immediate costs need to be considered, but also the changes that insurance systems can make to the incentive environment of providers. The discussion highlighted the different forms of inefficiency.

> ***Administrative inefficiency*** - The implications for efficiency need to be looked at broadly, in terms of the extra managerial and administrative demands of a newly introduced SHI system. These include the creation of the insurance fund or funds, the development of contracting methods to deal with providers, and skills to handle the reimbursement of funds whether at the

insurance fund level, at a separate purchaser level or at the provider level. The more bodies that are created to handle this process, the more complex it becomes with greater risks of inefficiency. This is particularly a danger with proposals for decentralised systems where many local bodies are created.

Provider inefficiency can occur in the duplication of services, lack of gatekeeper functions at primary level or the creation of parallel two or three tier services which will be costly and inefficient. For example, duplication of services could arise if publicly provided health services, such as immunisation or TB treatments, become available separately to members in private facilities under the insurance scheme. This is not only inefficient from a financial and managerial perspective but, if not properly regulated, could fragment provision of these vital services and reduce their effectiveness with negative implications for public health.

Purchaser inefficiency: One of the rationales of setting up social health insurance is to develop strong purchasing functions. The fund, or created purchasing body, is able to channel patients towards the providers that are most likely to deliver high quality and efficient health care. In practice this is only effective if accompanied by selective contracting skills. Without such skills in place, purchasers are unable to discriminate between providers on cost and quality. It was also noted that this function is not dependent on the way in which health care is financed, and could be set up within a tax based system.

5.2.4 The care package and responsibility for public health services

Diseases covered: Whatever population group is targeted for health insurance, dealing with questions of coverage for chronic communicable diseases such as HIV/AIDS and TB is an issue. Many participants felt that provision of public health services should be the government's responsibility. For all diseases any national health insurance scheme needs to determine the point at which benefits under the scheme no longer apply, at which point government care is sought again (this may mean that treatment effectively ceases). As a starting point, planners could consider what might be an efficient protocol for treatment of various diseases. In some contexts, it may be appropriate for the formal sector to pay more for a supplementary benefit to cover a wider range of diseases and care needs than those included in the basic services package.

Finding a way to handle HIV/AIDS. HIV/AIDS is a special case given the burden placed on the health service by sufferers seeking treatments for opportunistic infections. The issue is complex on a number of fronts: political, macro-economic, legal, cost effectiveness and public health. On the one hand, it may not be financially viable to include expensive long-term treatments but on the other hand, if these treatments are only available on the open market then members may incur catastrophic costs to access them. Sometimes, the issue is out of the hands of the health planners to decide - for example, the decision to include anti-retroviral drug treatments under the proposed South African SHI scheme was immaterial while the official government stance held that these drugs were ineffective[2].

[2] Since the workshop the government of South Africa has reversed its prior policy to accept that anti-retroviral drugs may be beneficial to people infected with HIV.

- SHI should at least cover treatments that have been shown to be cost-effective, such as the provision of ARVs for the prevention of mother to child transmission of HIV. Here international recommendations would have to adjusted for both the epidemiology of the disease in the country, and the cost of treatment provision.

- For HI schemes aimed at well off smaller groups, such as the formal sector only, it may be feasible to consult with members to allow them to choose to receive ARVs in return for higher premiums. Actuarial assessment would have to take into account the national epidemiology of the disease and the expected pricing of the ARVs over future years.

5.3 Opportunities to strengthen the SHI model for the SSA context

Several presentations emphasised the many trade offs in setting up SHI schemes, and that each design feature will have an advantage and a disadvantage. Examples of this include the tendency for there to be a trade off in focusing on the 'depth' or on the 'breadth' of insurance coverage - where depth indicates the comprehensiveness of the package of care and breadth the extent of the coverage.

Other choices that carry trade offs might be between centralising or decentralising fund management, or whether to have one or many insurance funds. The advantage of centralising the insurance fund, for example, might be strengthened regulation. The disadvantage would be that a centralised system imposes higher administrative costs, as collected funds must travel further. Hence discussion of strengthening the HI model again goes back to the question of 'what has the scheme been set up to do?' and must also combine consideration of the particular characteristics of the national context into which it is being introduced.

The extent to which SSA can learn from the experiences of other regions was countered by the recognition that its unique conditions may require unique solutions. It was the lessons learnt and experiences from Kenya and Tanzania that other SSA countries planning an SHI scheme found particularly relevant. The new revenue raising mechanisms adopted by Brazil (levy on bank transactions) and suggested for others (additional charge on electricity bill) were useful examples of solutions specifically created for the administrative and financial characteristics of these countries.

Workshop discussion of opportunities to strengthen the SHI model focused on the following areas:

- Extending coverage of the scheme into the informal sector and therefore improve equity and population risk sharing.

- Strengthening the robustness of the SHI system to mitigate against a worsening of the existing health sector failings, such as inequity of access, and cost escalation.

Extending coverage of the scheme into the informal sector and therefore improve equity and population risk sharing

If a population wide financing solution is sought, then a major focus of strengthening the SHI model is to find an effective way to reach the informal sector and to sustain

their participation. The workshop heard how community health insurance schemes across SSA have repeatedly failed for a number of reasons, including their small size and the limited population risk sharing this provides; the difficulty in finding the appropriate premium level to set, and limited cultural awareness of insurance principles. Typically these voluntary schemes have difficulty attracting members and face low renewal rates. Key points emerging from the discussion were: -

Recognise that the informal sector is heterogeneous and that multiple scheme designs may be required to suit different income groups of the informal sector, as opposed to a blanket fits-all scheme. The Kenya scheme for example is appropriate only for reasonably well off workers, earning over a certain income in the informal sector. The challenge then becomes how to link up the patchwork of schemes, to pool risk across a viable population size, in such a way that their individual design features are retained.

Marketing to the informal sector is vital to encourage people to see the advantages of joining and for them to understand how insurance works. The limited impact that Kenya has made in the informal sector has been achieved through a vigorous PR campaign, and in working through educational groups. Unfortunately there are no data on the size and cost of the informal sector participation in Kenya vis à vis the extent to which the scheme is successful at capturing a viable segment of the informal population rather than a population group with higher ill health risks as a result of adverse selection. Encouraging people to join and renew their membership year after year is the major challenge for community schemes.

Community health insurance schemes have been the subject of substantial international investigation for a number of years. For this reason, the workshop did not focus on these schemes.

Strengthening the robustness of the SHI system to reduce likelihood of a worsening of the existing health sector failings, such as inefficiency, inequity of access, and cost escalation.

It was recognised that part of strengthening the SHI system meant understanding and manipulating the incentive environment around the principal stakeholder groups involved: providers, purchasers, the insurance fund (if separate from the purchasers) and the members. Substantial preparatory work and initial feasibility studies are required, as well as institutional development and strengthening. There is a need for actuarial calculations based on the benefit package and provisions, and well defined and costed packages.

Solutions that could strengthen the robustness of the mechanism **to reduce problems associated with cost escalation** included:

- Maintain the system of co-payments to prevent members from over using the services. There is however a trade off between maintaining some form of co-payment but reducing the size of it for the insured so that members can still see the value of the scheme, and non-members will be encouraged to join.
- Alternatively, if the scheme is compulsory, limit the benefits provided under the scheme to catastrophic coverage only.
- Encourage providers to keep drug costs low by allowing reimbursement only for drugs on a government approved prescription list, based on the essential drugs list.
- Try to move away from a fee-for-service mechanism towards a capitation

based system which removes the incentive for providers to provide excessive treatments.

- Equalise benefits for all members, (i.e. all get the same benefits). Tanzania has to political resistance by creating tiered benefit packages that provide elite groups with better services. International experience has shown that this adds a further layer of cost and complexity to insurance administrative systems.

Solutions that could **encourage health care providers to behave efficiently** and provide quality services are: -

Developing the provider accreditation process through the use of contracts between purchaser and provider. The system of accreditation of facilities can be used as a tool for strengthening service quality across the health sector. One of the strengths of a health insurance structure is the enhanced purchaser function but this relies on developing contracting skills. Basic measures of provider efficiency, such as length of stay for hospital care, œuld be assessed as part of the accreditation process.

Allow PHC facilities to become accredited. International experience has shown that it is more cost-effective to provide care from PHC facilities than from hospitals. If ambulatory services are to be provided amongst the benefits, then the whole health system may be encourage to operate more effectively if PHC clinics can be brought into the contracts. Caution needs to be exercised here however to ensure that monitoring systems are sufficiently developed to counteract fraud at this level.

Solutions that could **prevent the health system from becoming more inequitable** under SHI focused on the direct targeting of the poor through specific funds for their use, or the development of specific incentives to encourage providers to treat the uninsured. They included: -

- Creation of a 'health for the poor' fund, that allow money to be channeled directly into it for rather than into general fund that the elite will probably capture. Ghana is proposing an 'exemption fund' in its plans for SHI.
- Creation of a fund for the uninsured into which is transferred a proportion of insured person's payroll tax.
- Pool some element of the funds from different schemes at local level for reallocation on a capitation basis.
- Allow the formal sector to pay more for a supplementary benefit to cover a wider range of diseases and care needs than those included in the basic services package.

ANNEX A: PROGRAMME

PROGRAMME
DFID HEALTH INSURANCE WORKSHOP
9-10 April 2002

BMA House
Tavistock Square
London

Workshop objectives:

The DFID Health and Population Department is hosting a two-day workshop in April on health insurance in sub-Saharan Africa. There is significant interest at country level in developing, expanding and reforming insurance schemes, including in Malawi, Ghana, Kenya, Nigeria and Tanzania. The introduction or expansion of health insurance has implications for overall resource mobilisation for health and its allocation, and for the equitable and efficient delivery of services for both insured and non-insured users, including access for the poor.

The programme will include presentations on experience in Europe, Latin America, and Asia, and case studies from African countries that are planning or have developed insurance schemes. Working group sessions will focus on lessons learned and on developing health insurance schemes in low income countries which respond to the sector's policy objectives.

Given the mix of countries attending, two objectives have been identified for the workshop:

- To review and draw together the international evidence and experience on how far and how health insurance can make a useful contribution to country health systems development in Sub Saharan Africa (SSA) in terms of:
    - The policy objectives for introducing HI (revenue generation; risk sharing; improving the health system through efficient 'purchasing')
    - Whether it facilitates generation of additional resources for health and how to extend schemes to an increasing share of the population
    - Whether and how it can achieve better results in terms of efficient health service delivery and improved access, for the insured and for others (including the poor)
    - How to deal with HIV/AIDS.

- Through this process, to identify areas of consensus, issues of relevance to countries and issues for further work.

Countries represented include:
South Africa, Kenya, Zimbabwe, Tanzania, Ghana, Nigeria, Malawi, Côte d'Ivoire

Background information and papers for this workshop can be obtained by accessing the following webpage link: http://www.healthsystemsrc.org/health2002.htm

PROGRAMME
DFID HEALTH INSURANCE WORKSHOP
9-10 April 2002
BMA House, Tavistock Square, London

Day 1, Tuesday 9th April

TIME	ACTIVITY	PRESENTER/S	CHAIR/ FACILITATOR
9.00 – 9.30	**Registration and coffee**		
9.30 – 10.00	Welcome and introductions Objectives of the workshop	Martin Taylor, DFID	Ken Grant, Director of HSRC
10.00 -10.30	**Principles of health insurance** **Experience and trends in Europe**	Anna Dixon, London School of Economics	
10.30 – 10.50	*Comments and discussion*		
10.50 – 11.20	**Coffee**		
11.20 – 11.40	Case studies from Asia	Tim Ensor, University of York	Veronica Walford, HSRC
11.40 – 12.00	Case studies from Latin America	Alejandra Rossetti, Mexico	
12.00 – 12.20	Experience and trends from the Balkan region	Joao Costa, IHSD	
12.20 – 12.40	Emerging issues for Sub-Saharan Africa	Ceri Thompson, IHSD	
12.40 – 13.00	*Comments and questions*		
13.00 – 14.00	**Lunch**		
14.00 – 15.30	**Issue 1: The politics, objectives and the process of setting up health insurance** • Country case study – Tanzania • Country case study – Côte d'Ivoire **Group work**	Emmanuel Humba, National Health Insurance Fund, Tanzania Max Mapunda, Ministry of Health, Tanzania Jean-Pierre Sery, Ministry of Social Affairs, Côte d'Ivoire	Alejandra Rossetti, Mexico
15.30 – 15.45	**Tea**		
15.45 – 17.15	**Issue 2: What is the role of health insurance in poverty reduction? What specific steps can be taken to ensure the poor do not lose out when an insurance scheme is developed?** Introduction **Group work**		Gerald Bloom, Institute for Development Studies
17.15 – 17.45	*Feedback on ideas*		Martin Taylor, DFID
18.00 – 19.30	**Cocktail reception**		

Day 2, Wednesday 10th April

TIME	ACTIVITY	PRESENTER/S	CHAIR/ FACILITATOR
9.15 – 10.15	**Plenary panel: Improving service efficiency and coverage** • Country case study: Kenya • Country case study: Ghana • Innovative ways to collect funds: Kosovo and Brazil Introduction to the group work	Stephen Muchiri, Ministry of Health, Kenya TBC Joao Costa, IHSD Tim Ensor, University of York	Ken Grant, HSRC
10.15 – 12.15	**Issue 3: Mechanisms to ensure efficient and effective service provision funded by Health Insurance** **Group work**		Tim Ensor, University of York
	Coffee		
	Issue 4: Mechanisms to raise more funding for health and to increase the numbers covered by insurance? **Group work**		Mark Pearson, HSRC Joao Costa, HSRC
12.15 – 13.00	*Feedback from groups and discussion*		Ken Grant, HSRC
13.00 – 14.00	**Lunch**		
14.00 – 15.15	**Issue 5: Mechanisms for risk sharing: How to decide what should be in the benefit package? How to deal with HIV/AIDS and other chronic illness?** Introduction **Group discussions:** **5a:** What are the most important services to cover for risk sharing purposes? **5b:** What policies are realistic on HIV/AIDS?		David Daniels, HSRC
15.15 – 15.30	*Feedback from Groups*		
15.30 – 16.15	**Tea** Preparation of conclusions by country delegates and on issues for further study		
16.15 – 17.30	**Conclusions** – issues of relevance to countries, and areas identified for further work	Country delegates	Veronica Walford, HSRC

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