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Briefings for Health Financing Policy-Making in Cambodia – #2

This series of policy briefs intends to support and inform decision-makers in Cambodia on key issues related to health financing and social health protection. These briefs are not scientific papers, but rather summarise evidence and technical concepts that decision-makers may consider in their discussions. – All briefs are available in Khmer and English.

Transitioning from Voluntary Micro Insurance to Universal Health Coverage:

Could Cambodia follow Ghana's path?

Introduction

Cambodia's current draft health financing policy foresees the development of financing schemes targeting different segments of the population, with the ultimate goal of transitioning to a unified system to achieve universal health coverage. A key element in this policy is reducing the fragmentation of existing social health protection (SHP) schemes.

These policy endeavours could benefit from the experience of other developing countries, especially Ghana – a low-income country in sub-Saharan Africa that faced similar challenges a decade earlier. In 2003 Ghana established its National Health Insurance Scheme (NHIS). With NHIS, Ghana consolidated the different community-based health insurance (CBHI) schemes in the country into a single national programme by enacting key legislation and structural reforms.

Key messages

- In 2000, Ghana's social health protection (SHP) system was relatively similar to the situation in Cambodia today.
- In 2003, Ghana began a popular reform of its SHP system to work towards universal health coverage.
- Based on the evidence and experiences of Ghana, similar reforms could be implemented in Cambodia, especially:
  - Establish a single national SHP fund for the informal sector, built on existing experience and network of health equity funds.
  - Substantially fund access to public health services by enforcing direct taxes such as on corporate income, and indirect taxes such as value added tax (VAT).
  - Complement general revenues with acceptable and affordable contributions from formal and informal sector workers, along with dedicated government revenue (earmarked taxes).
  - Equalise financial risk across the country and different SHP funds.
- Key to the adoption and implementation of these significant reforms is political commitment at the highest levels.
- However, policy-makers can gain wide political support for reforms that benefit the whole country.

Table 1: Comparative country data and selected health expenditure indicators between Ghana (2000) and Cambodia (2012).

	Cambodia	Ghana
Population	14.86 million	19.53 million
Gross domestic product (GDP) per capita	USD 1036	USD 255-400
% of population below poverty line	19.8% (2011)	30%
Average GDP growth rate	7.3%	3-3.7%
% of population in the informal sector	73%	83%
General government expenditure on health, as % of total health expenditure	20%*	49%
General government expenditure on health, as % of general government expenditure	12%*	8.3%
Total health expenditure on health, as % of gross domestic product (GDP)	7.4%*	2.4%
Catastrophic expenditure incidence related to health	7.1%*	1.3% (1999)

*Source: World Health Organization, Cambodian National Health Account 2012

Rationale

The situation in Ghana before its 2003 reforms was very similar to Cambodia today, and provides an opportunity to examine how similar reforms could be implemented in Cambodia. Prior to NHIS, Ghana had a health financing system based on user fees. Exemptions for the poor existed but were ineffective due to a lack of government funding. In the 1990s, this situation triggered the establishment of local voluntary micro health insurance schemes run by nongovernmental or community-based organisations. By 2003, there were about 58 such schemes, with widely varying district coverage rates (from 2% to 25% of the population), but with low nationwide coverage of only 1% to 2%.

In Cambodia, user fees were introduced in 1996. These fees have created constraints to health care access by the poor and other low-income population groups. Fee exemptions for the poor were implemented, but have proven ineffective. This situation led to the emergence of fragmented SHP instruments, including health equity funds (HEFs) and micro health insurance schemes.[1] In 2012, there were 18 micro health insurance schemes, with varying coverage rates (up to 40% of district households). Together they covered approximately 300,000 Cambodians, or around 2% of the population, approximately the same coverage as micro health insurance in Ghana prior to NHIS. However, Cambodia has a structural advantage compared to Ghana, thanks to its extensive HEF coverage. In 2012, 45 HEF schemes covered poor households in 53% of the public referral hospital coverage areas and 31% of the public health centres in the country.

1 See also "Briefings for Health Finance Policy-Making in Cambodia - #1. Extending Social Health Protection in Cambodia: How can health equity funds pave the way for universal health coverage?"

The Genesis of Ghana's National Health Insurance Scheme

Access to health care in Ghana turned into a key political issue during the 2000 elections, whereby there was strong political pressure to adopt a national health insurance system as a means for reducing direct out-of-pocket payments at public health facilities (user fees). This became a central theme of the elections, and one of the first priorities of the newly elected government.

Design and structure

Stewardship. Ghana's NHIS built on the existing fragmented network of micro insurance schemes, which were integrated into a single national system and transitioned into publicly subsidised, government-funded, district-wide mutual health insurance schemes (DMHIS). DMHIS serve as branches of NHIS; they are semi-autonomous and regulated by the independent National Health Insurance Authority (NHIA). Apart from DMHIS, the law allows for two additional categories of schemes that can also access public subsidies: private mutual health insurance (smaller, private, community-based non-profit schemes) and private commercial health insurance (private for-profit schemes). Both types of schemes are regulated by NHIA, which is also responsible for accrediting and monitoring health care providers contracted by the schemes.

Resource collection. Enrolment in one of the three types of schemes is compulsory, but people can choose their preferred scheme. In reality, there is no enforcement (in contrast to other countries such as Rwanda). Formal sector workers are automatically enrolled, with a 2.5% payroll contribution.

Premiums charged by DMHIS from informal sector workers are set according to capacity-to-pay, ranging from USD 5-8 per year for the very poor up to USD 32-53 for the very rich. In practice, many DMHIS charge only the lowest rate.

A 2.5% national health insurance levy (NHIL), added to the standard value added tax (VAT) rate, complements the contributions, national budget allocations from other taxes and premiums collected. This dedicated consumption tax was introduced as the main funding instrument for NHIS. Supported by a relatively robust economy in the decade before establishment (with a growth rate similar to present-day Cambodia's), this decision displayed serious commitment by the political leadership and was vital to the progress of NHIS. Early data from Ghana, suggested that the NHIL and VAT in general were actually mildly progressive as poorer populations paid only mildly less compared to the rich. Overall, the NHIL only represents a small part of the government expenditure on health which mainly comes from more progressive taxes such as personal and corporate income taxes, and import duties.

Pooling. The National Health Insurance Fund (NHIF) is the national risk equalisation and funding mechanism for DMHIS. It is financed by the premiums of informal sector workers (4-5%), payroll contributions of formal workers (16-17%), and the NHIL (61-73%).

Ghana deliberately decided not to concerned itself with the risk of adverse selection when engaging in its reforms, based on the understanding that insurance concepts should not simply be expanded into a national social health protection mechanism. From the perspective of an insurance company, avoiding households with higher risks and needs is essential in reducing costs. This is in direct contrast to the social values of universal health coverage. The priority of a national, social health protection scheme is to ensure that those households most in need of protection are enrolled and protected by the scheme. Thus, instead of excluding high-risk individuals, Ghana's policy-makers exempted them, including children (under 18 years old) of enrolled parents, old people, pregnant women and the indigent. Overall, these high-risk groups constitute more than 70% of NHIS membership.

Purchasing. The minimum benefits package provided by all schemes covers 95% of health conditions in Ghana, including inpatient and outpatient services, maternity care, emergency care and essential drugs. Benefits are portable across districts using a single national NHIS identification card.

NHIS reimburses providers using a payment mechanism based on diagnostic-related groupings (whereby treatment cases are grouped by their different rates), which is essentially a capitated rate per patient visit.

Evidence and achievements

The introduction of NHIS led to a rapid increase in health coverage to currently over one third of Ghana's 19 million people (with DMHIS operating in 145 of 170 districts). It also contributed to a rise in the financial resources available to the health sector, an increase in health service utilisation, with considerable satisfaction with the services and scheme, and a decline in out-of-pocket payments and catastrophic expenditures for health care.

Continuous adjustments have been required by policy-makers over the short history of NHIS. Like most countries that have made significant progress towards universal health coverage, Ghana's health financing system went through an initial phase of rapid institutional development and expenditure growth. In the next phase, the government will be required to secure its financial sustainability with improvements in revenue collection, and cost containment through efficiency gains and rationalisation of services.

Conclusions and recommendations

The success of NHIS has demonstrated that it is possible for a country with limited technical and financial resources to move rapidly towards universal health coverage by addressing the needs of the poor and both formal and informal sector workers, irrespective of rural or urban residence. However, this was only possible through comprehensive organisational reform combined with the dedication and allocation of new resources, and supported by strong political commitment.

In the Cambodian context, several points from the Ghanaian experience could be considered relevant:

- Ghana built its national SHP system on existing local and fragmented schemes, similar to the ones operating in Cambodia today;
- The political gains of reform were substantial for policy-makers;
- Dedicated taxes, levied to complement contributions from informal sector workers, were accepted by the public as the scheme benefited both the majority of the population and those most in need;
- Adverse selection arguments were dismissed, in line with the principles of universal health coverage;
- Cost containment was not directly addressed, as the establishment of new institutions and mechanisms was considered the highest priority.

The experience of Ghana provides a possible direction for the implementation of Cambodia's recently drafted health financing policy. This document outlines a future national health financing system that would not be very different from Ghana's NHIS. The broad policy decisions that are required to initiate such a reform in Cambodia may not be easy to make, but the associated political and socioeconomic gains are considerable. Thus, Cambodian policy-makers may consider making reforms of their country's health financing arrangements after examining the effects of a decade of similar reforms in a country that faced comparable socioeconomic challenges.

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