The Role of Social Health Insurance in Financing Healthcare in LMICs

IHEA 2025 Pre-Congress Session
"The Role of Social Health Insurance in Financing Healthcare in LMICs"
19 July 2025 | Bali, Indonesia

KEMRI | Wellcome Trust

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Session objectives

This session aims to:

Share and reflect on global evidence regarding the performance of Social Health Insurance (SHI) schemes in low- and middle-income countries (LMICs);

Explore institutional and organizational arrangements underpinning SHI in Africa; and

Discuss country experiences from **varying stages** of SHI implementation, including Ghana, Kenya, Nigeria, and Zambia

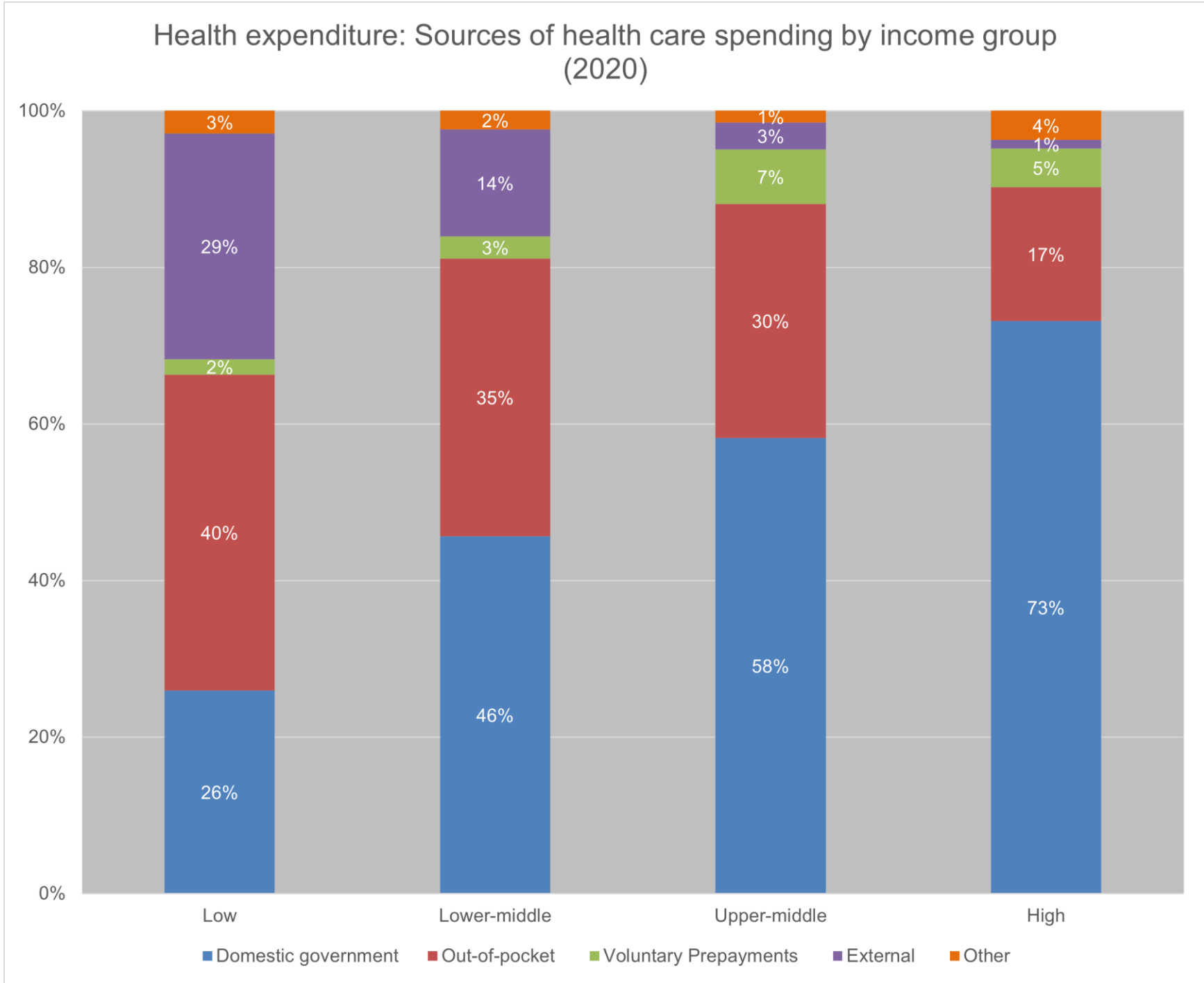
Program

Time	Details	Presenter/Chair
5 min	Welcome, session objectives and program	Edwine Barasa
15 min	Framing: SHI in LMICs	Kara Hanson
15 min	Lessons from Outliers	Edwine Barasa
15 min	Institutional Arrangements	Beryl Maritim
30 min	Discussant Reflections **Panel 1: Evidence Panel** (Kara, Edwine, Beryl)	John Ataguba
15 min	***Break***	
50 min	Country Case studies • Health insurance schemes that have been in existence longer: ▪ Ghana- Senanu Kwesi Djokoto ▪ Nigeria-Kelechi Ohiri • Newer health insurance schemes: ▪ Kenya- Dr. Mercy Mwangangi ▪ Zambia – Michael Njapua	Ghana, Nigeria, Kenya, Zambia
45 min	**Panel 2: All Speakers** (Framing + Country Reps + Discussants)	Moderated by Ama Fenny
20 min	**Closing Reflections & Discussion**	Joe Kutzin
	End	

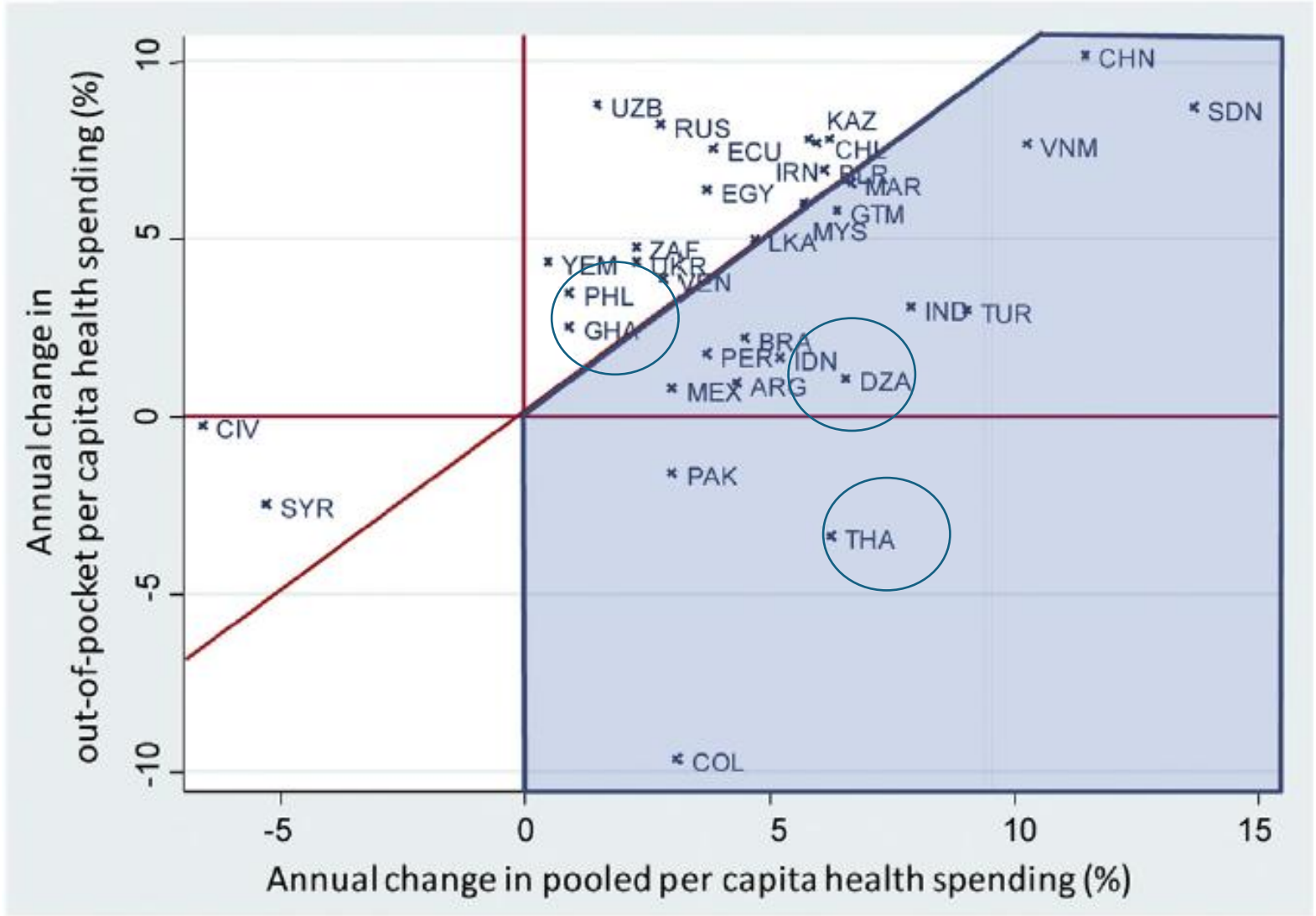
The role of social health insurance in financing health in LMICs – Framing presentation

Kara Hanson

July 19, 2025


Health expenditure: Sources of health care spending by income group (2020)
100%
80%
60%
40%
20%
0%
3%
29%
2%
40%
26%
2%
14%
3%
35%
46%
1%
3%
7%
30%
58%
4%
1%
5%
17%
73%
Low
Lower-middle
Upper-middle
High
Domestic government
Out-of-pocket
Voluntary Prepayments
External
Other

TRANSITIONS ARE NOT AUTOMATIC OR INEVITABLE, SO POLICY MATTERS



Fan and Savedoff 2014

Fan and Savedoff 2014

What do we mean by SHI (in the classical sense)?

Compulsory (*de jure* vs. *de facto*)

Contributory (non-risk related, with entitlement linked to contributions)

Government often pays contributions for specified groups

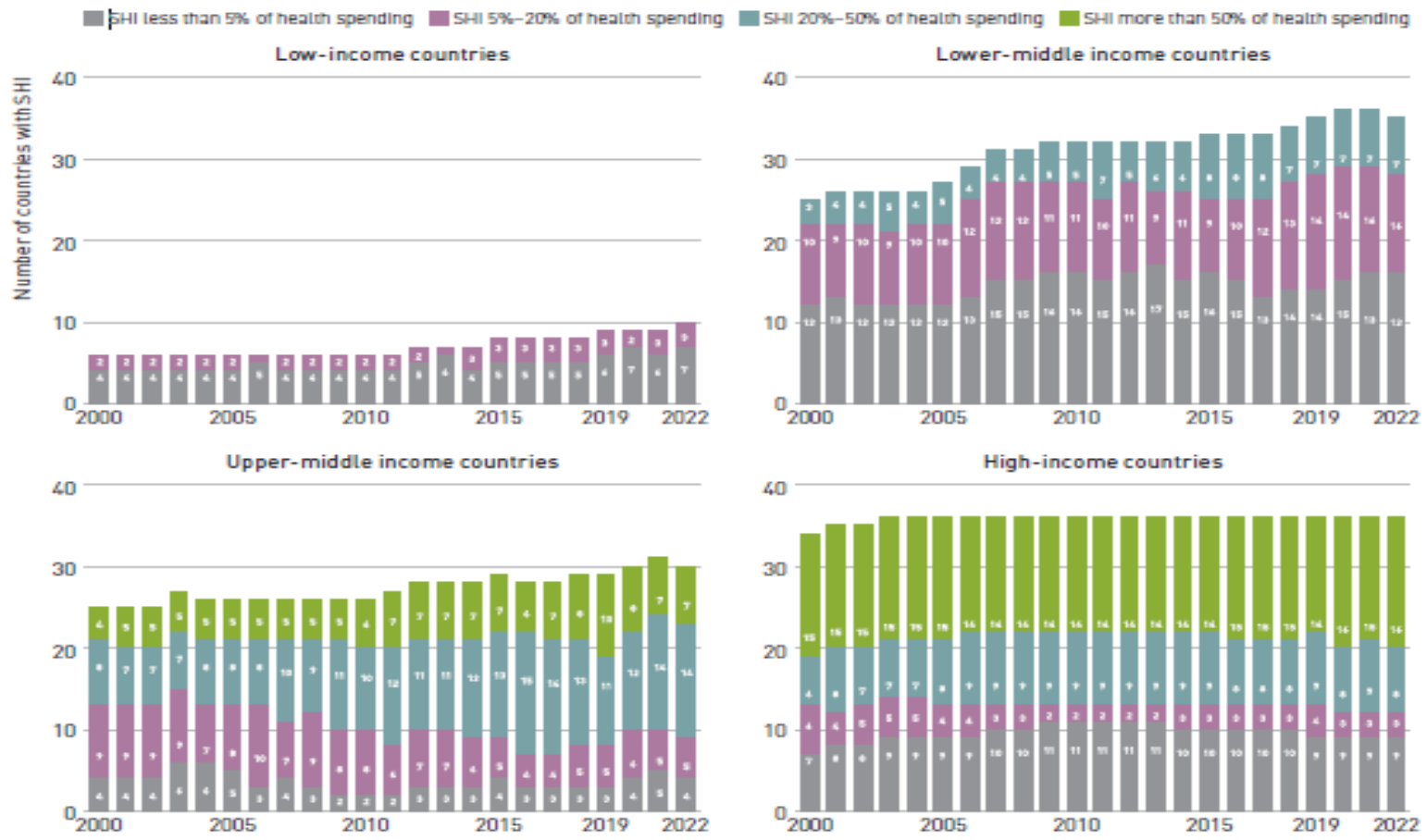
Revenue is earmarked for health services

Separation of purchaser and provider (dedicated SHI delivery system or purchaser provider split)*(at least historically)

SHI share of CHE increases with income level

SHI plays a small role in lower income countries

FIG. 2.6 While more than two-thirds of countries had a SHI scheme in 2022, all the countries that financed more than half of total health spending through SHI were upper-middle or high income



Data source: WHO Global Health Expenditure Database, 2024.

Source : WHO 2024 Global Health Expenditure Report

SHI coverage is also low when measured at household level

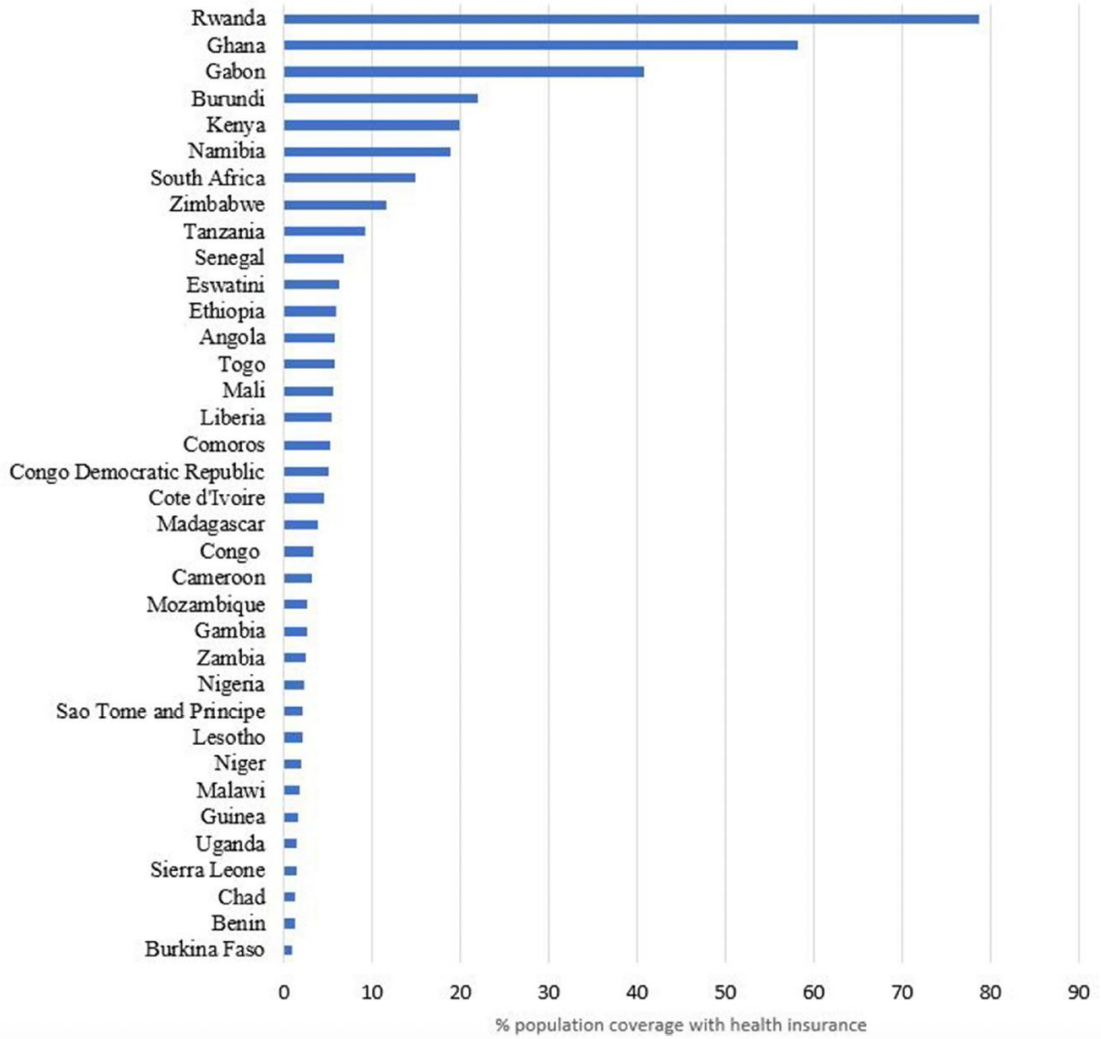
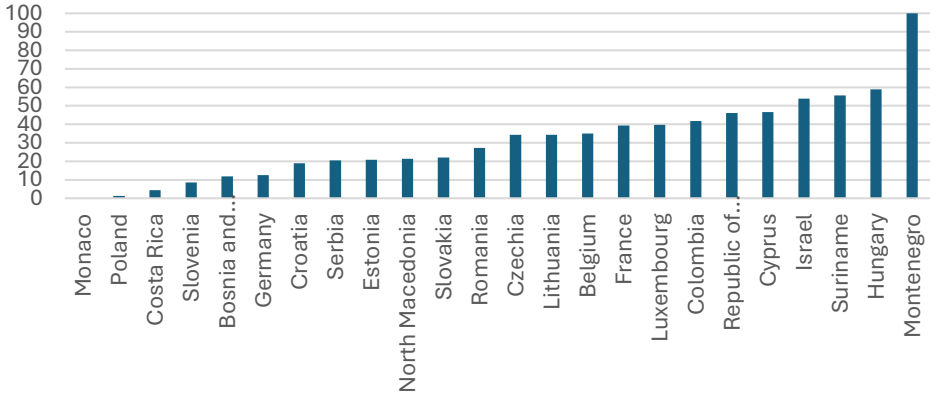


Figure 1 Mean level of health insurance coverage with any form of health insurance in 36 sub-Saharan African countries.

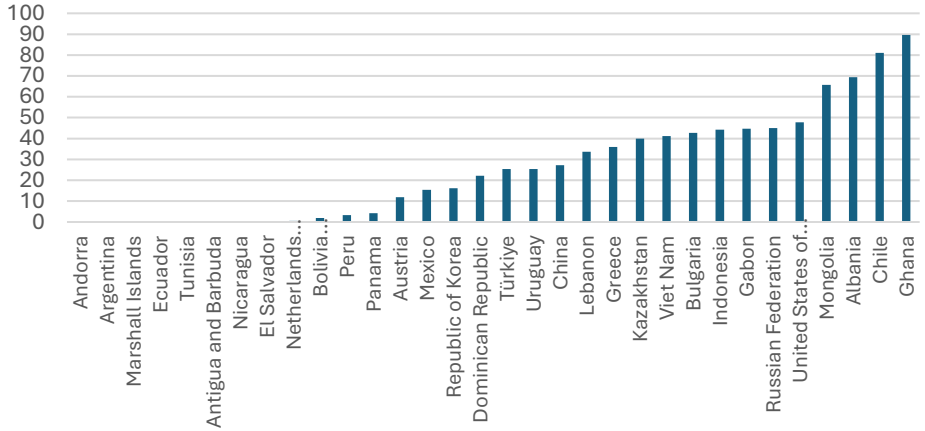
Barasa et al. 2020 BMJ GH

Budget transfers are an important financing source for SHI

Government transfer to SHI, countries where SHI > 50% of CHE



Government transfer as share of total SHI, SHI 21-40% of CHE



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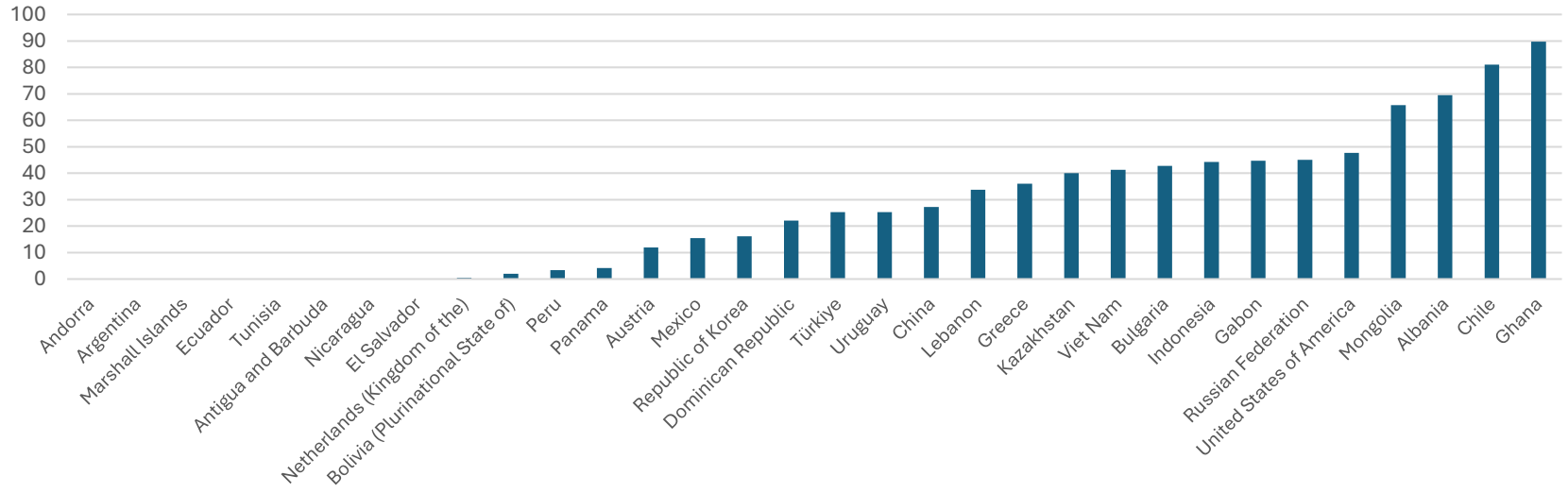
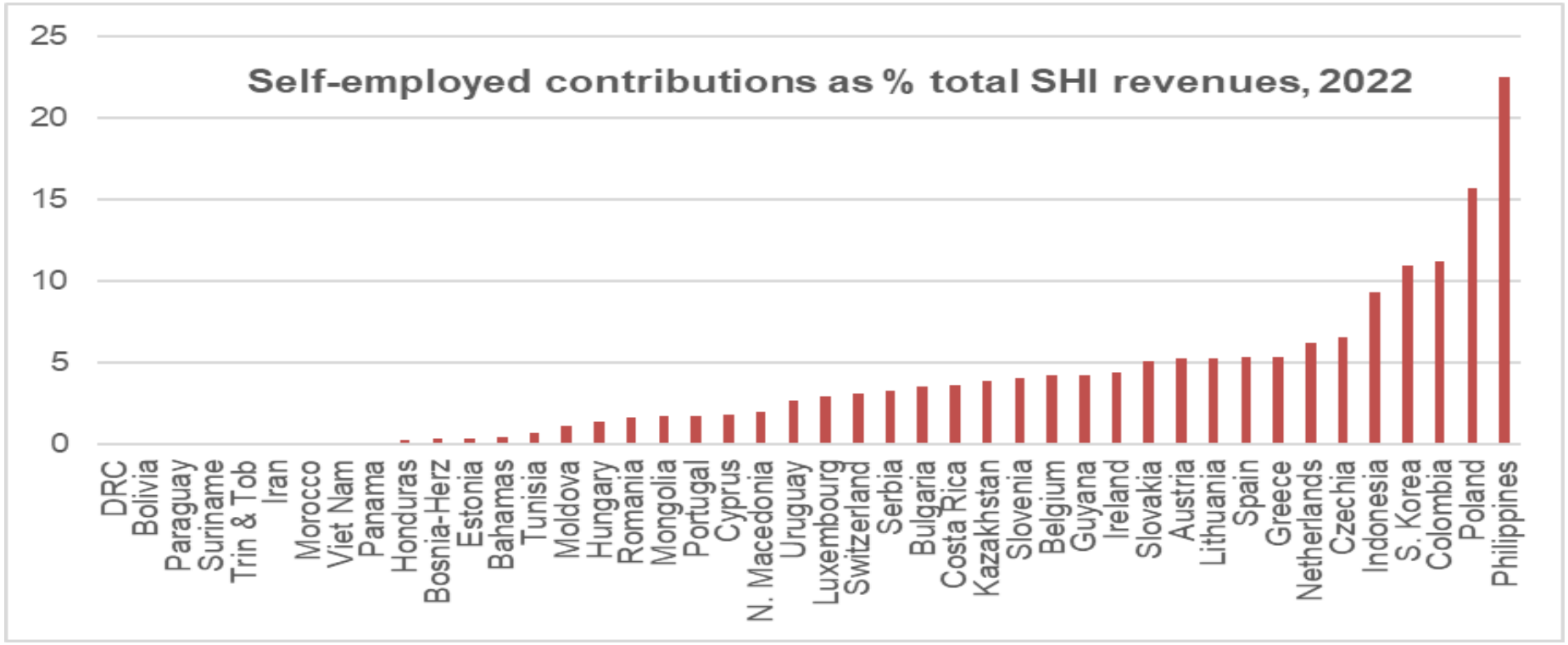


Informality the key limitation

A constraint on tax collection more generally

For the self-employed (a proxy for informally employed), it means joining SHI is de facto voluntary

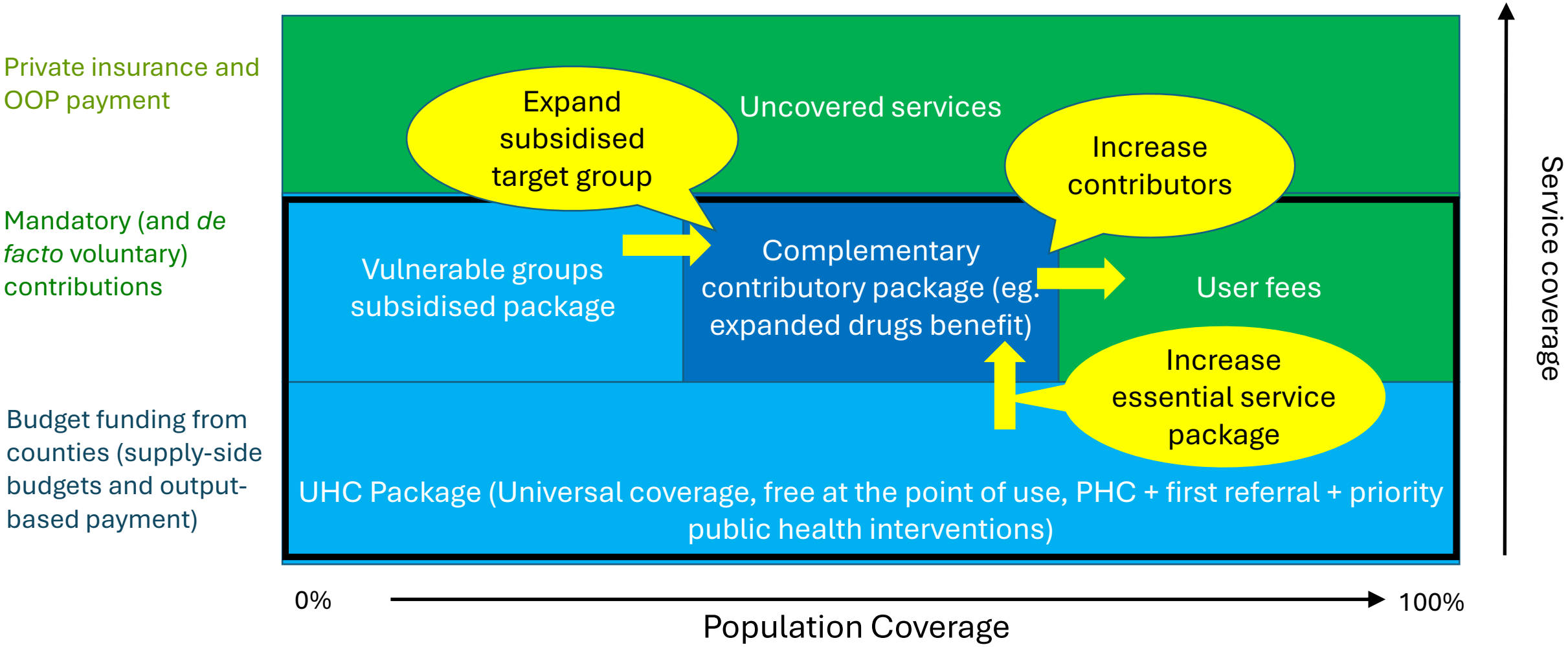


How does SHI fit into the “mosaic” of coverage schemes moving towards UHC?

In early stages there are gaps in coverage, differences in copayment rates and benefits

These are gradually reduced through expansion and harmonization

Differentiated benefits, unified framework



With thanks to Joe Kutzin

Areas for exploration today

What institutional and organisational arrangements for SHI contribute to increased coverage (and equity, efficiency)?

What can we learn from outliers? How generalisable are these lessons?

Hybrid arrangements are important, even in those countries where SHI is a predominant financing source – SHI with substantial budget subsidy.

How can we ensure that we maintain a focus on the system, rather than the scheme?

Outliers in Social Health Insurance in LMICs

Edwine Barasa
KEMRI-Wellcome Trust Research Programme

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The Case against Contributory Health Insurance in LMICs

Contents lists available at ScienceDirect

Social Science & Medicine

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Addiction to a bad idea, especially in low- and middle-income countries: Contributory health insurance

Abdo S. Yazbeck [a,*], Agnes L. Soucat [b], Ajay Tandon [c], Cheryl Cashin [d], Joseph Kutzin [e], Julia Watson [f], Sarah Thomson [g], Son Nam Nguyen [h], Tamas Evetovits [g]

GLOBAL HEALTH POLICY

By Abdo S. Yazbeck, William D. Savedoff, William C. Hsiao, Joe Kutzin, Agnès Soucat, Ajay Tandon, Adam Wagstaff, and Winnie Chi-Man Yip

COMMENTARY

The Case Against Labor-Tax-Financed Social Health Insurance For Low- And Low-Middle-Income Countries

The Case against Contributory Health Insurance in LMICs

- High **labour informality**, and **poverty**
- Contributory health insurance achieves low coverage
  - Highly **inequitable**
  - Mobilizes **minimal revenues**
  - Inefficiencies – **adverse selection**
  - Financial **sustainability** challenges

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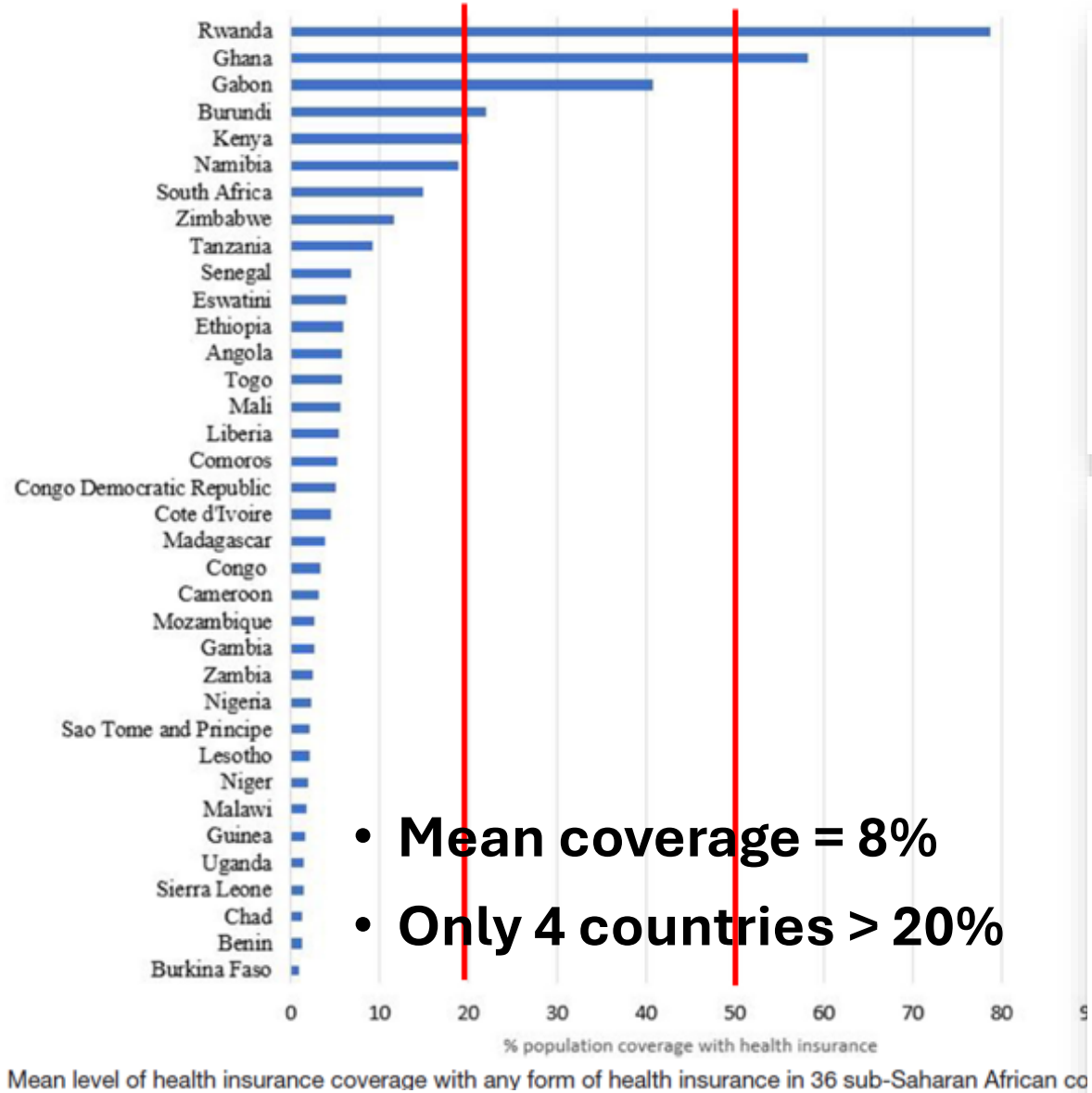

Mean level of health insurance coverage with any form of health insurance in 36 sub-Saharan African co

- **Mean coverage = 8%**
- **Only 4 countries > 20%**

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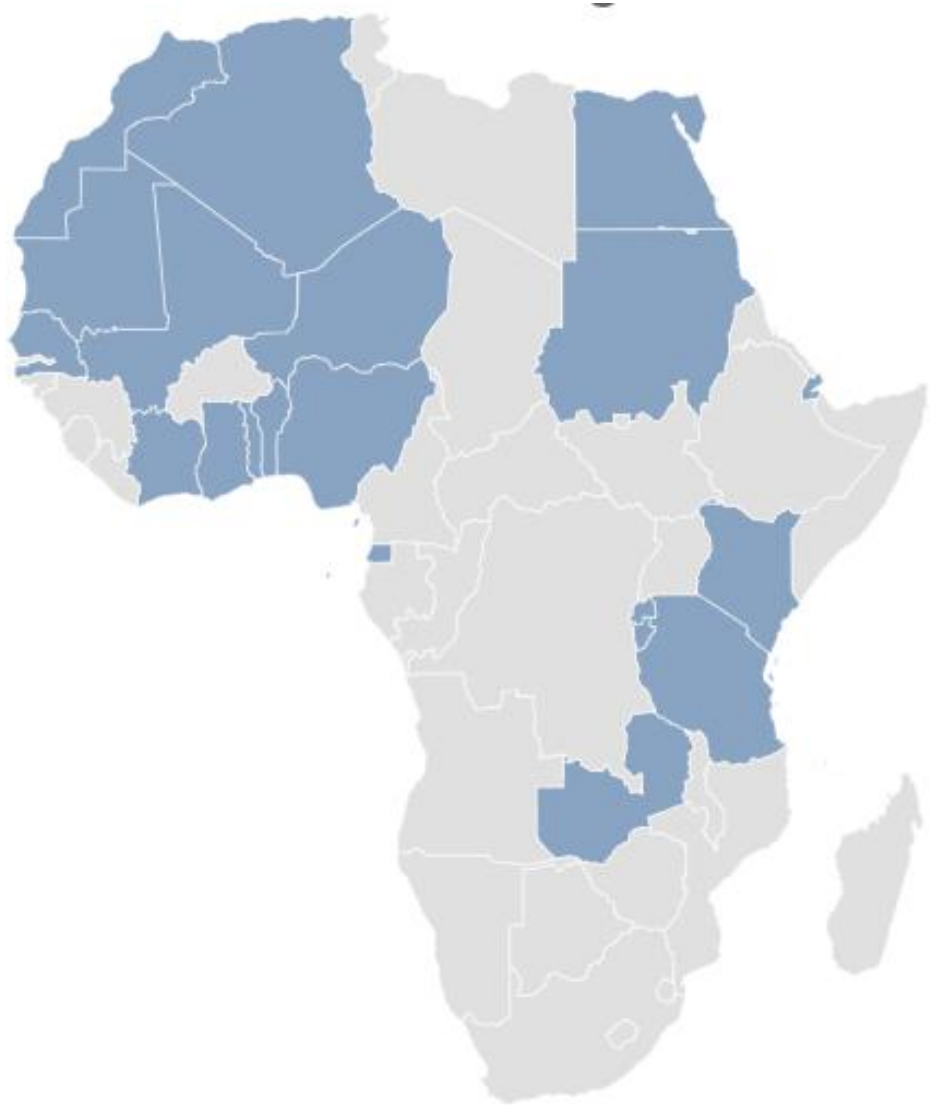
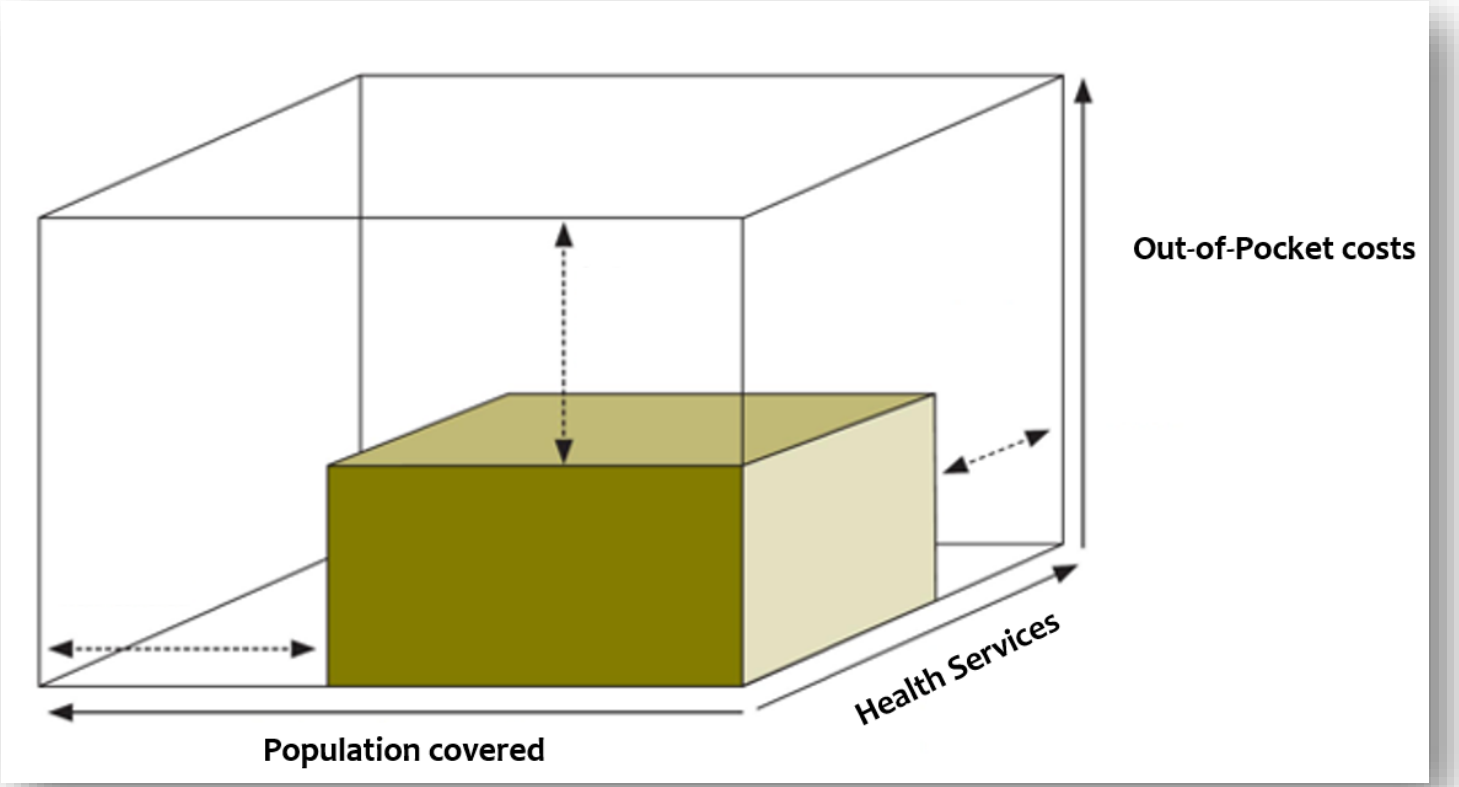
24 (out of 54) African countries list SHI as a source of healthcare revenues



Outlier Countries: how to measure performance?



1) Financial risk protection
2) Service coverage

3) Population covered

4) Equity – financing & Coverage
5) Efficiency
6) Quality

Some LMIC countries have achieved high levels of population enrollment with SHI

Region	Country	Income classification	% Health insurance coverage
Asia	Thailand	UMIC	100%
Asia	China	UMIC	97%
Latin America	Colombia	UMIC	96%
Asia	Philipines	LMIC	92%
Asia	Vietnam	LMIC	92%
Africa	Rwanda	LIC	90%
Latin America	Mexico	UMIC	88%
Asia	Indonesia	UMIC	85%
Latin America	Peru	UMIC	83%
Africa	Ghana	LMIC	69%
Latin America	Argentina	UMIC	64%

Most outliers are UMIC's; reforms (and significant progress) began when they were LMIC's

Region	Country	Income classification	% Health insurance coverage
Asia	Thailand	UMIC	100%
Asia	China	UMIC	97%
Latin America	Colombia	UMIC	96%
Latin America	Mexico	UMIC	88%
Asia	Indonesia	UMIC	85%
Latin America	Peru	UMIC	83%
Latin America	Argentina	UMIC	64%
Asia	Philipines	LMIC	92%
Asia	Vietnam	LMIC	92%
Africa	Ghana	LMIC	69%
Africa	Rwanda	LIC	90%

Outliers also face the challenge of high informality and poverty

Region	Country	Income classification	% Health insurance coverage	% poor	% Informal
Africa	Rwanda	LIC	90%	49%	87%
Asia	Indonesia	UMIC	85%	60%	80%
Africa	Ghana	LMIC	69%	11%	78%
Asia	Vietnam	LMIC	92%	5%	69%
Latin America	Peru	UMIC	83%	34%	68%
Asia	Thailand	UMIC	100%	6%	65%
Latin America	Colombia	UMIC	96%	39%	58%
Latin America	Mexico	UMIC	88%	44%	57%
Asia	China	UMIC	97%	13%	54%
Latin America	Argentina	UMIC	64%	40%	51%
Asia	Philipines	LMIC	92%	18%	50%

High population enrollment, with limited financial risk protection

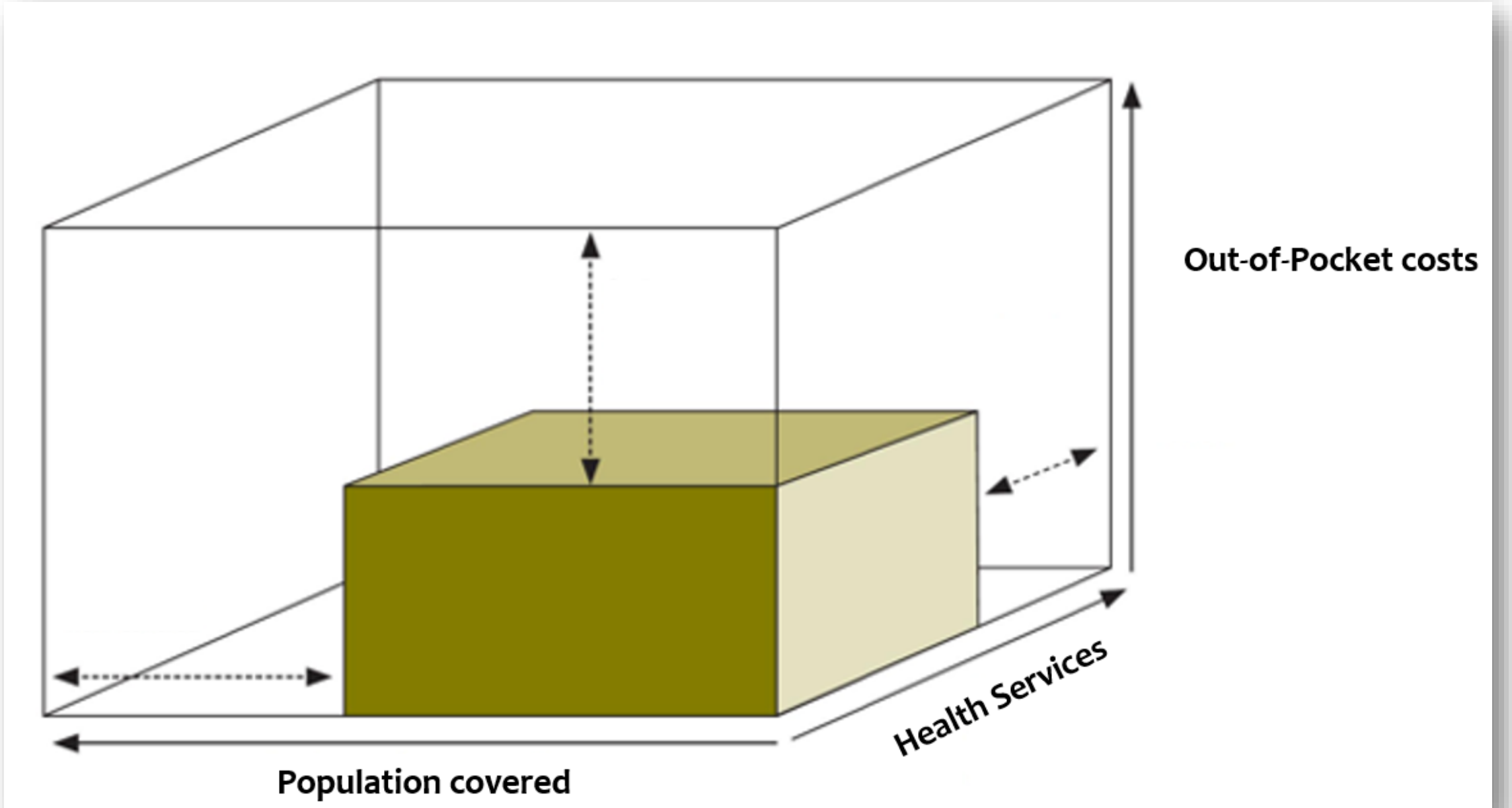
Region	Country	Income classification	% Health insurance coverage	OOP as % of THE
Asia	Philipines	LMIC	92%	45%
Asia	Vietnam	LMIC	92%	40%
Latin America	Mexico	UMIC	88%	39%
Asia	China	UMIC	97%	34%
Asia	Indonesia	UMIC	85%	33%
Africa	Ghana	LMIC	69%	25%
Latin America	Argentina	UMIC	64%	26%
Latin America	Peru	UMIC	83%	27%
Latin America	Colombia	UMIC	96%	15%
Asia	Thailand	UMIC	100%	9%
Africa	Rwanda	LIC	90%	10%

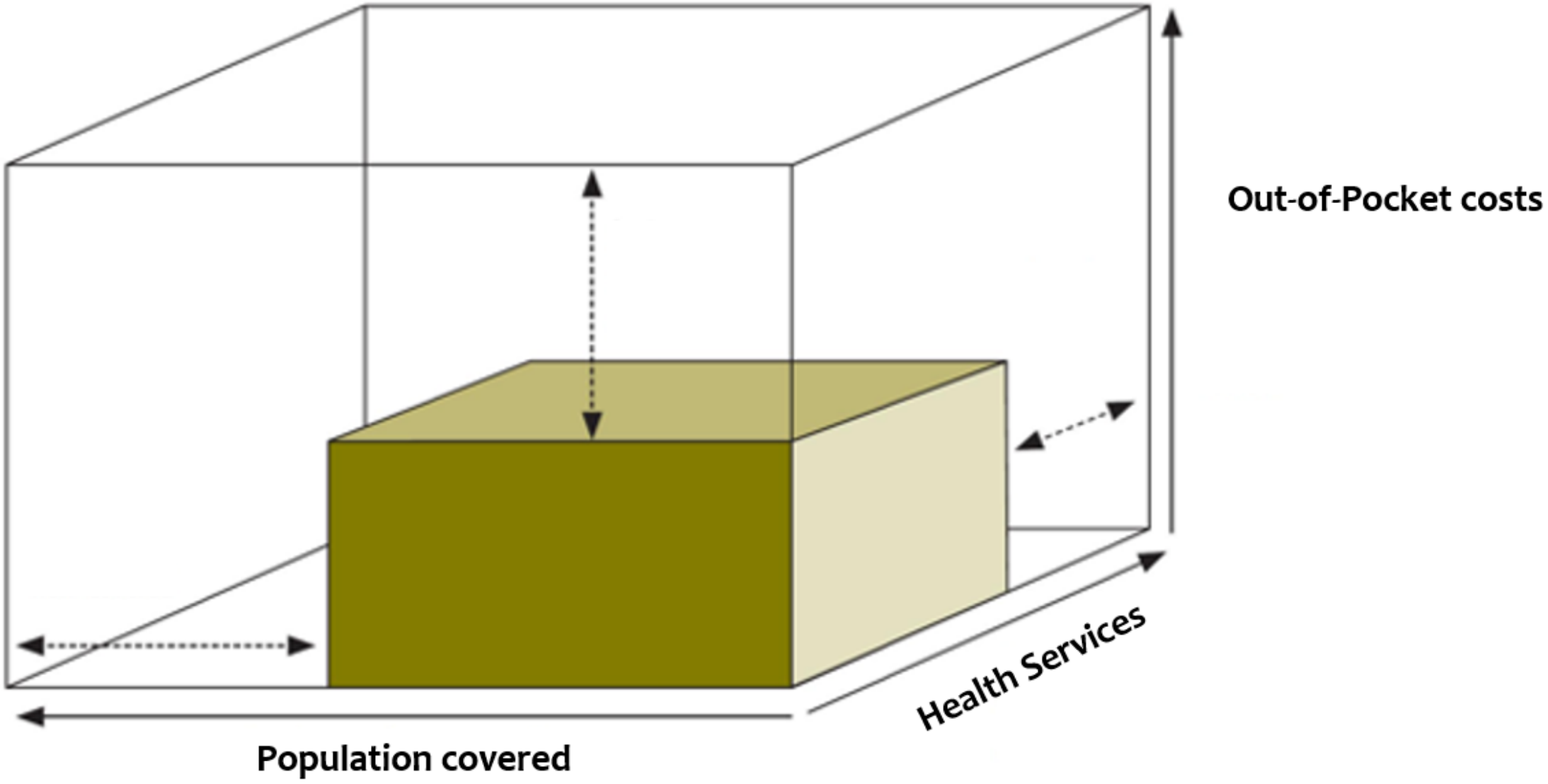
Low depth of coverage

Most UMIC outliers have achieved high service coverage, LMIC Outliers still experience low service coverage

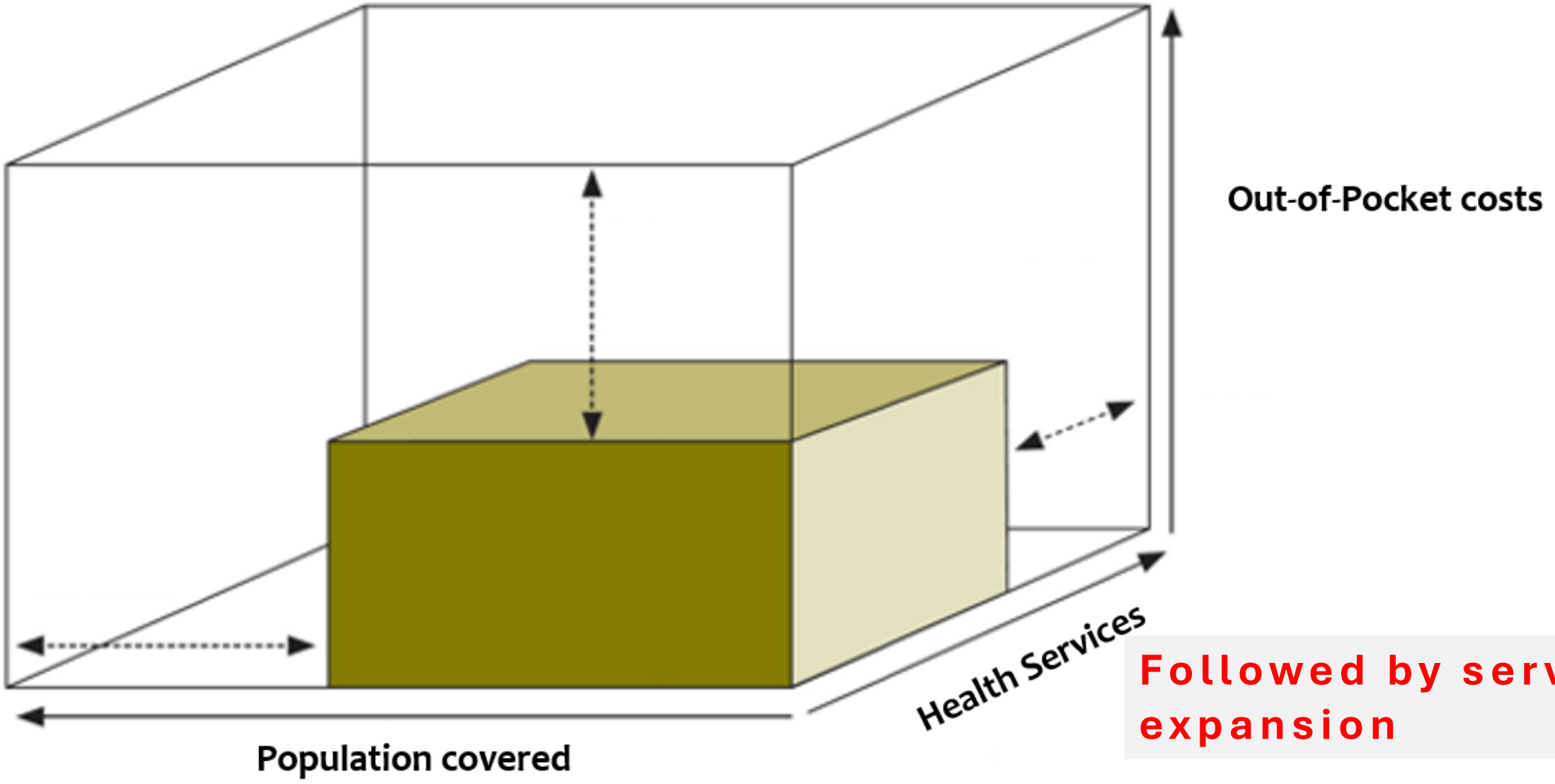
Region	Country	Income classification	% Health insurance coverage	OOP as % of THE	Service Coverage
Asia	China	UMIC	97%	34%	80%
Latin America	Colombia	UMIC	96%	15%	80%
Asia	Thailand	UMIC	100%	9%	80%
Latin America	Argentina	UMIC	64%	26%	79%
Latin America	Mexico	UMIC	88%	39%	75%
Latin America	Peru	UMIC	83%	27%	71%
Asia	Vietnam	LMIC	92%	40%	68%
Asia	Philipines	LMIC	92%	45%	58%
Asia	Indonesia	UMIC	85%	33%	55%
Africa	Rwanda	LIC	90%	10%	49%
Africa	Ghana	LMIC	69%	25%	48%

Low breath of coverage


Out-of-Pocket costs
Health Services
Population covered

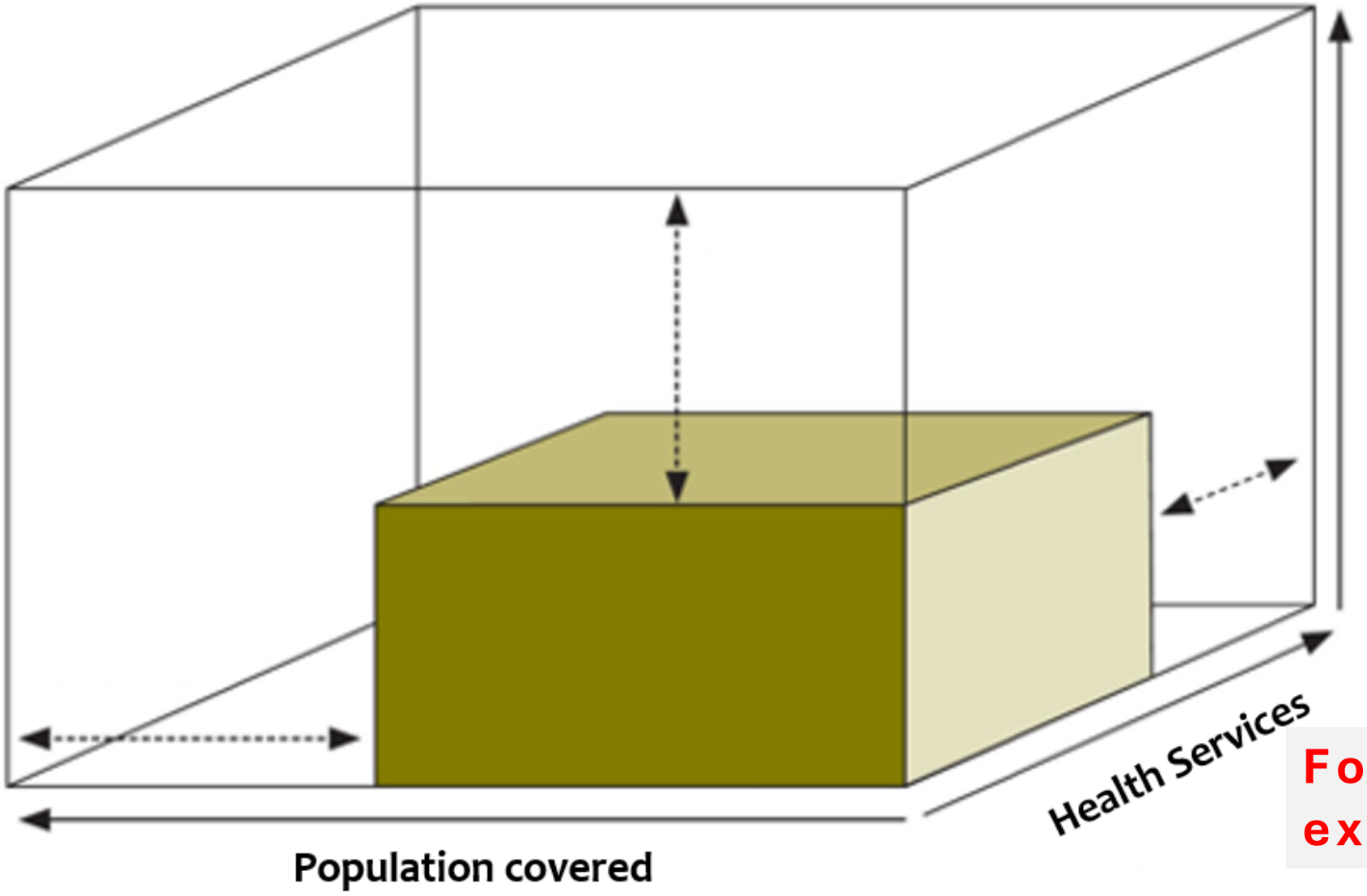


Outliers prioritized population coverage



Followed by service expansion

Outliers prioritized population coverage



Yet to achieve reduction in OOP?

Followed by service expansion

Outliers prioritized population coverage

Revenue Mobilization: Voluntary contributions do not mobilize meaningful revenues in outlier countries

Region	Country	Voluntary contributions % CHE
Africa	Ghana	2%
Africa	Rwanda	2%
Asia	China	9%
Asia	Indonesia	5%
Asia	Philipines	9%
Asia	Thailand	15%
Asia	Vietnam	5%
Latin America	Argentina	12%
Latin America	Colombia	9%
Latin America	Mexico	7%
Latin America	Peru	8%

Revenue Mobilization: Employee payroll contributions also do not mobilize meaningful revenues

Region	Country	Employee premium contributions % of CHE
Africa	Ghana	
Africa	Rwanda	
Asia	China	8%
Asia	Indonesia	2%
Asia	Philipines	2%
Asia	Thailand	3%
Asia	Vietnam	3%
Latin America	Argentina	12%
Latin America	Colombia	23%
Latin America	Mexico	4%
Latin America	Peru	0%

Revenue Mobilization: Employer matching contributions boost overall revenues mobilized

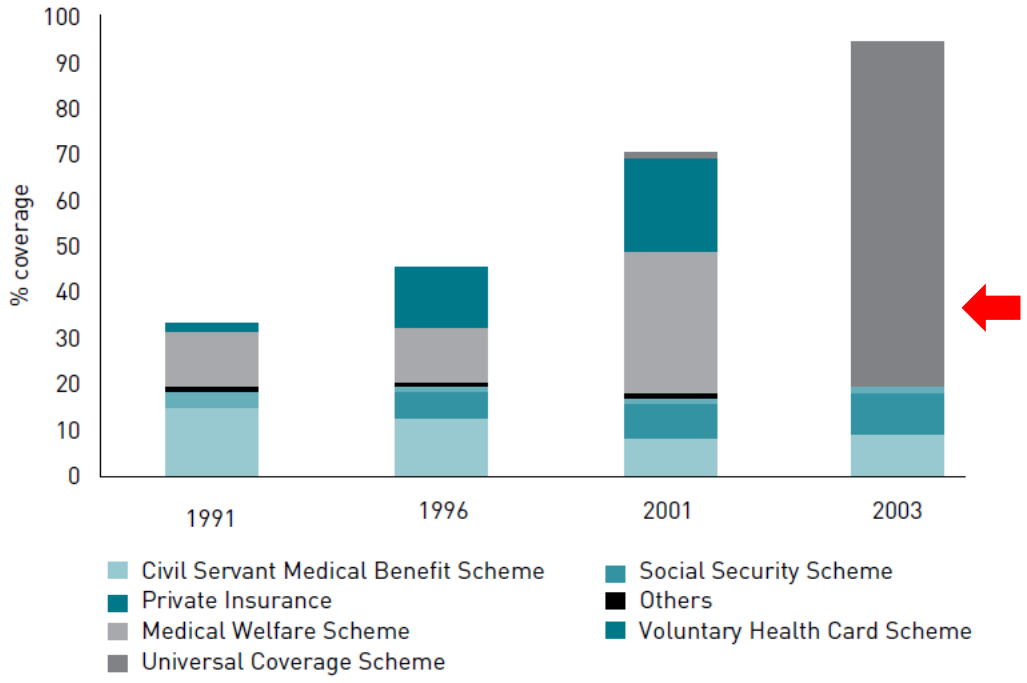
Region	Country	Employee premium contributions % of CHE	Employer matching contributions % of CHE
Africa	Ghana		
Africa	Rwanda		
Asia	China	8%	15%
Asia	Indonesia	2%	8%
Asia	Philipines	2%	2%
Asia	Thailand	3%	3%
Asia	Vietnam	3%	7%
Latin America	Argentina	12%	20%
Latin America	Colombia	23%	8%
Latin America	Mexico	4%	20%
Latin America	Peru	0%	23%

Revenue Mobilization: Outlier countries have substantial government subsidies – tax allocations

Region	Country	Government subsidy to SHI
Africa	Ghana	90%
Africa	Rwanda	50%
Asia	China	27%
Asia	Indonesia	44%
Asia	Philipines	50%
Asia	Thailand	33%
Asia	Vietnam	41%
Latin America	Colombia	42%
Latin America	Mexico	15%
Latin America	Peru	3%

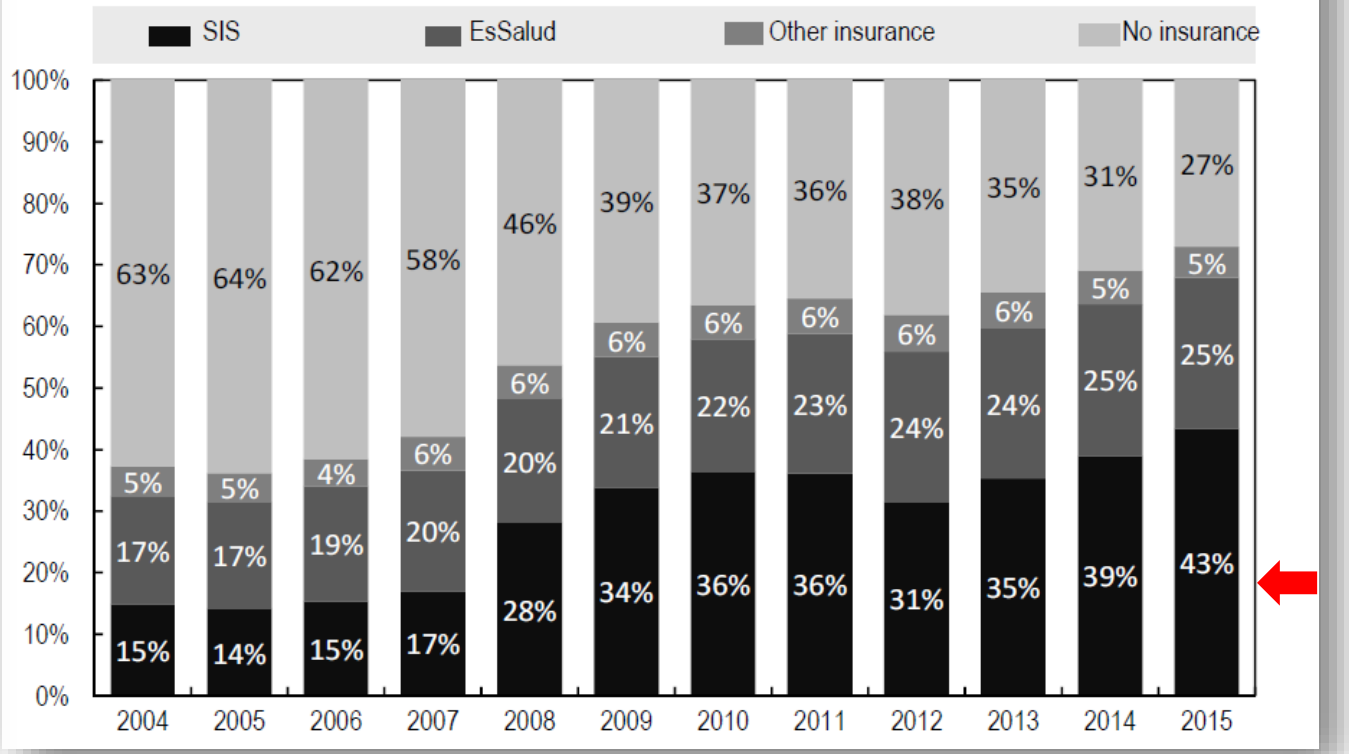
Population enrollment: Increase in population enrollment achieved through subsidizing membership for the poor and informal sector

Figure 6.1 Coverage of health insurance, 1991–2003



Source: Analysis of NSO Health and Welfare Surveys, 1991, 1996, 2001 and 2003

Figure 1.13. Health insurance coverage in Peru, 2004-15



Countries introduced tax financed mechanisms targeting the uncovered – poor/informal sector. E.g. Programa SUMAR (Argentina), UCS (Thailand), SR in Colombia

Risk Pooling

- Asian outliers – trend towards c**onsolidation** of risk pools – e.g. Vietnam, Indonesia, Philipines
- Latin American outliers – characterized by fragmented pools – Peru, Argentina, Colombia
- Existence or **risk - equalization** mechanisms – e.g. Colombia, Argentina

Purchasing

- **Variation** in **benefit specification** processes – some countries have evidence informed processes – Thailand, Philippines
- Some countries have **unified benefits**, while others (e.g. Indonesia) have **stratified benefits** across pools
- Capitation commonly used to pay for outpatient care, while case-based/DRG used to pay for inpatient
- Some countries have **blended provider payment mechanisms** e.g:
  - Thailand UCS – DRG + Global budget
  - Indonesia JKN – Capitation + pay for performance

Lessons

- Population enrollment to SHI ≠ universal health coverage
  - Financial risk protection
  - Service coverage
- Population coverage expansion made possible by substantial **government subsidies** targeting the poor and informal sector
- General taxes allocation + "innovative financing"
  - E.g. taxes on **tobacco and alcohol** (80% earmarked to healthcare) have fully subsidized insurance premiums for **senior citizens** and the **poorest 40%** in the Philipines
- Trend towards **pool consolidation** or **integration** (cross-subsidy)
- Trend towards establishing and using **evidence-informed benefit package definition** processes
- Progressive shift from **fee-for-service** to **capitation & case-based** methods, and **blended** provider payment methods

Institutional design of health insurance schemes in 21 African countries

Beryl Maritim, PhD | KEMRI Wellcome Trust

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“In an ideal health financing system, health financing rules are formulated and designed in such a way as to contribute to reaching the health financing objectives and performance indicators”

Inke Mathauer and Guy Carrin; 2010

The role of institutional design and organizational practice for health financing performance and universal coverage

Background

- **African countries are increasingly rolling out public health insurance schemes by legislation as a health financing mechanism for UHC**
  - 25+ countries have passed HI laws since 2010, many post-2015 SDGs
- Legislation doesn't just authorize HI - it determines how inclusive, efficient, and responsive the SYSTEM can be.
  - Legal rules shape who gets covered, how money flows, how providers are paid, and how citizens are protected
- Despite growing legislative activity, there is little comparative insight on how these laws are structured and whether they embed the principles needed for equitable financing for health.

Methodology

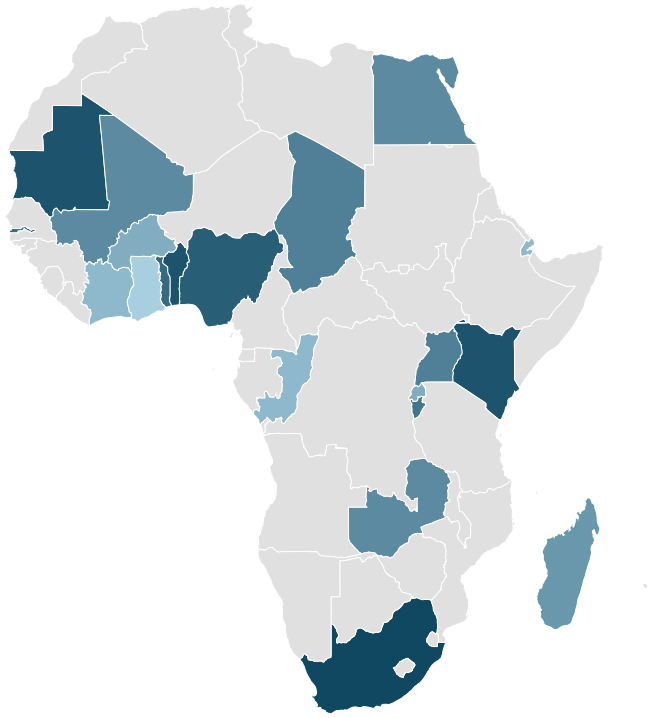
- We applied a framework analysis originally developed by Carrin et al. 2010: structure of the laws passed in African countries to establish national health insurance schemes along the three main health financing functions
  - Assessed the rules relating to health financing functions: Revenue collection; Pooling; Purchasing and provision of services
- Inclusion criteria: (i) Enacted between Jan 2010 -Dec 2024. (ii) Establish a public health insurance scheme as a mechanism for health financing

	Document review
1	National government websites
2	Official national health insurance scheme websites
3	Official journal and gazette websites

Source:

Scope of study

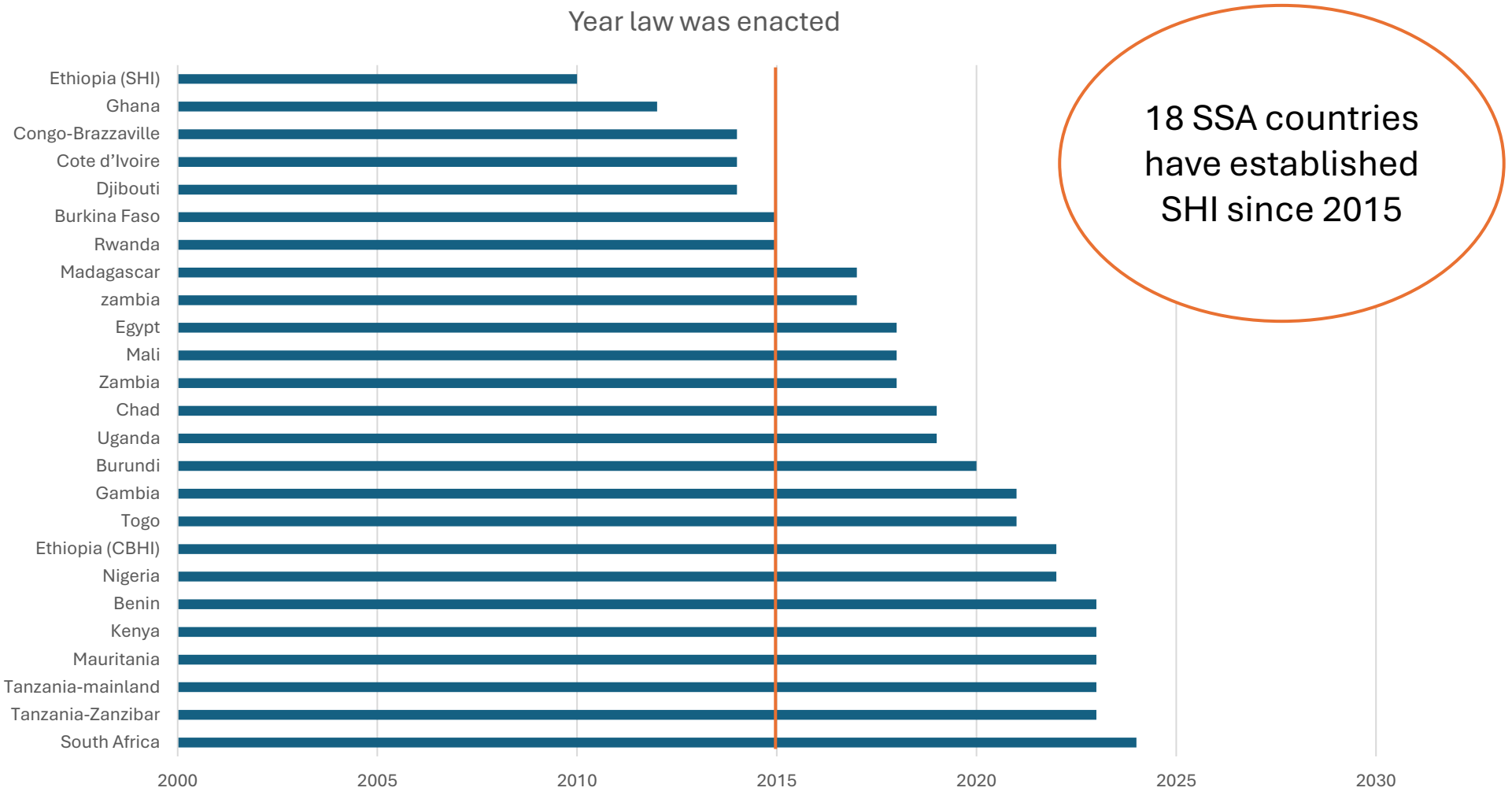
- Out of the 54 countries, 34 have a form of public health insurance provided by a health insurance scheme
  - Excluded: 20 countries using other health financing mechanisms not health insurance
- Of the 34 countries, 25 countries enacted their laws since 2010. Libya and Sudan laws weren't publicly available and excluded from the study.



Health insurance models

Model Type	Description	Countries
1. National SHI / NHI Systems	Single national scheme (compulsory or subsidized), covering most population groups	**Ghana, Kenya, Rwanda, Togo, Benin, Djibouti, Mauritania, Sierra Leone, Zambia, Madagascar, Burkina Faso, South Africa, Côte d'Ivoire, Mali, Egypt**
2. Mixed Models	Layered schemes (e.g., SHI + CBHI + targeted groups), often at national/subnational levels	**Nigeria, Ethiopia, Gabon, Chad, Congo-Brazzaville**

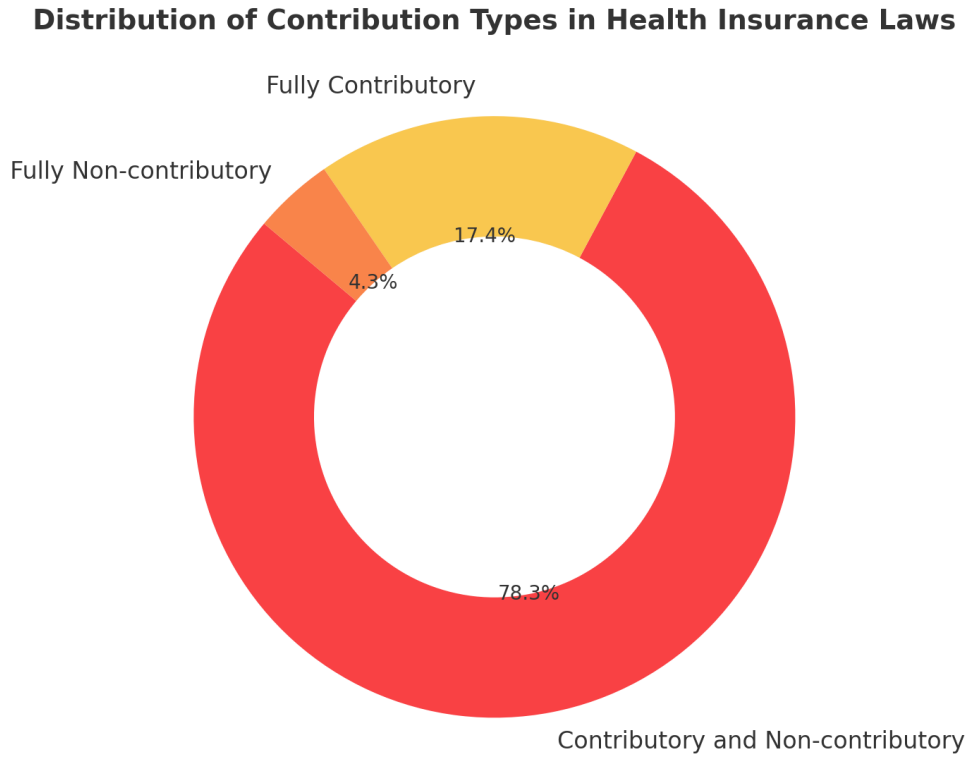
Enactment of Health insurance programs across Africa



18 SSA countries have established SHI since 2015

Design Features of SHI: Revenue mobilization

- **Fully non-contributory:** South Africa
- **Fully contributory:** Djibouti
- **Mixed systems:** Most countries, combining payroll contributions and government subsidies
- **Other sources:**
  - **Earmarked taxes** (e.g., telecom, sin taxes) – Ghana, Benin, Sierra Leone, Rwanda
  - **Seed financing for setup** – Togo, Sierra Leone



Source:

Design Features of SHI: Enrolment rules

Enrollment Type	Countries
Fully Mandatory (entire population)	Kenya, Ethiopia (CBHI & SHI), Benin, Ghana, Nigeria, Zambia, Chad, Cote d'Ivoire, Tanzania-mainland, Uganda, South Africa, Togo, Congo-Brazzaville, Burkina Faso, Sierra Leone, Egypt, Djibouti, Gambia
Mixed (mandatory + voluntary)	Burundi *(mandatory for formal workers, voluntary for informal)*
Voluntary enrollment	Madagascar, Mauritania
Conditional Mandatory	Rwanda, Gambia *(only those without private insurance are required to enroll)*

Design Features of SHI: Contribution Rates & Affordability

Proportional, and flat rate payments rates employed. Challenge of determining income level for the informal sector

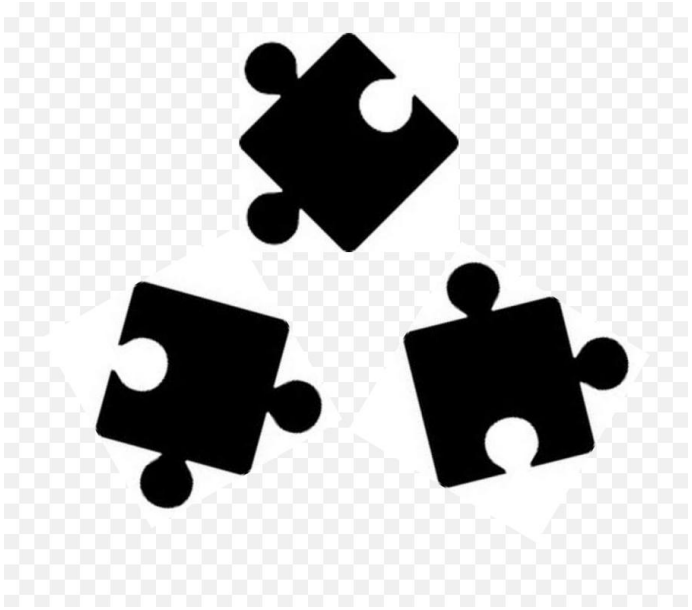
Country	Rate (%)	
Kenya	2.75% of gross	Paid annually for formal and informal workers
Zambia	2% of basic salary 1% of declared income for self employed	Low rate, equal split (1%:1%)
Mauritania	$17.65/month flat	65% paid by State, 35% by household
Côte d'Ivoire	$1.73 flat per month	Paid equally by household and employer

Source:

Equity Measures – Subsidies for Vulnerable Groups

Country	Beneficiaries	Identification Method	Who Pays
Kenya	Indigent households	Means testing by MoH and Social Protection	Government appropriation
Nigeria	Poorest deciles	National Social Register	Federal, State, Local govts
Ghana	Children, elderly, pregnant	Ministerial classification	Health insurance levy + govt
Benin	Extreme and moderate poor	Community ranking + livelihood tests	Mobile tax + government
Rwanda	Ubudehe Category I	Community socioeconomic classification	Government subsidy

Design Features of SHI: Overview of Pooling Arrangements



- **Half of the countries (10)** establish **multiple fragmented pools**, often organized by population groups (formal, informal, vulnerable).
- **Only 3 countries – Chad, Ethiopia, and Rwanda –** have **legal provisions for cross-subsidization** across pools.
- **10 countries** have a **single national pool**, promoting more efficient risk pooling and redistribution.

Purchasing: Provider payment methods design

- Fee-for-service (FFS) is the **most commonly specified** mechanism, appearing in the laws of 12 countries.
- **Capitation** is included in 10 countries, often **intended for Primary Health Care (PHC).**
- **Diagnosis-Related Groups** (DRGs) are referenced in 8 countries, mostly for **hospital-level care**.
- **Global budget models** appear in 4 countries (e.g., South Africa, Kenya, Djibouti, Mauritania).
- Kenya explicitly articulates a **blended provider payment model**, combining capitation, global budgets, and performance-based elements.

Source:

Who Develops the Benefit Package?

Technical Committees	Kenya, Ghana, Djibouti, Madagascar, South Africa	Often include representatives from health ministries, insurance authorities, and providers.
Oversight Ministries	Benin, Burkina Faso, Togo, Mali	Ministries of Health or Health + Finance; reflect centralized policy control.
Insurance Agency/Board	Ethiopia, Zambia	Developed internally by scheme managers.
Council of Ministers	Mauritania, Congo-Brazzaville	High-level executive decision-making; less technical detail in formulation.
Joint/Mixed Entities	Nigeria, Côte d'Ivoire, Kenya	Involve negotiations between insurers, providers, and technical pricing panels.

Source:

Design Features of SHI: Governance

- Only 4 countries (e.g., South Africa, Benin) have non-political or merit-based CEO appointment mechanisms.
  - In most cases, the CEO is appointed by Presidents or Ministers, introducing political influence.
- Formal grievance mechanisms are defined in law in most countries, including Kenya, Ghana, Ethiopia, Nigeria, and Uganda.
  - Some laws specify complaint channels (e.g., scheme board, courts, managing authority) and timelines for resolution—ranging from 14 days (Uganda) to 3 months (Egypt, South Africa

Source:

Design Features of SHI: Governance

- Countries with Legal Caps on Administrative Costs

Country	Cap on Administrative Costs	Details
Kenya	**5%**	Of total funds (as per SHA Act)
Burundi	**10%**	Of total scheme expenditure
Zambia	**10%**	Of total scheme expenditure
Tanzania (mainland)	**15%**	Of total funds, aligned with CIPRES standards
Uganda	**15%** (3% of investment earnings also capped)	As defined in the NHIF Act
Benin	**10%** for core admin + **5%** for other services	Separated caps defined by function

Source:

Common Implementation Challenges in SHI Laws

Equity gaps due to contributory design

- Most schemes tie access to ability to pay → pro-rich bias.
- Regressive flat contributions persist (e.g., Côte d'Ivoire, Mauritania).
- Means-testing and subsidization often underdeveloped or inconsistently defined.

Fragmentation of risk pools

- 10 countries operate multiple pools without cross-subsidy (e.g., Nigeria, Burundi).

Weak governance & accountability structures

- CEO appointments often politicized.

Source:

Reform Trends in National health insurance Systems in Africa

Legal and operational reforms:

- **South Africa** introduces a single risk pool
- **Kenya:** introduces blended payments
- **Togo & Benin**: Introduced new indigent subsidy programs and performance-based allocations.
- **Rwanda**: Scale-up of cross-subsidization and CBHI integration across districts.

Digital Systems & Efficiency:

- **Claims automation** mandated in Ethiopia, Kenya, Nigeria, Ghana.
- **Biometric or digital ID verification is included in NHI laws in Kenya, South Africa, Benin, Togo, Ethiopia, Nigeria, Djibouti, and Zambia** to support enrollment and fraud prevention.

Source:

How SHI Design Influences UHC Goals

SHI Design Element	Equity	Efficiency	Financial Risk Protection (FRP)
Mandatory Enrollment & Subsidies	Ensures inclusion of poor and informal workers	Reduces adverse selection and fragmentation	Prevents catastrophic OOP by covering all population groups
Pooling Arrangements	Enables cross-subsidization across income & risk groups	Simplifies administration when risk pools are integrated	Stabilizes funding and coverage for high-cost individuals
Benefit Package Design	Prioritizes essential services for underserved groups	Enables cost control when services are costed and prioritized	Prevents OOP for essential health needs
Provider Payment Mechanisms	Avoids under-provision to vulnerable groups (e.g. via capitation)	Curbs overprovision	Reduces incentives for informal charging or overbilling
Governance & Accountability	Builds trust and transparency, encouraging broader coverage	Minimizes waste, leakage, and politicized spending	Ensures funds are used for service delivery not admin overhead

Thank you!

Questions and discussion?

Break

Q&A; Discussion

Prof. John Ataguba

Social Health Insurance in Ghana

Dr. Senanu Kwesi Djokoto
Deputy Chief Executive, Operations
National Health Insurance Authority, Ghana

IHEA 2025 Pre-Congress Session
"The Role of Social Health Insurance in Financing Healthcare in LMICs"
19 July 2025 | Bali, Indonesia

Context

Key national health financing indicators:

- Government allocation to health as a % of government budget: **7%***
- Breakdown of funding sources: **NHIS (21%), OOP (25%), Donors (16%)***

Government structure:

- A Central Government with a democratically elected President and Parliamentarians
- 16 Administrative Regions with Ministers

Implications for NHIS governance:

- A centralized tax system facilitates earmarking and pooling of funds for the scheme
- A Ministry of Health with national scope for health policies and strategies
- Central system of governance mimicked by NHIA with Regional and District presence

**Source: Global Health Expenditure, 2022*

Institutional Design of Ghana's NHIS

- **Lead agency/implementer:**
  - The National Health Insurance Authority (NHIA)

- **Legal Status**:
  - Autonomous body set up by an Act of Parliament (Act 852) to administer the National Health Insurance Scheme (NHIS)

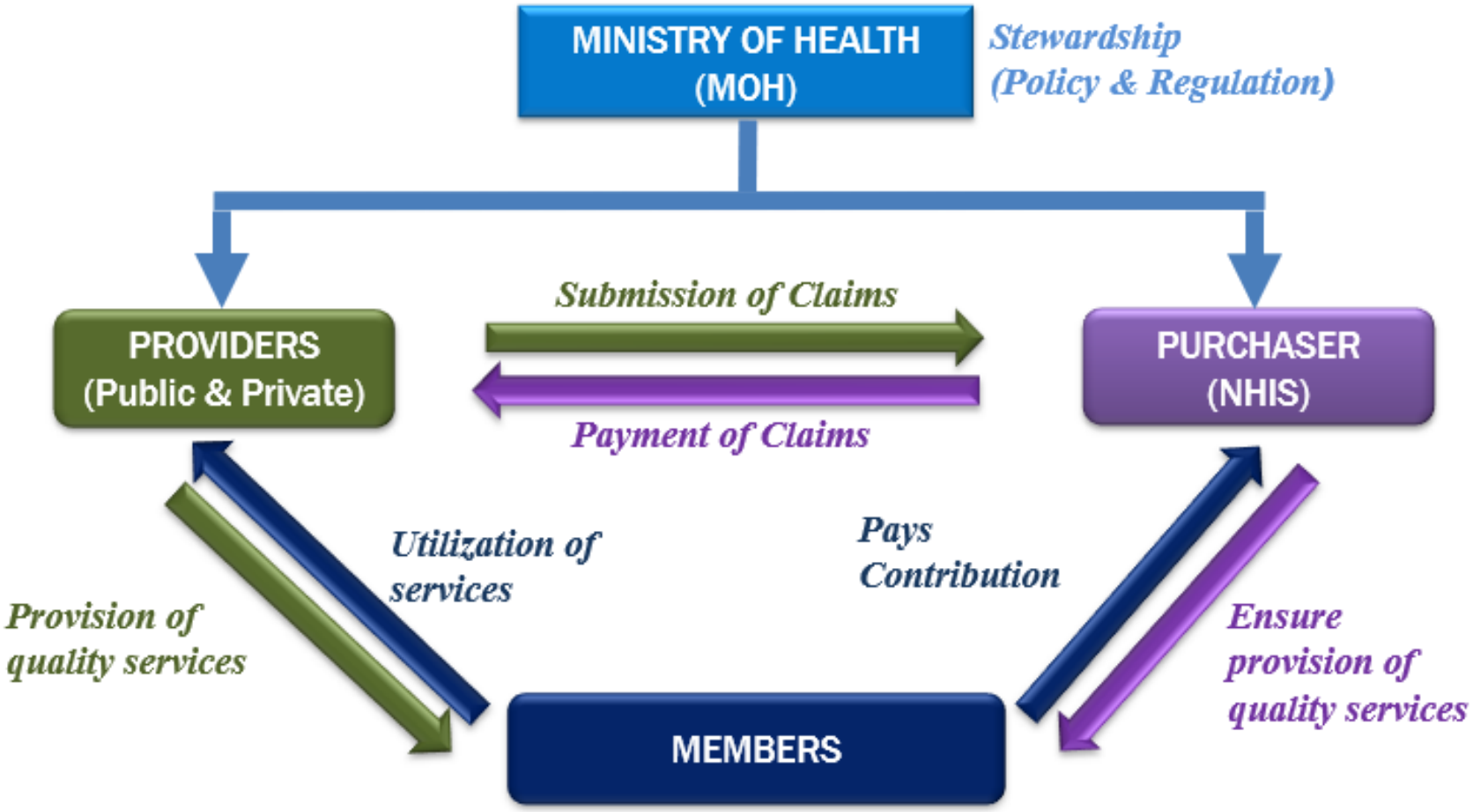
- **Policy and regulatory oversight:**
  - The Ministry of Health (MOH) is the sector lead and provides policy direction
  - The Parliamentary Select Committee on Health provides direct oversight

Institutional Design of Ghana's NHIS

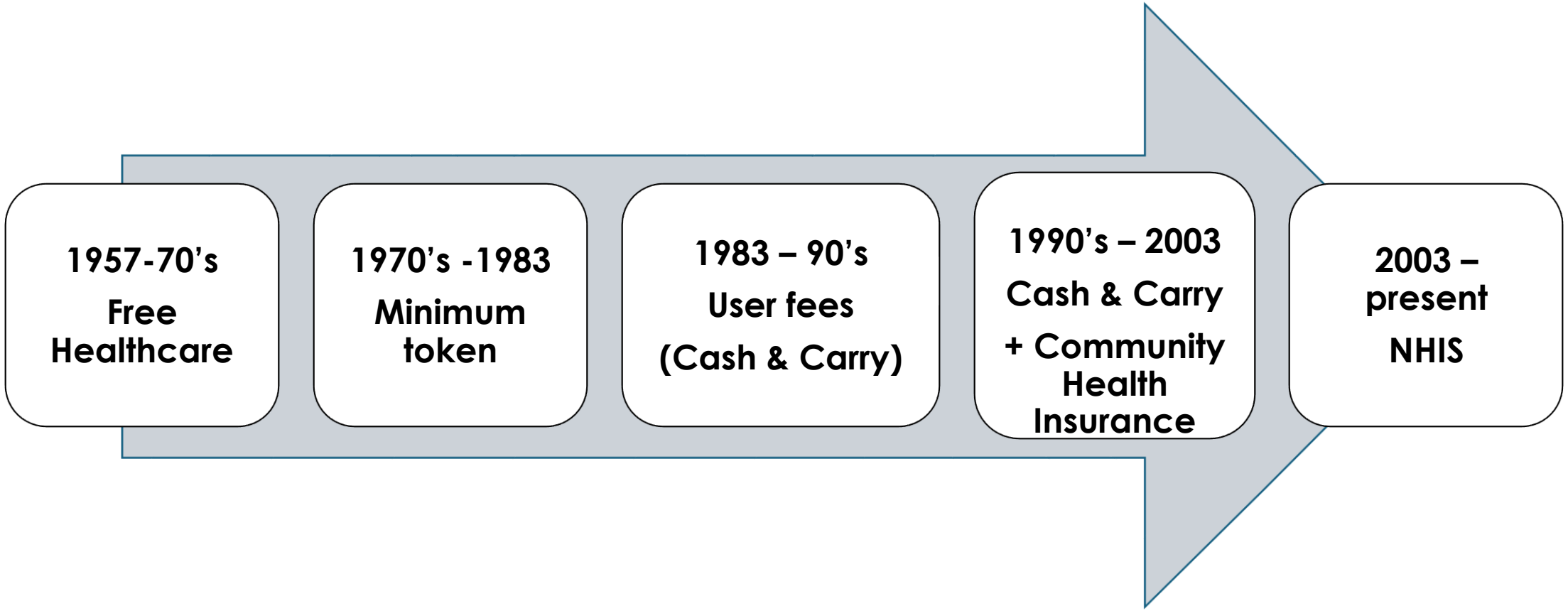
- **Purchaser–provider split:**
  - A clear separation between the purchaser(NHIA) and providers
  - Providers are contracted from the Public (Ghana Health Service), Faith Based (Christian Health Association of Ghana or Ahmadiyah Health Services) and Private Sectors.

- **Coordination mechanisms:**
  - Health service provision is managed at the national level and coordinated through the Health Directorates in Regions and Districts
  - NHIS is managed centrally with Regional and District offices for oversight and monitoring
  - Private Health Insurance schemes exist and are regulated by NHIS

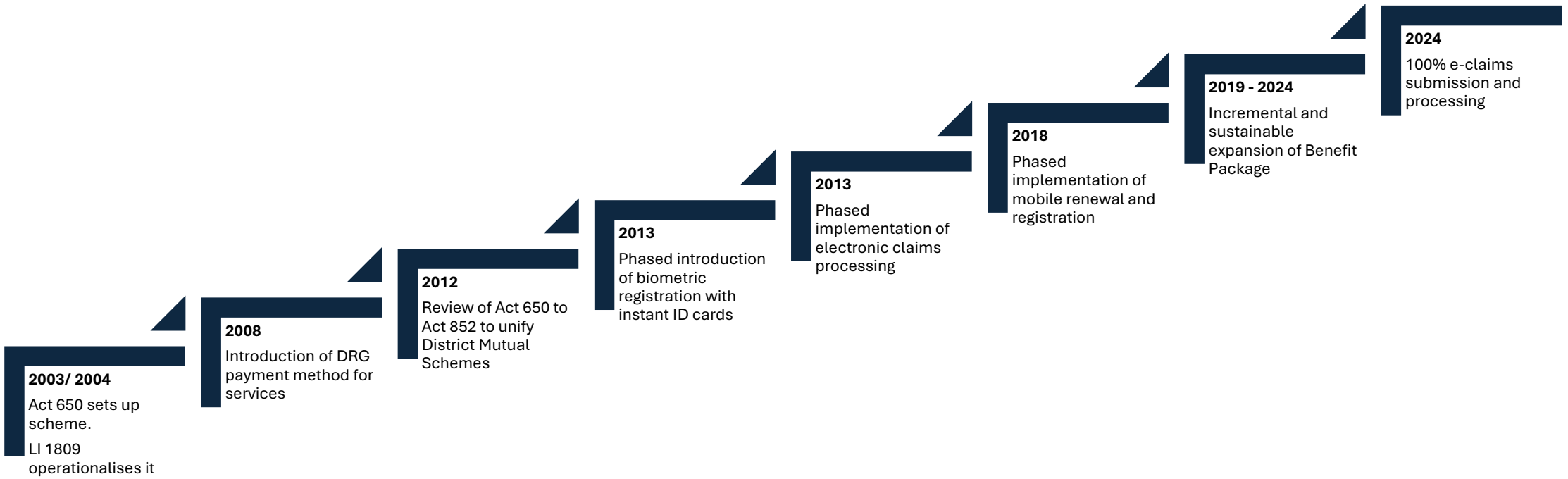
Institutional Design of Ghana's NHIS



Evolution Of Health Financing Reforms In Ghana



Evolution of NHIA Operations



Source: NHIA Annual Reports

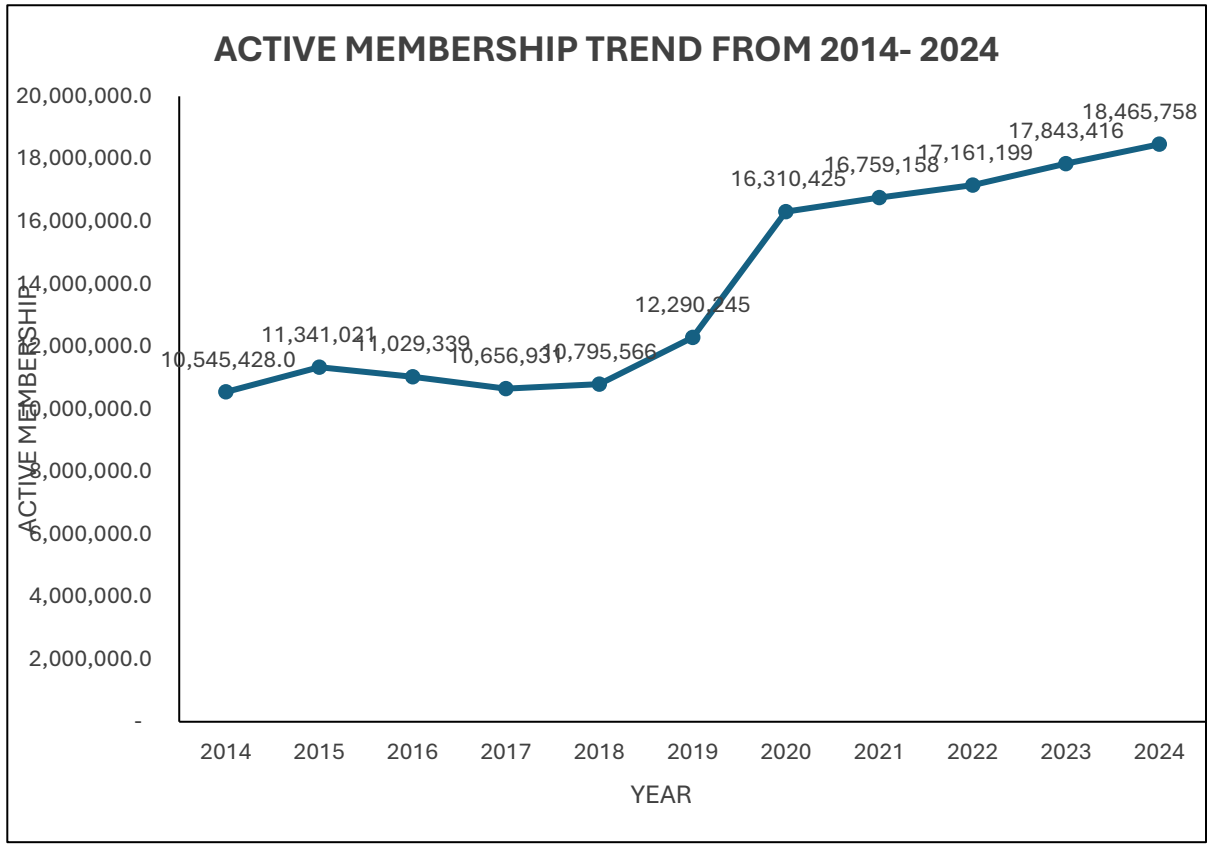
Design Features of Ghana's NHIS: Member enrollment

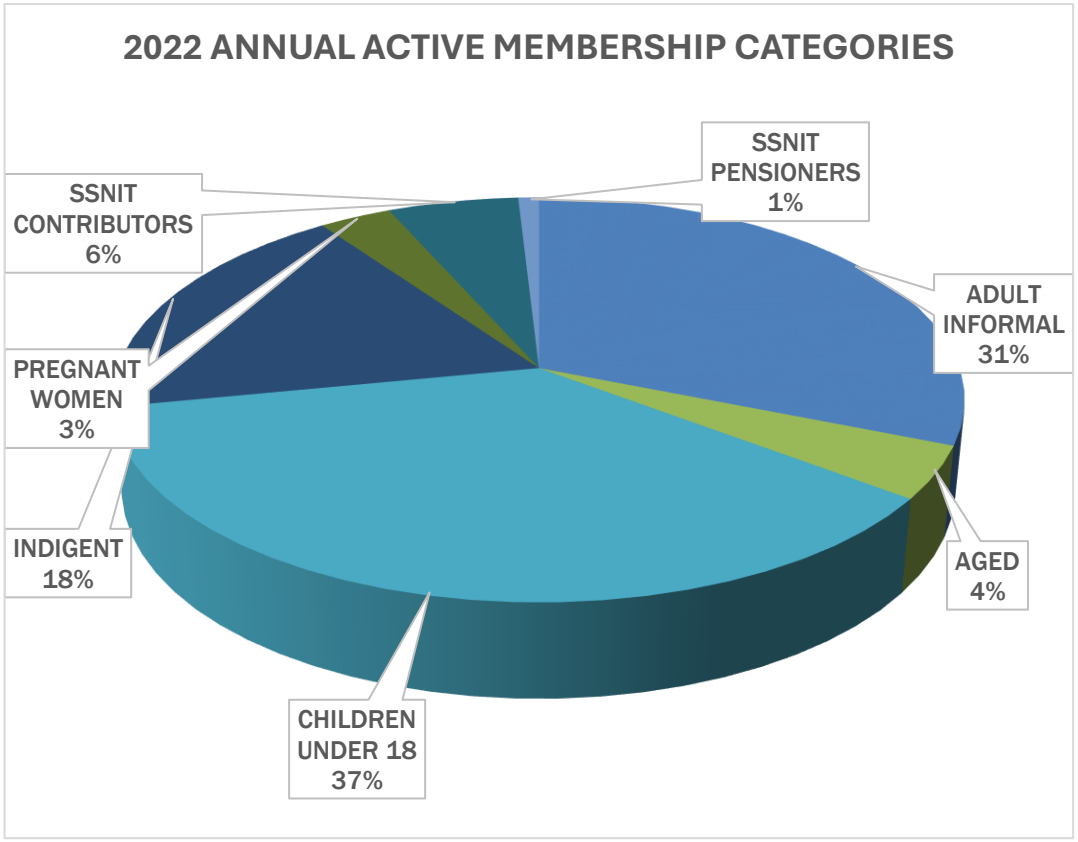
- **Enrollment eligibility:**
  - All Ghanaians and foreigners resident in Ghana

- **Membership regulations:**
  - Mandatory by law (Act 852) but requires self registration and renewal
  - Mandate not enforced even though there are sanctions for defaulting to enroll

- **Enrollment strategies for poor and informal sector:**
  - Low premium (average of GHS 22 or USD 2.12) plus registration fees
  - Community outreach and sensitisation led by decentralized offices
  - Collaboration with Ministries and Agencies – Ministry of Gender, GES, LEAP, UNICEF
  - Premium exemption for vulnerable and indigent population groups certified by LEAP and Social Welfare
  - Premium and waiting period waivers- Aged Policy, Free Maternal Policy, 90-day Policy for new borns
  - NHIS membership as a pre-requisite for school admission
  - Group renewals
  - Instant ID cards issuance

Design Features of Ghana's NHIS: Member enrollment





2024 Annual Active Members – 18,465,758 (56%)

Premium Exempt Members – 69%

Source: NHIA Membership Portal

Design Features of Ghana's NHIS: Revenue mobilization

- **Sources of funding:**
  - Percentages of Value Added Tax and Social Security Contributions
  - Others- Premiums, Road Fund, Investment Income, Donors, Internally Generated Funds

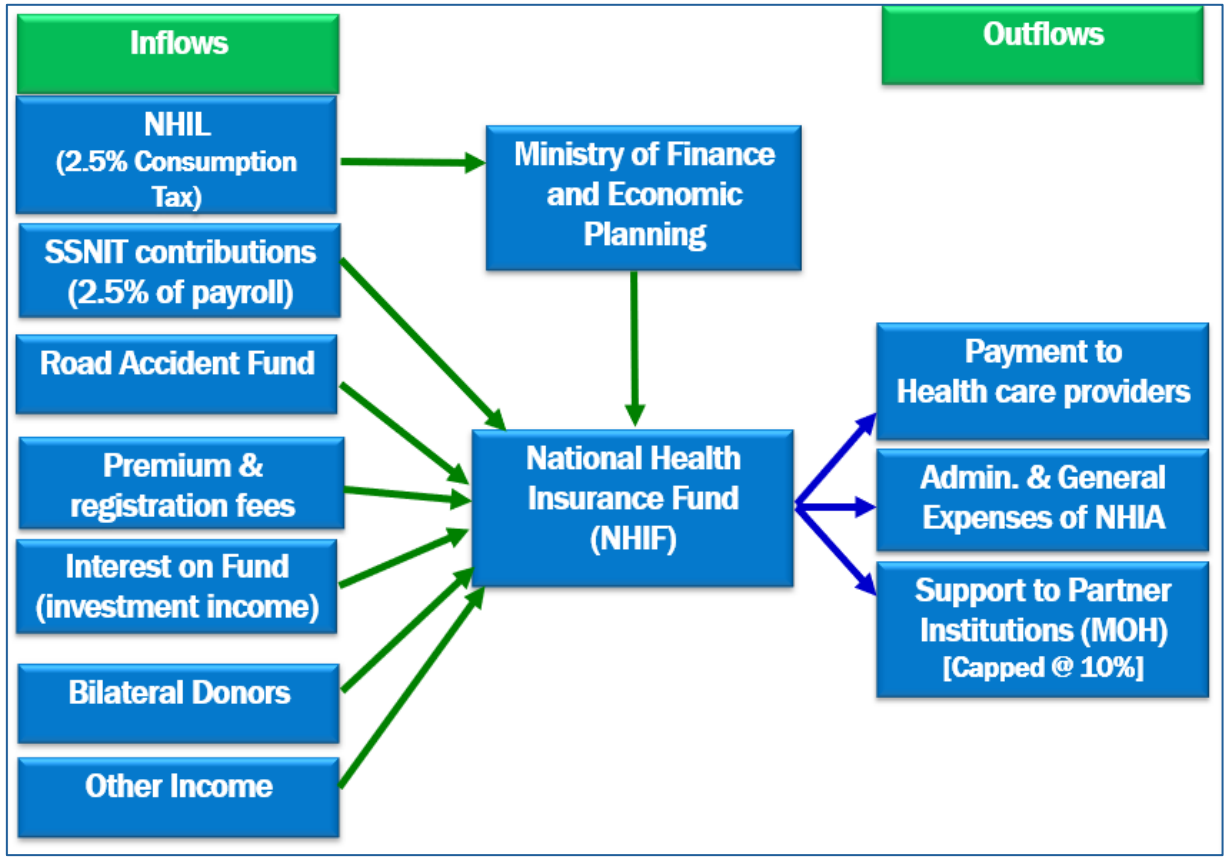
- **Contribution mechanisms:**
  - Earmarked tax and social security contributions deposited in Consolidated Fund
  - Premiums and others collected by NHIA and deposited in NHIF

- **Contribution mechanisms:**
  - VAT component dependent on purchases
  - Social security contribution dependent on income
  - Premiums dependent on locality and category

Source: NHIS Act 852, 2012

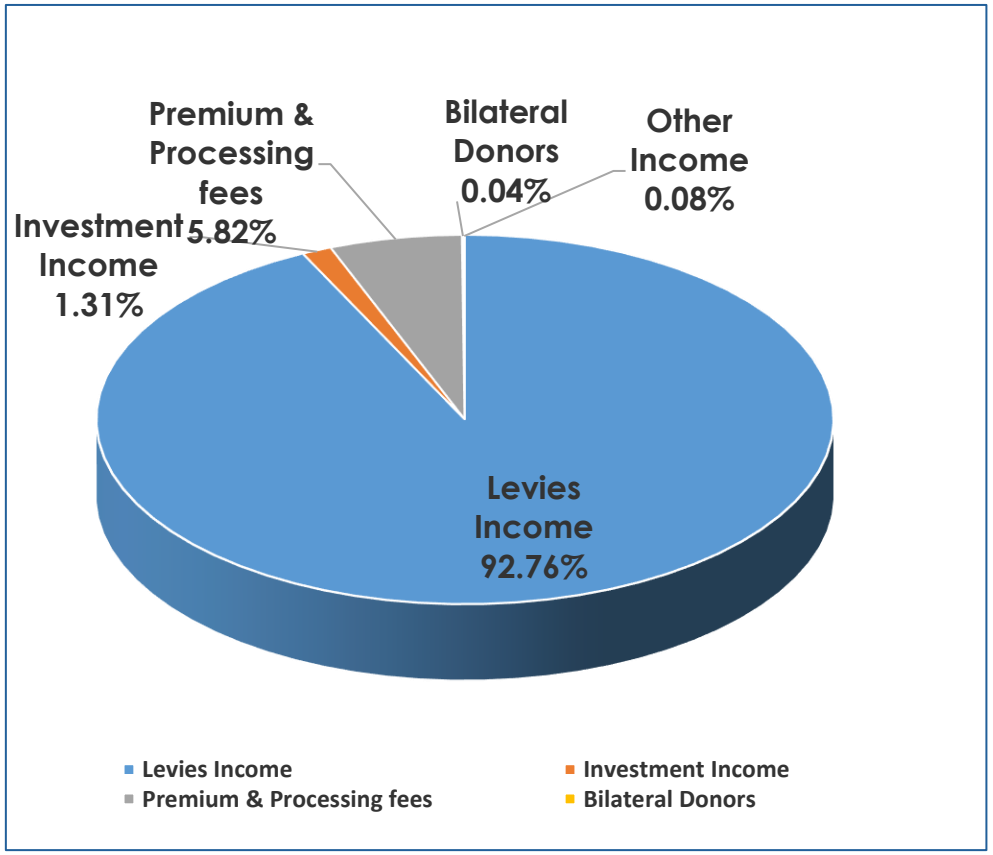
Design Features of Ghana's NHIS: Revenue mobilization

Funding Sources And Outflows



Source: NHIS Act 852, 2012

Sources Of Revenue



Design Features of SHI: Pooling

- **Pooling:**
  - One pool of funds (National Health Insurance Fund)
  - Funds intended for all members with a universal Benefit Package (no differentiation of service packages)

Design Features of Ghana's NHIS: Purchasing

- **Benefit Package:**
  - Implicit package of services with explicit exclusion list
  - Incremental inclusions based on actuarial determination of budget impact and sustainability

- **Facility Contracting:**
  - Public, Faith-based and Private facilities
  - Primary, Secondary and Tertiary levels of care
  - Credentialing and contracts are required before service provision is reimbursed
  - About 5000 plus credentialled facilities with active or provisional credentials nationwide

- **Provider payment mechanisms:**
  - Ghana Diagnostic Related Grouping (G-DRG) for services
  - Fee-for-services for medicines

- **Contracting, performance-based features, or quality incentives**
  - Automatic renewal of credentials for well performing facilities

Financial performance

- **Benefit payout ratio:**
  - 57% of revenue paid for direct claims reimbursement in 2024
  - 37% of this for inpatient services and 60% for outpatient

- **Medical loss ratio:**
  - An average of 51% of expenditure is on claims reimbursement over past 10 years
  - Additional 10% statutory allocation to MOH for essential medicines and health projects
  - Aiming at 75% expenditure for claims reimbursement by 2026

- **Surplus/Losses:**
  - 2024 revenue- GHS 7,431 million (average annual growth rate of 23%)
  - 2024 claims expenditure- GHS 2,358.53
  - Scheme operates with consistent surplus which has increased in recent years

Source: NHIA/ World Bank 2025 Efficiency Analysis

Persistent or Emerging Challenges

Bottlenecks along financing channels- recently resolved with uncapping of NHIF and commitment to regular inflows by government.

Identification and certification of poor and vulnerable populations

Network connectivity challenges for registration and service provision authentication

Demands for illegal top-up payments from members

Withdrawal of donor support causing increased expectation of NHIS coverage for programmes

Recent or Planned Reform

Digital registration and renewals to address queues and drive membership

Call centre for complaints and enquiries

Nationwide task force to stamp-out illegal copayments

Digital systems for claims management

Expansion of benefit package to improve financial risk protection

Review of payment methods underway to align with health care delivery reforms- Free Primary HealthCare & Ghana Medical Trust Fund

Lessons and Reflections

- **Key success factors or enablers:**
  - An Act of Parliament that backs operations
  - Contracting of providers nationwide for access
  - Enforcement of quality assurance and strategic purchasing arrangements
  - Biometric registration to provide data for decision making
  - Effective monitoring and supervision
  - Sanctions policy in place

- **What didn't work, and why:**
  - Provider payment reforms- inadequate engagement and sensitization
  - Biometric authentication at provider site- network down times and provider reluctance

- **What other countries could adapt:**
  - Earmarked funds for scheme
  - Implement a defined benefit package and analyse for budget impact before expansion
  - Invest in digitalization of operations to provide the needed data for decision making

Source:

Thank you!

Questions and discussion?

Social health insurance in Nigeria

IHEA 2025 Pre-Congress Session

Presentation by Dr. Kelechi Ohiri – DG/CEO, NHIA Nigeria

July 2025

Outline

Overview and context

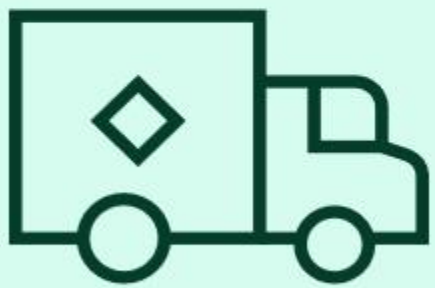
Operating model

Challenges and reforms

Lessons learned and looking forward

Nigeria experiences increasing burden on its healthcare system with low public sector spend and limited SHI coverage

Increased demand for healthcare services addressing RMNCAH, Infectious as well as NCDs, cancers and renal failure



Despite recent increases, there's low government allocation to health **(5-6% of total budget)**

High out of pocket expenditure (>75% of total healthcare expenditure)

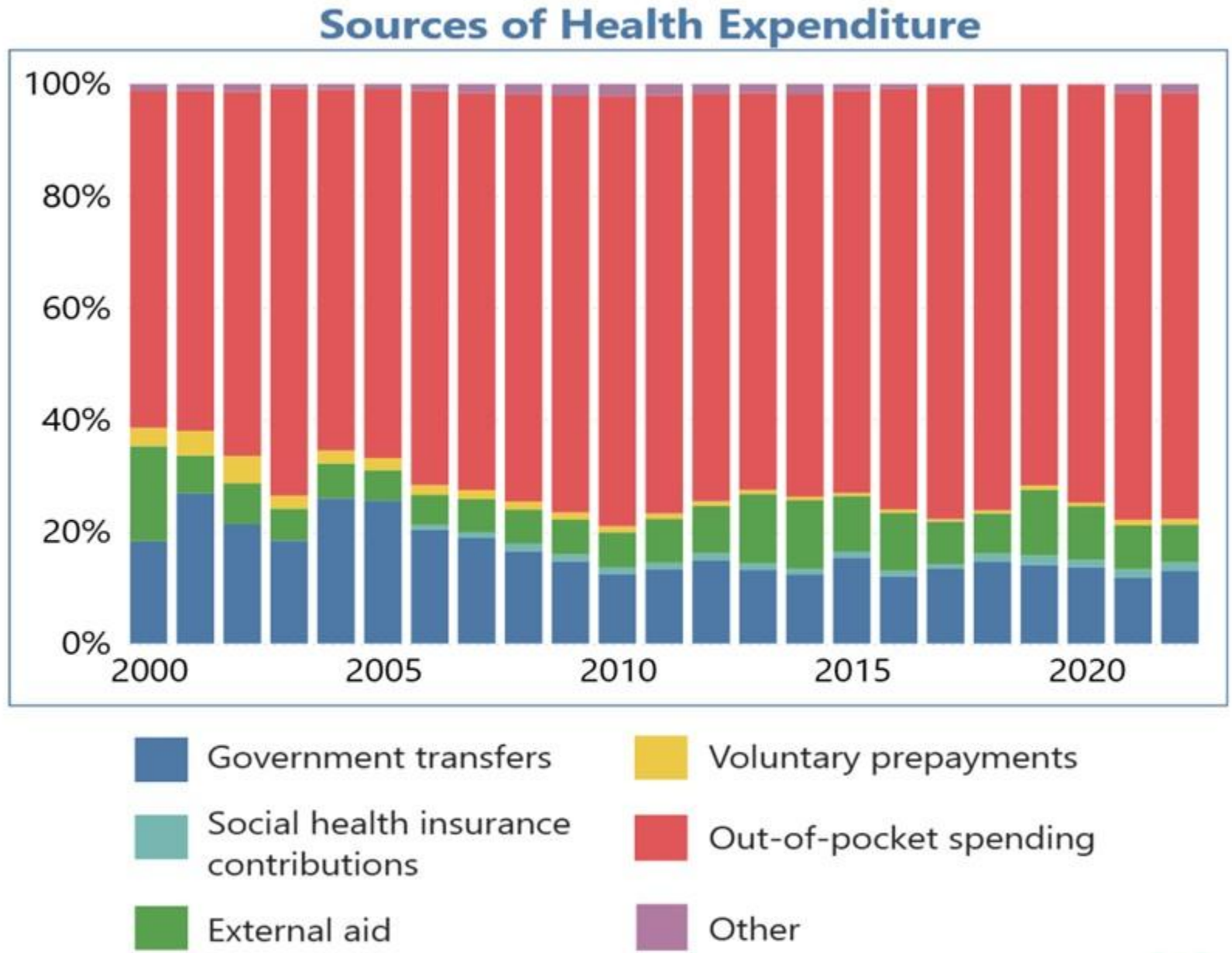
Govt expenditure accounts for ~13% of total healthcare expenditure

Low contribution of social health insurance (subsidized healthcare cost) to total healthcare expenditure (~2% of total)

Low coverage of health insurance (10% of Nigerians covered)

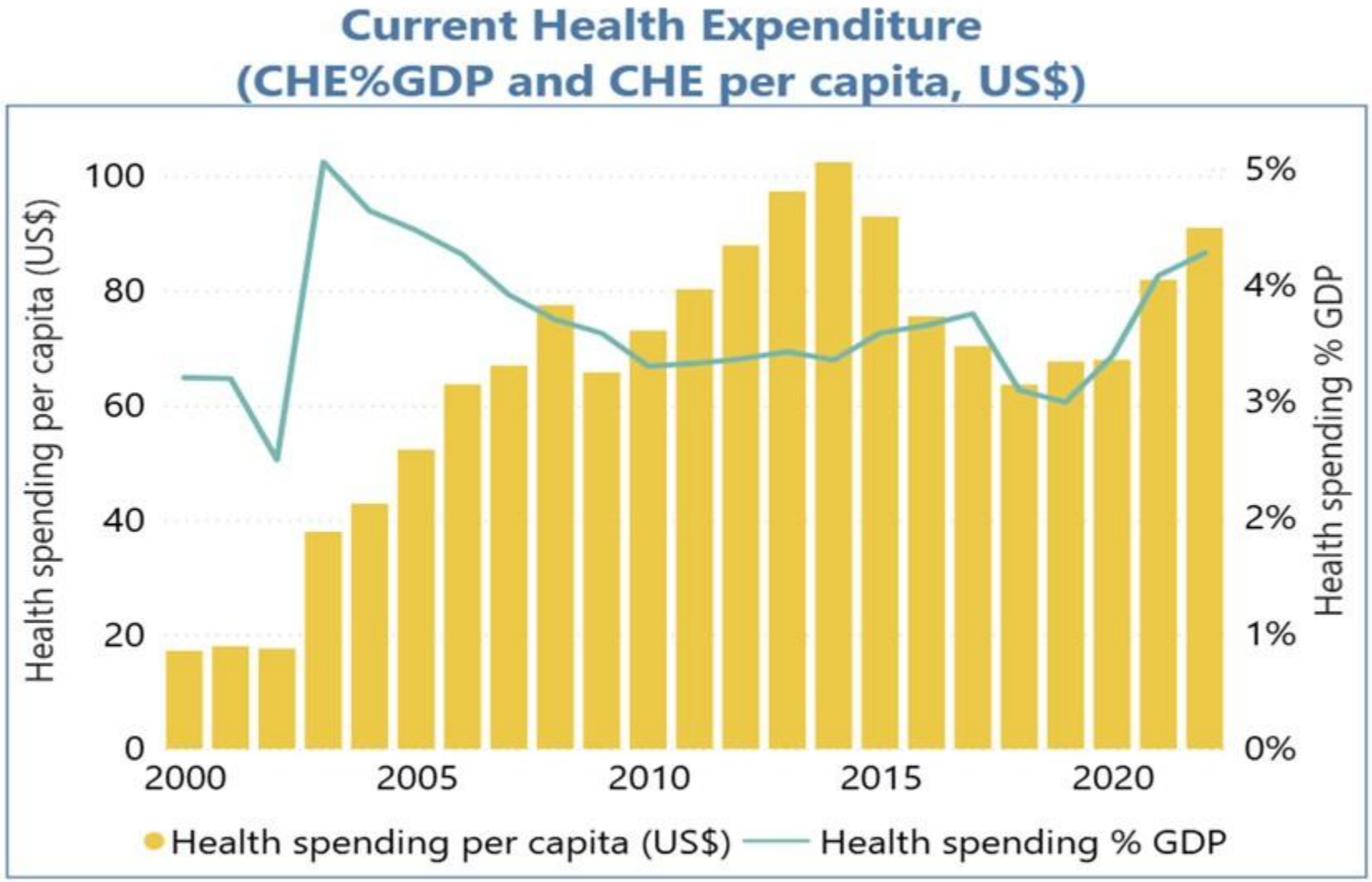
Source: WHO global health expenditure database, UNICEF, AVCA

Despite rising SHI contributions, out-of-pocket payments remain the dominant source of health expenditure



Source: WHO global health expenditure database, UNICEF, AVCA

Health spending per capita and as a percentage of GDP continue to grow in recent years



Source: WHO global health expenditure database, UNICEF, AVCA

Since the 1999 law establishing the National Health Insurance Scheme, social health insurance in Nigeria has undergone significant evolution

1999

A law for the **establishment of the National Health Insurance Scheme (NHIS)** was enacted

2005

Oficial lau**nch of the NHIS on 6th June 2005**

Commencement of the Formal Sector programme for public sector employees at the federal level

2007

NHIS piloted the Community Based Social Health Insurance Programme (CBSHIP), opening a new market segment for HMOs

2014

Establishment of BHCPF in the National Health Act of 2014 **– to provide funding for the inclusion of vulnerable groups**

2020

Launch of GIFSHIP programme to include informal sector, families and groups

2022

N**HIA Act 2022 was signed to law** to making **health insurance mandatory**

Establishment of State health insurance schemes to deepen coverage at the subnational level

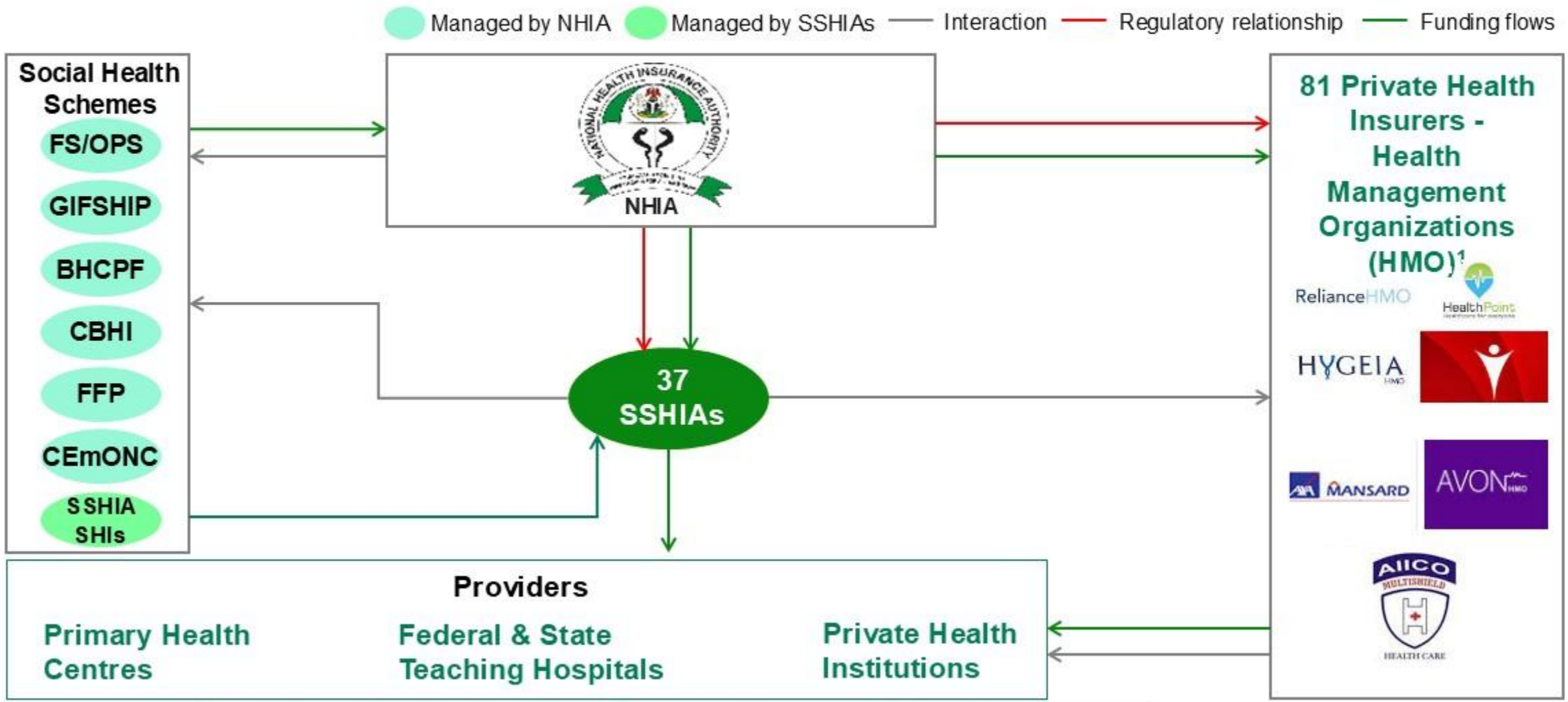
Establishment of Vulnerable Group Fund

2024

Commencement of maternal health initiatives[1] – Financial access to CEmONC[2] and FFP[2]

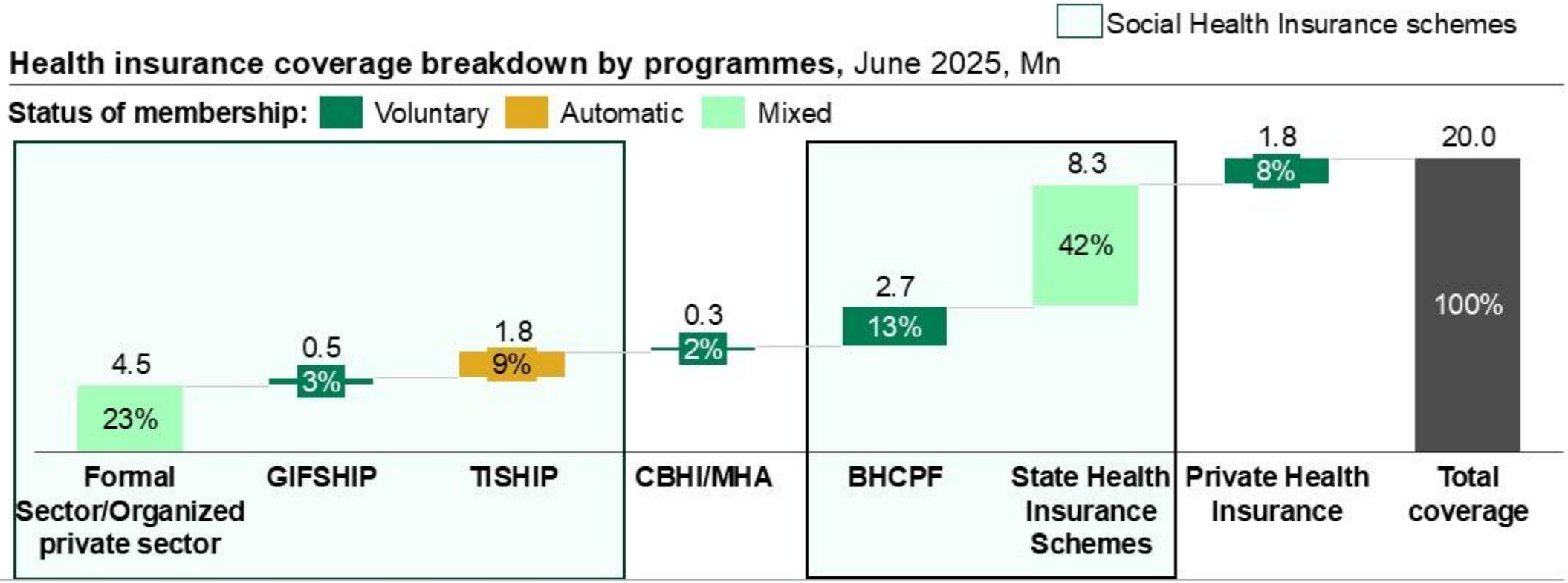
1. Payment for emergency conditions and subsequent enrolment in social health insurance
2. CEmONC: Comprehensive Emergency Obstetric and Neonatal Care; FFP: Fistula Free Programme

Social health insurance schemes are managed by public institutions both at the national and sub-national levels



1. Some HMOs have a dual role of third-party adminsitrators for specific interventions e.g., CEmONC and FFP

Nigeria's health insurance coverage is about 20 million, with social health insurance schemes accounting for ~90% of total coverage



Eligible population group	Formal sector: All Federal public sector employees Organized private sector: Private sector employees	Individuals employed (formally or informally) or unemployed	Tertiary institution students	Community Based Health Insurance Scheme	Vulnerable individuals	Residents of state (whether workers, employed or unemployed)	Private individuals Private sector employees

Outline

Overview and context

Operating model

Challenges and reforms

Lessons learned and looking forward

The operating model of SHI schemes is anchored on three elements

1

Revenue mobilization and pooling

Sources of funding for the social health insurance schemes, **contribution and pooling mechanism**

2

Purchasing

Benefit package design approach, approach to empanelment of facilities and payment mechanisms

3

Financial performance

Benefit and administrative payout ratio of NHIA social health insurance schemes and PHI schemes

1. Funding sources vary across schemes, contribution rates are determined by the benefit package, and risk pools remain fragmented at the subnational level

Programmes	Formal sector	OPS	GIFSHIP	TISHIP	BHCPF	SSHIs
Source of funding	• Federal Government	• Co-payment by beneficiaries and employer	• Beneficiaries	• Student's parents through the tertiary institutions	• Federal Government	• State Government • Beneficiaries
Pooling	**National level pooling**: NHIA pools the funds of Formal Sector, OPS and GIFSHIP				State-level pooling for target beneficiaries National level reserve pool to manage risk	
Revenue beneficiary	NHIA				• N/A	State SHIs
Contribution rates (USD terms)	• 5% equivalent of of employee income	• 10% of income – Employer • 5% of income- Employee	• ~USD14 average	• Variable based on students' tuition	• At least 1% of Consolidated Revenue of the Federation	• ~USD 10.4 average

2. NHIA adopts an evidence-based, structured approach to designing SHI benefit packages and contracting healthcare facilities

Benefit package development

- NHIA adopts a structured and evidence-based approach (backed by actuarial analysis) in the development of the benefit packages.
- **Technical considerations**
  - Assessment of Disease Burden
  - Service Availability Assessment
  - Financial Sustainability Analysis
  - Stakeholder Consultation
- **Equity and political economy considerations**
  - Government sectoral priorities
  - Civil society and stakeholder pressures

Healthcare facilities eligibility and contracting

- **Public and private healthcare facilities** (spanning all levels of care) are eligible for contracting
- **Contracting process** includes:
  - Verification of facilities accreditation status
  - Empanelment of these facilities under the specific SHI scheme
  - Execution of service contracts by HMOs (on behalf of NHIA) with these facilities

Payment provider mechanisms

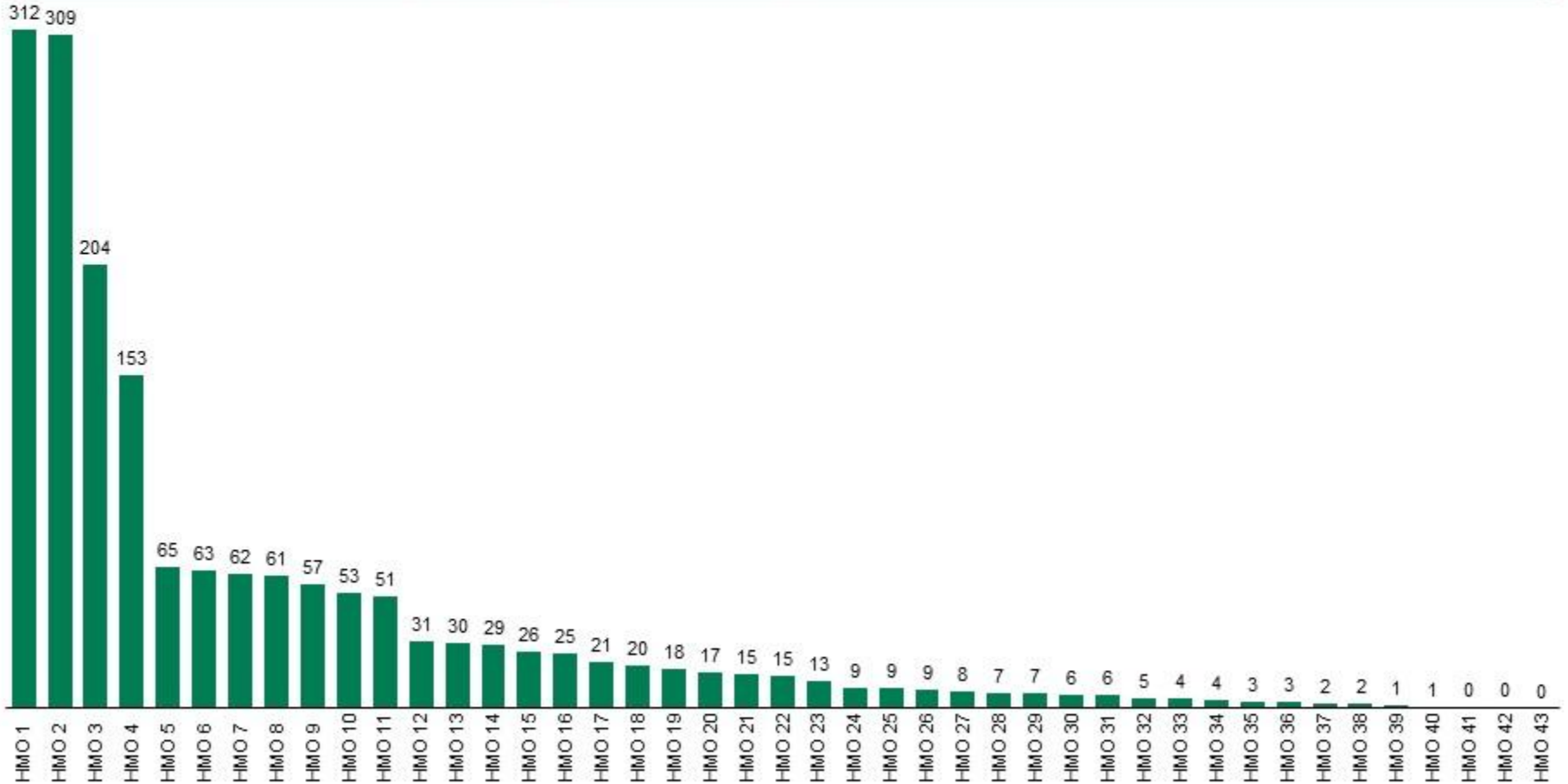
- **Capitation:** For primary healthcare services.
- **Fee-for-Service (FFS):** For selected outpatient and inpatient services. (e.g., Secondary care, Tertiary care and other referral services).
- **Bundled payments** for specific interventions (FFP) currently being explored

3. Sustainability and profitability metrics are used to assess the financial health of Nigeria's health insurance industry

Category	Metric	Formulae	Criteria: Not healthy	Criteria: Healthy
Sustainability	1 **Capital Adequacy Ratio**	(Admissible assets – Admissible liabilities) / Higher of capital available or 15% of gross written premium	<=1.5	>1.5
Profitability	2 **Loss Ratio**	**SHI:** (Capitation + Fee for service) / total contribution	<70% or >90%	70% - 90%
		Private: Medical claims expense / gross earned premium	<70% or >90%	70% - 90%
	3 **Expense Ratio**	**SHI:** (Tech + admin + overheads + provisions for reserves and reinsurance) / total contribution	>30%	<=30%
		Private: (Operating expense + reinsurance expense – depreciation and amortization) / gross earned premium	>35%	<=35%
	4 **Combined Ratio**	(Medical claims expense + Operating expense) / gross earned premium	<80% or >105%	80% - 105%

3. The PHI industry is concentrated with 5 HMOs accounting for 60% of total private plan enrolees

Total private plan enrollees by HMOs as at 2023, #'thousands



Key Takeaway

There is a potential to cover **up to an additional 5 million private** enrollees if all HMOs covered **a minimum of 50,000 lives**

Source: NHIA

3. Overall, PHI industry's performance indicates variable financial health and risk levels

Assessment of 54 HMOs based on submission compliance

Source: HMO Audited Financial Statements 2023

Key Takeaways

52% of HMOs have capital adequacy ratio less than 150%, indicating potential risk in sustaining financial viability

50% of HMOs have loss ratios below global health insurance industry benchmarks of less than 70%, indicating a market where players could be characterized by as either:

1. Players have low-risk pools – suggestive of adverse selection
2. Limited quality and cost of care that enrollees can access; hence low claims

Outline

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Lessons learned and looking forward

Despite significant progress over the years, SHI in Nigeria continues to face operational and structural challenges

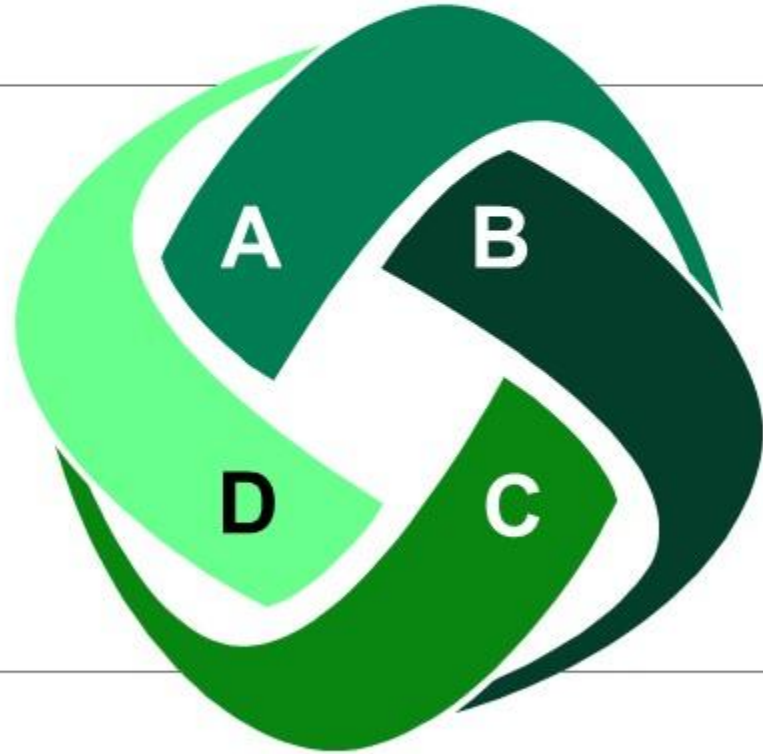
Deep dives next

Low total coverage

- **Low health insurance penetration (9% as at June 2025)**

Uneven distribution of coverage

- **Significant gap in coverage of vulnerable groups**
- **High focus on formal sector population only** (62% formal sector covered vs only 1% of informal sector population covered as at 2023)



Under-developed market

- **Fragmented risk pools** and weak risk management practices
- **Variable competency levels** within public SHI schemes

Sub-optimal quality

- **No uniform defined minimum benefit package of health services across social health insurance schemes** that serves as entry point into health insurance for all

To address these gaps, NHIA as the promoter of health insurance in Nigeria developed a strategy anchored on four key pillars

Goal

Bring millions of Nigerians out of health poverty

1 Coverage

- **Enforce health insurance mandate**
- **Increase awareness** of health insurance
- Rebuild citizens' **trust** through enforcement

2 Equity

- Strengthen **operationalization of equity programs BHCPF and VGF**
- **Integrate** health insurance as **part of broader social safety net**

3 Quality

- **Strengthen use of evidence to inform design**
- **Incentivize focus on primary care** and prevention
- **Reform** quality, empanelment and accreditation

4 Sustainability

- **Ensure sustainability and viability** of health insurance ecosystem
- **Strengthen capacity, viability** of public and Private Schemes
- **Ensure capital adequacy and effective risk pools**

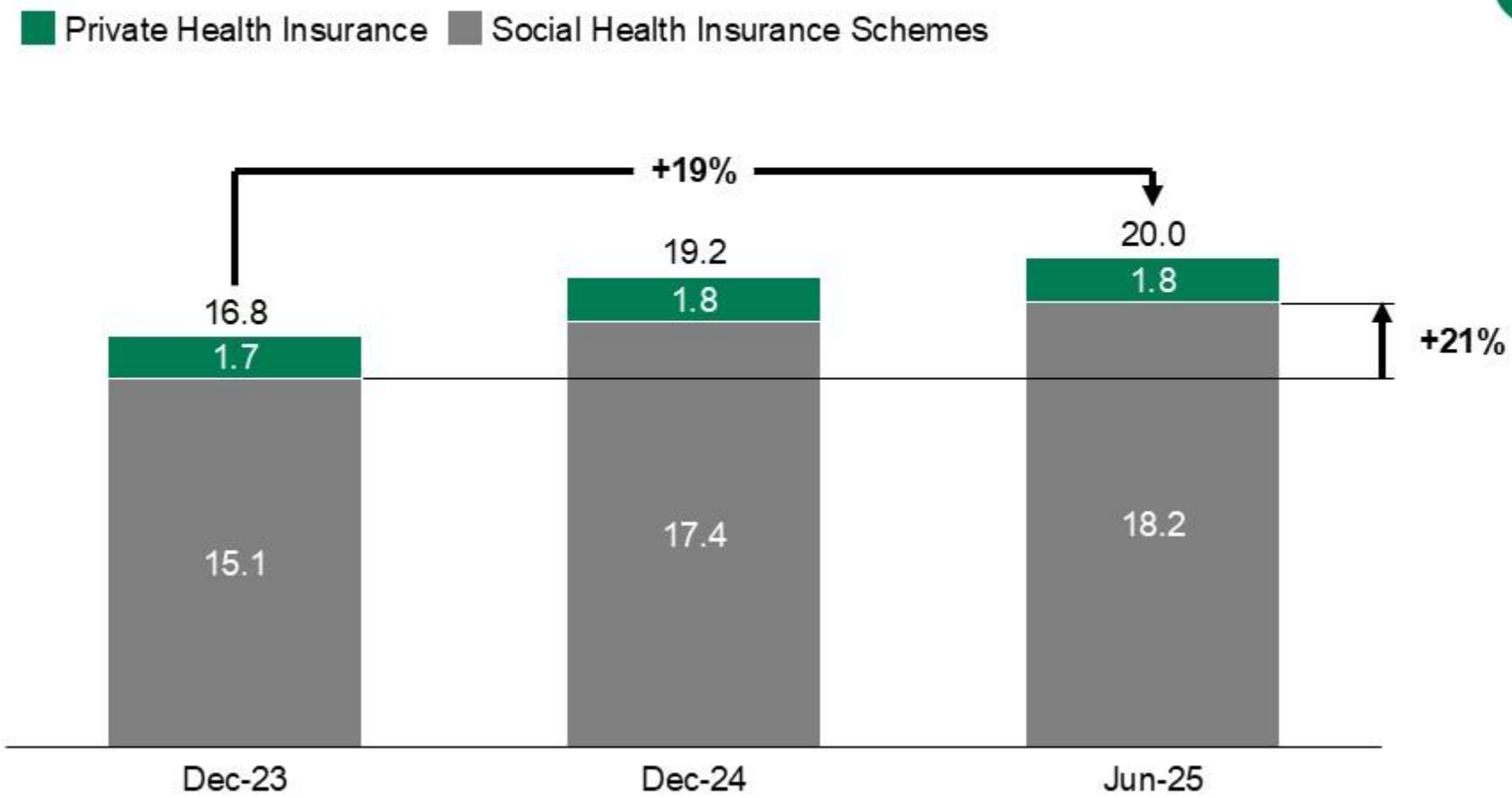
5 **Drive citizen-centered engagement**

6 **Use data and technology to improve care quality and availability**

7 **Optimize organisational health and structure**

1. Coverage: Nigeria's health insurance coverage has grown by 19%, with SHI schemes driving majority of this growth

Health Insurance coverage breakdown by schemes, Dec 2023 – H1 2025



Key Insights

Total health insurance coverage grew by **19% between Dec 2023 and Jun 2025**

Majority of this growth was driven by social health insurance schemes, which experienced **21% growth between Dec 2023 and Jun 2025**

Source: NHIA

2. Equity: Since 2024, an additional 800,000 lives have been enrolled into BHCPF scheme with programmatic and operational updates made to the guidelines

Enrolled additional ~800k citizens into the BHCPF program bringing the **total enrolment to ~2.67 million**

Kicked off review of BHCPF guidelines including the development of the BMPHS

Worked with various stakeholders to increase funding **for the BHCPF**, **vulnerable populations** and **individuals facing catastrophic expenditure** from chronic conditions

2. Equity: Two maternal health initiatives launched in 2024 have reached over 7,000 women within 12 months, further expanding SHI coverage

Goal: Reduce maternal mortality of poor and vulnerable women at risk of mortality due to obstetric and fistula complications and ensure sustainable access to care by enrolling them into health insurance

Fistula Free Programme

17 Secondary and tertiary hospitals (Fistula centers) actively participating in the project

2,690 Women treated between June 2024 and June 2025

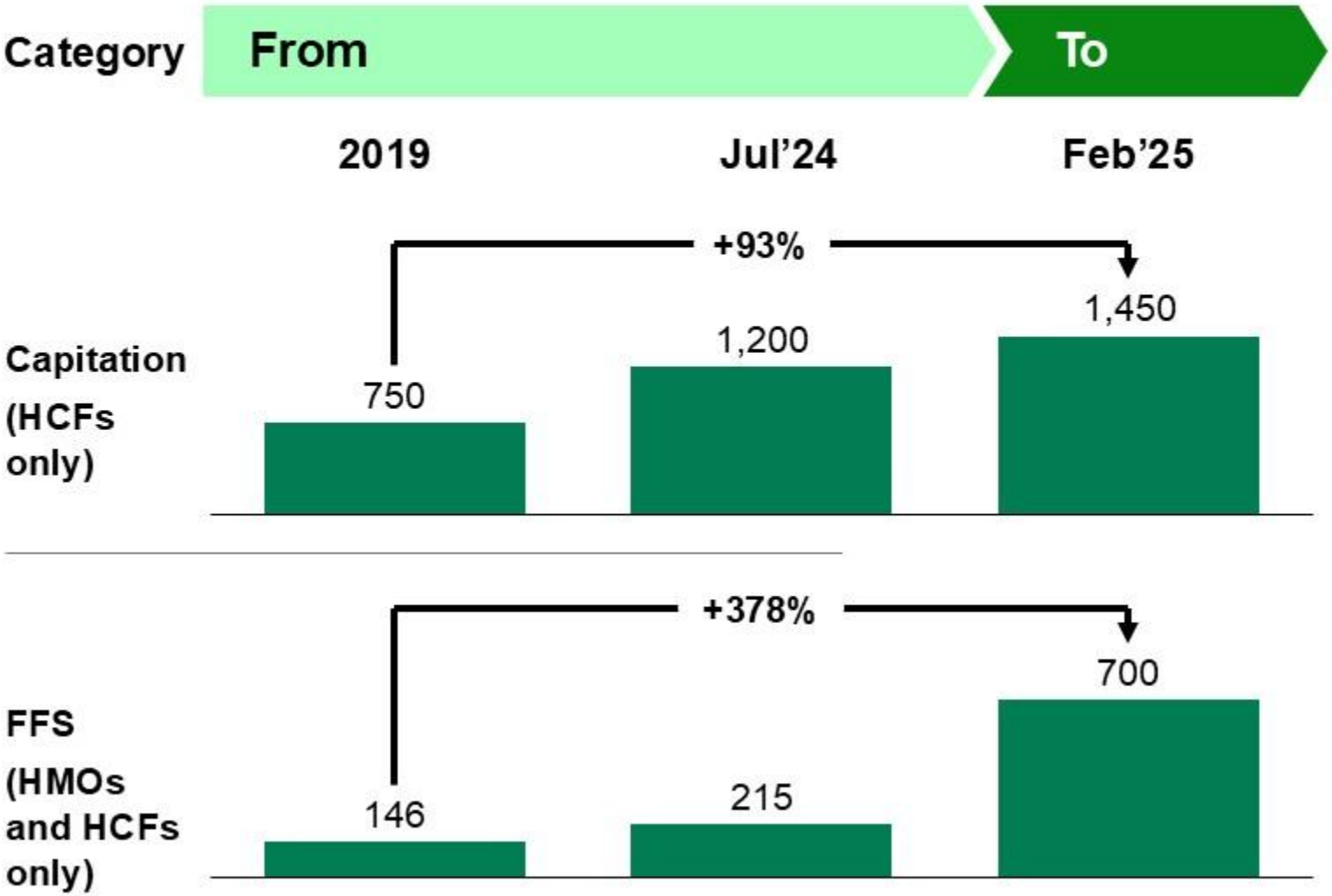
CEmOC programme

200+ Referral centers (Secondary and Tertiary hospitals) participating

>5,000 Women accessed services between September 2024 and June 2025

Source: NHIA Fistula Free Programme Team, NHIA CEmOC programme team

3. Quality: Tariffs were revised based on actuarial evidence to incentivize quality of care – capitation by 90% and fee-for-service by 380%



Rationale for change

To upgrade the previous rate, last reviewed a decade ago based on actuarial analysis of the benefit package.
To ensure fair compensation that incentivizes good quality care in line with operational guidelines

Source: NHIA

4. Sustainability: Key reforms have been launched to strengthen SHI schemes and accelerate progress toward UHC

- **Introduced basic minimum package of health services (BMPHS)** to reduce fragmentation across plans
- **All states** now have an **operational** state health insurance scheme backed by law
- **Launched initiatives to strengthen the capacity of SSHIAs** at state level
- **Introduced and enforced guidelines** for improving quality of care

Source: NHIA

4. Sustainability: Collaboration with stakeholders has enabled the introduction of additional equity interventions following recent DAH transitions

Family planning commodities

HIV

Tuberculosis

- Pilots with the Global Fund underway to insure people living with HIV/AIDS and TB
- The benefit package is being reviewed to integrate critical treatments and services

Outline

Overview and context

Operating model

Challenges and reforms

Lessons learned and looking forward

Our journey so far has highlighted four key lessons

1. **Beneficiary-centered design drives innovation and reinforces the value of health insurance** in the minds of Nigerians, helping to drive coverage

2. **Investing in evidence generation and translation is critical** for informing policies and strengthening regulatory oversight in the health insurance ecosystem

3. **Targeted programs for vulnerable groups should include holistic support beyond primary care** that addresses related social issues to through other social protection and inclusion mechanisms to ensure sustainable outcomes

4. **Benefit package designs should target the integration of contributory and non-contributory SHI schemes**

Source: NHIA Maternal Intervention Team

Looking ahead, our medium-term reforms will include the following to advance health insurance in Nigeria

Priority areas	Key priorities
1  **Resource mobilization**	• **Explore innovative financing mechanisms** to expand health insurance coverage for the poor and vulnerable and to ensure sustainability of SHI schemes
2  **Risk pooling and integration**	• **Invest in technology and data systems** to integrate multiple schemes into a unified national risk pool • **Deploy interoperable solutions** to enable portability of coverage across different administrators • **Centralize and strengthen reserves** to improve risk management and cross-subsidization
3  **Provider payment models**	• **Transition from line-item fee-for-service to bundled payments** aligned with ICD-11 codes • **Link provider incentives to measurable improvements in quality of care** and health outcomes
4  **Citizen Engagement**	• **Work with civil society, law makers, and other stakeholders at the subnational levels** to engage citizens and keep them at the center of our reforms

THANK YOU

Social Health Insurance in Zambia

Michael Njapau

Director General

National Health Insurance Management Authority

IHEA 2025 Pre-Congress Session
"The Role of Social Health Insurance in Financing Healthcare in LMICs"
19 July 2025 | Bali, Indonesia

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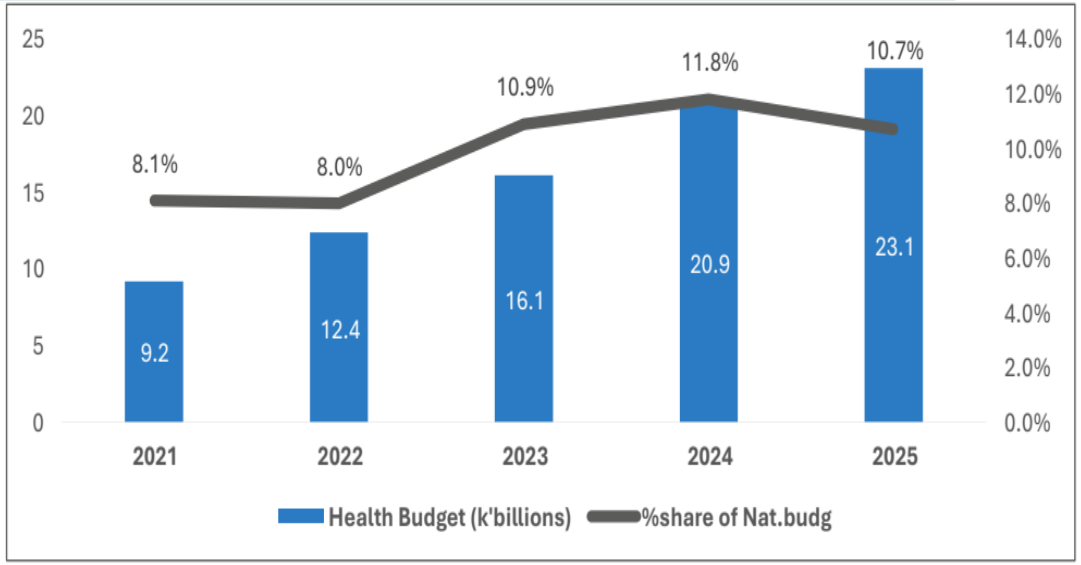
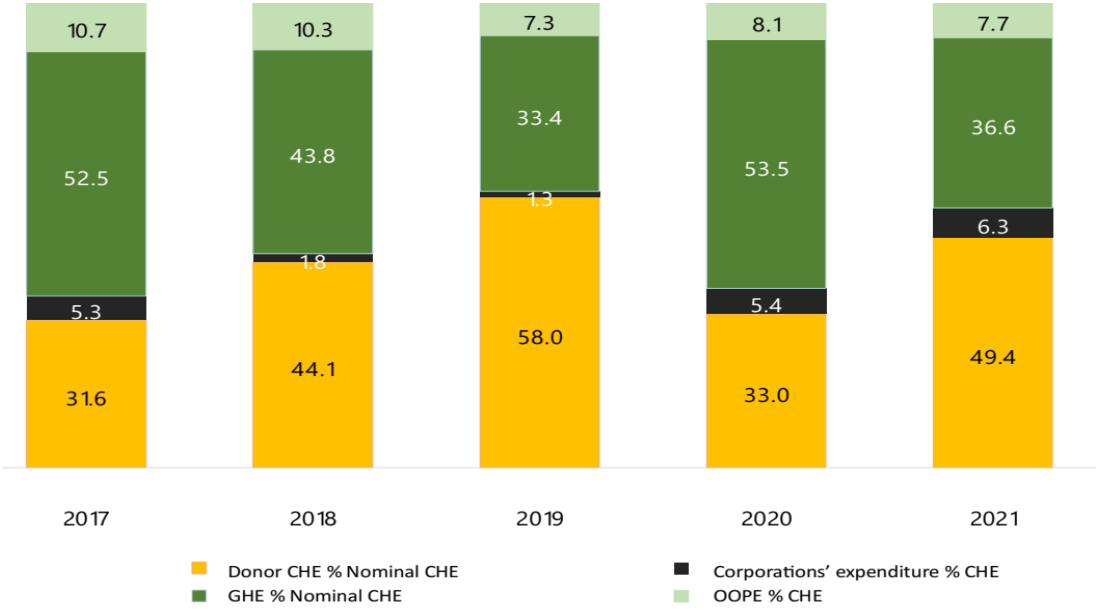
Presentation Outline

1. Health Financing Context in Zambia
2. Background to the NHIS
3. Progress on NHIS Implementation
4. Challenges in NHIS Implementation
5. Lessons from NHIS Implementation

Health Financing Context of Zambia

- Central government and donor funding are the main sources of health systems financing.
- Donor funding has been concentrated in vertical programme/diseases, monthly HIV/TB/Malaria.
- Nominally, the Health budget has been increasing but remains below 15% of total budget allocation.
- Out of Pocket Payments remain considerably low at below 10% of total Current Health Expenditure.
- The low Out of Pocket Expenditure in part is due to the impact of the Social Health Insurance Scheme introduced in 2019.
- Health Service Provision in Zambia remains predominantly public sector driven, augmented by the private sector in urban areas.





Source:

Background to the National Health Insurance Scheme

The **NHIS** was established by the NHI Act No.2 of 2018 as a Health Financing Mechanism to complement General Tax Revenue financing to the health sector by:

1. Providing Financial Risk Protection from catastrophic and impoverishing health expenditures arising from out-of-pocket payments for healthcare services – ***Demand Side of Healthcare***
2. Ensuring the availability of funds to the health sector for improved service provision – ***Supply Side of Healthcare***
3. Enhancing equity in access to health services by expanding provision of insured health services to all citizens – ***Equity objective***
4. Harnessing private sector participation in the provision of health care services – ***Service provision expansion objective***
5. Being a vehicle for achieving **Universal Health Coverage** – where ALL individuals and communities receive the health services, they need without suffering financial hardship.

Source:

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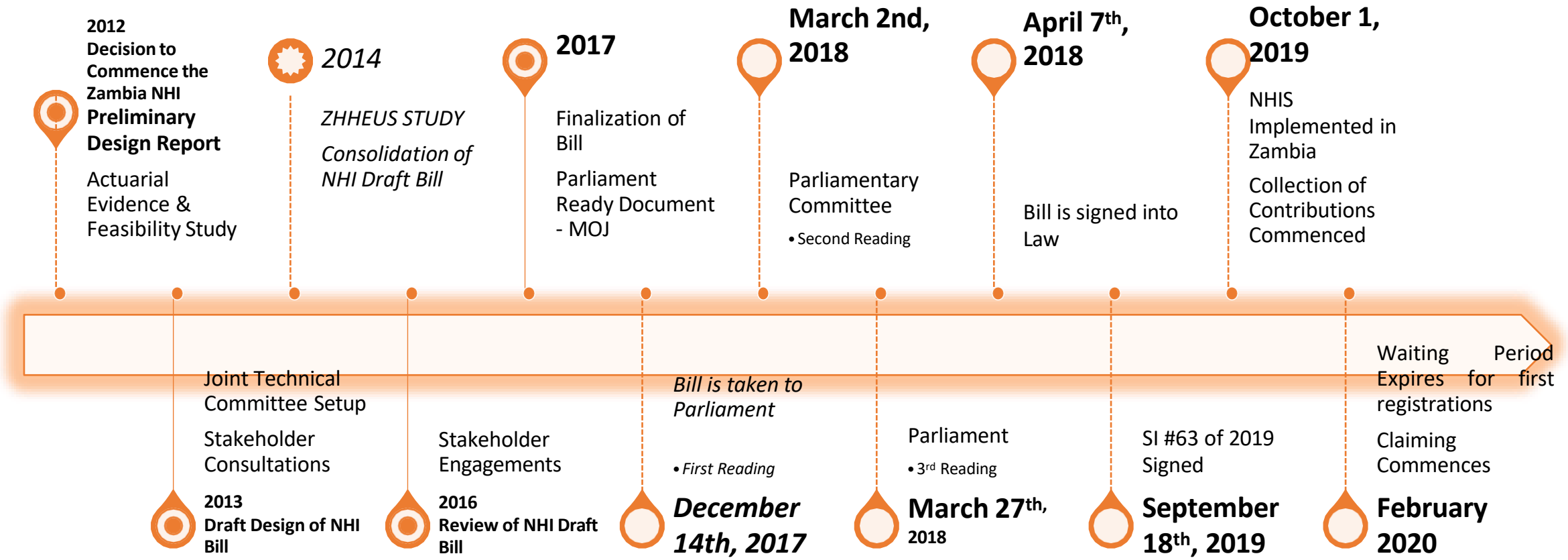
Timeline to the Establishment of the NHIS in Zambia



National Health Insurance Scheme – Key Features

- **Mandatory** *(Formal Sector)* prepayment of health care – According to ability to paying – NHI Act No. 2 of 2018
- **Universal access** – All are to be covered
- **Comprehensive** Services – As defined in the benefits package
- **Financial risk protection** – Do not need to pay at the point of demand
- **Single fund & payer -** To pool funds and purchase care on behalf of contributors
- **Strategic purchaser** – to purchase health services from accredited health care providers as per the defined Health Benefits Package
- **Multiple health care providers** – both public and private health care providers accredited will provide health services to the population

Source:

National Health Insurance Scheme - Financing Sources

NHIMA manages the National Health Insurance Fund, whose functions are to:

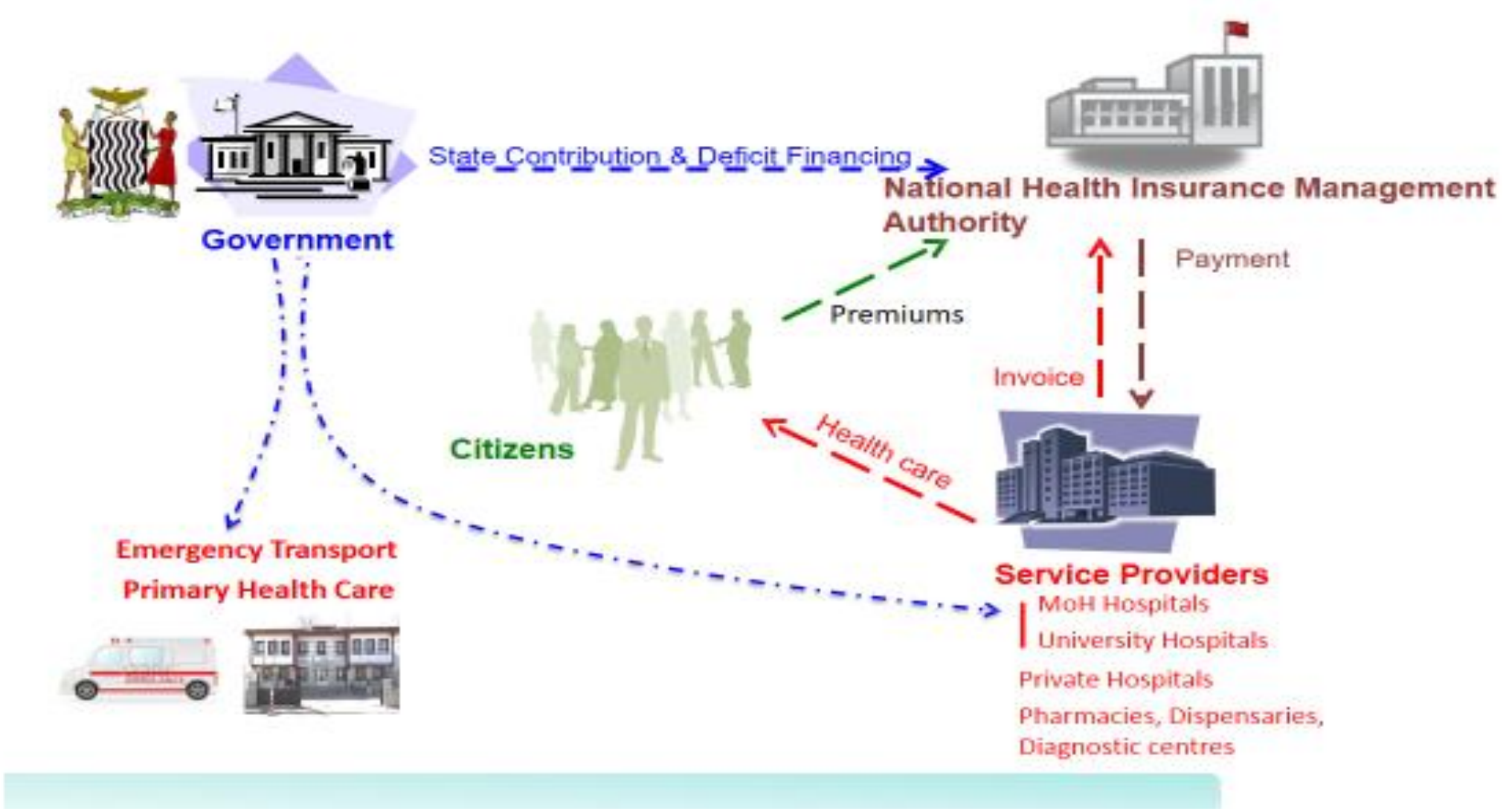
1. Pay for the cost of insured health care services accessed by members of the Scheme.
2. Pay administrative and management expenses, and
3. Pay for programmes for the promotion of access to insured health care services that the Minister may, in consultation with the Authority, determine.

Fund Sources, as per the NHI Act are to be:

1. Contributions paid into the Fund (Currently 2% of Basic Income) – Main source of funding.
2. Monies as may be appropriated by Parliament for the purpose of the Scheme – Yet to happen since inception.
3. Monies as may be paid to the Fund by way of loans, grants, or donations.
4. Such monies as may, by or under any other law, be payable to the Fund.
5. Interest arising out of any investment of the Fund

Source:

NHIS Design Features: Revenue mobilization, Pooling & Purchasing

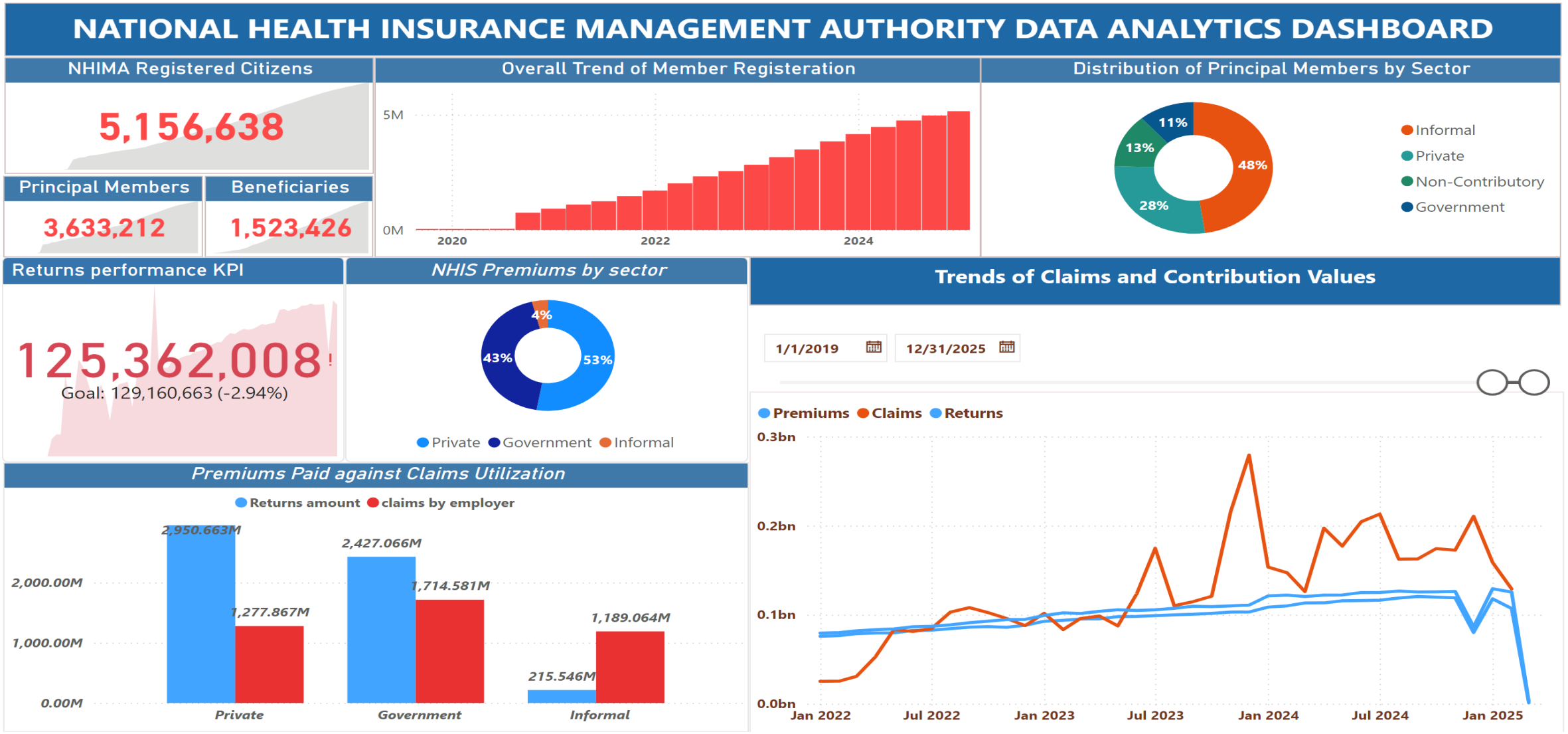


NHIS Design Features: Benefits Package Highlights

1. **Medical Care:** Consultations, examinations, Diagnostic services (Radiology and laboratory) and Nursing Care.
2. **Surgery:** General Surgery, Anesthetics, Orthopedics, Pediatric Surgery and Ear, Nose and Throat.
3. **Maternity and Neonatal Care:** Antenatal Care, Delivery (Normal or Assisted), Caesarean Section and Postnatal Care.
4. **Eye Care Services:** Selected services
5. **Oral Health Services:** Selected services
6. **Pharmaceutical Drugs and Supplies:** Prescription generic drugs on the essential drugs list prescribed by an accredited heath care provider an approved or use under the Scheme, Medical supplies and Blood products –**EXCLUDING ART DRUGS**
7. **Physiotherapy:** Selected services

Source:

NHIS Membership Composition and Growth: 2019 – 2025



Emerging Challenges in NHIS Implementation

The key NHIS implementation finances the following key challenges:

1. Limited **collections capacity** of the Scheme based on 2% of basic pay of the limited formal sector.
2. High **informal sector** Scheme utilisation with low contributions and low compliance.
3. High poverty levels – resulting in **dependency on the limited formal** sector collections.
4. Demand **shifting in service utilisation** from the public sector to the private sector – leading to high costs related to private sector utilisation.

Source:

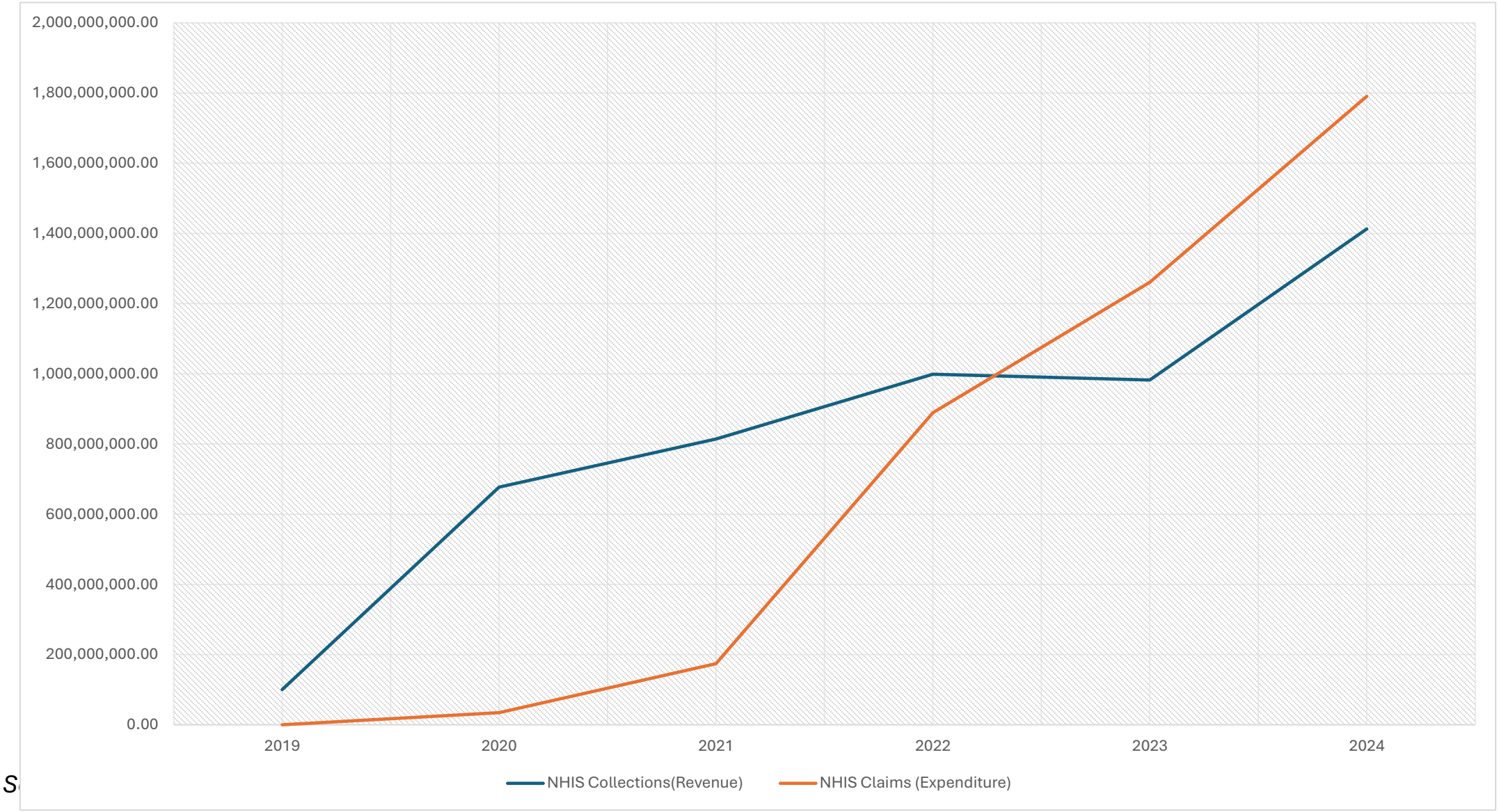
Implications of Challenges – Insolvency Risk

The identified challenges have resulted in the following:

1. Scheme insolvency risk from limited formal sector collections to meet the demand for Universal Health Coverage.
2. Scheme insolvency risk arising from limited informal sector collections and low compliance.
3. Limited coverage for the poor and vulnerable, thus constraining progress towards Universal Health Coverage.

Source:

Implications of Challenges – Realized Financing Risk



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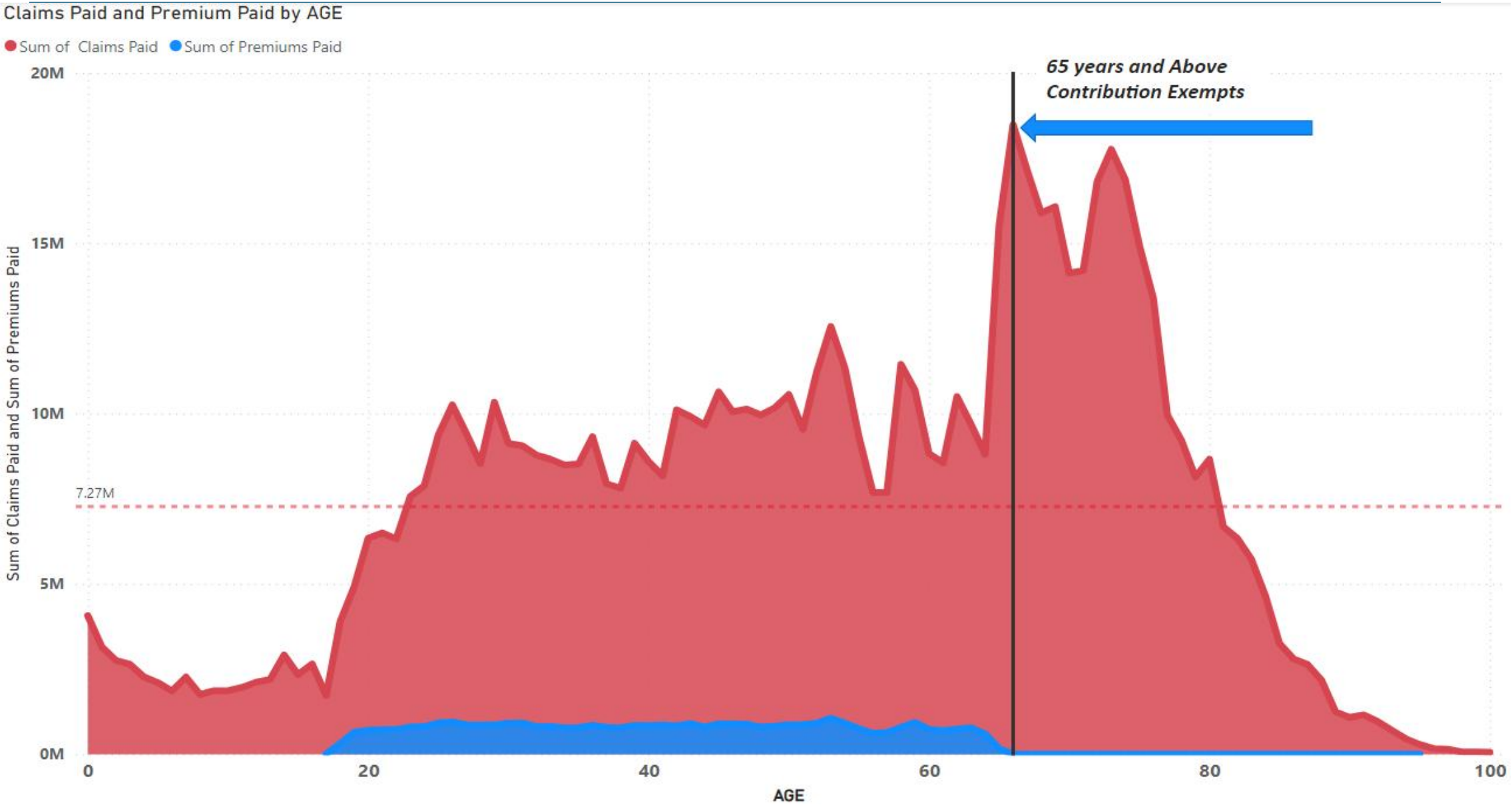
Informal Sector Challenge – Pervasive Adverse Selection



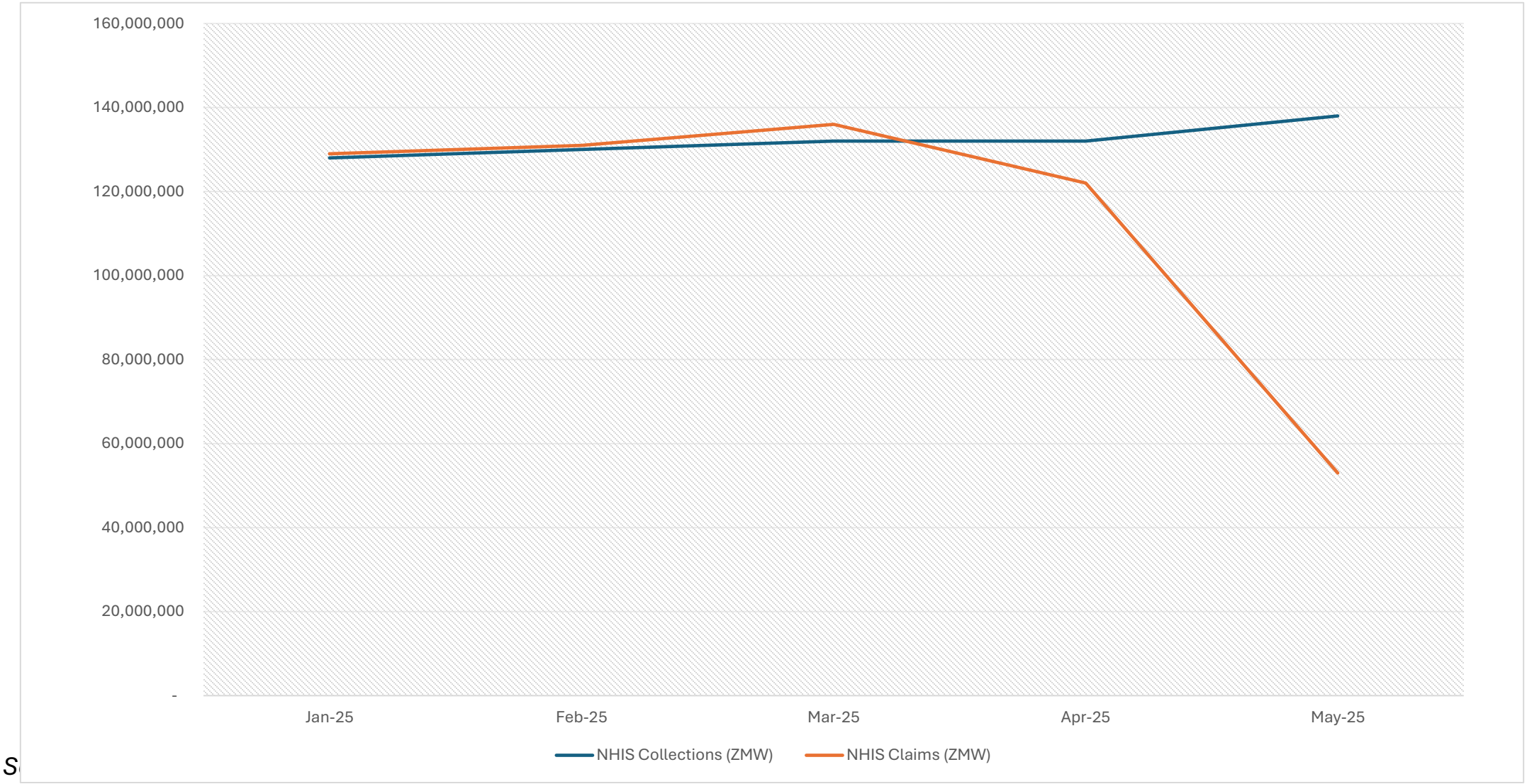
Reforms on Financial Sustainability Challenge

To address the challenges identified, Management is implementing the following:

1. Changing the contributory base from ***Basic Income to Gross Monthly Income*** – **Subject to Cabinet Approval.** This raises revenues by 50% and increases contributions compliance.
2. Revising the ***Benefits Package*** – elimination of high-cost drivers and curbing abuse by healthcare providers – Effected January 2025.
3. Enhancing informal sector contributions compliance – Re-designing incentive structure for informal sector registration **–** Effected January 2024.
4. Rolling out the ***Health Insurance Subsidy Pilot Project*** with **US$1.5 million** Global Fund support for the Poor & Vulnerable Households – 16, 000 out of 1.3 million (Only 1.2%) – Since May 2024.
5. Designing a ***Differentiated Benefits Package*** for different contributing categories.

Source:

Reform Results from Benefits Package Revision – Financial Solvency Trajectory



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Lessons and Reflections

- High ***political will*** is critical for initiation and sustainability of the Scheme – Initial Capital Injection to build Scheme Financial Reserves is critical.
- Public healthcare system needs to be ***service ready and available*** for high level Scheme acceptance.
- ***Benefit Package design*** must be influenced by the ***feasibility of financing.*** Begin with a limited Benefits Package linked to financing feasibility.
- Prioritize investment in public healthcare providers – ***enhance their capacity*** to deliver higher quality services.
- The public does not distinguish between ***Financing and Service Provision*** – there is need for NHIS institutions to work closely with Health Service Provision – but maintain provider/purchaser split.
- The private sector motive of profit maximization must be noted at Scheme design phase – ***Provider Induced Demand.***
- The ***informal sector remains a challenge***, and a big source of ***adverse selection*** – Scheme design rules must account for this for Scheme sustainability.

Source:

Thank you!

Questions and discussion?

Q&A; Discussion

Prof. Ama Fenny

Reflections and closing remarks

Joe Kutzin| Snr Research Fellow, R4D

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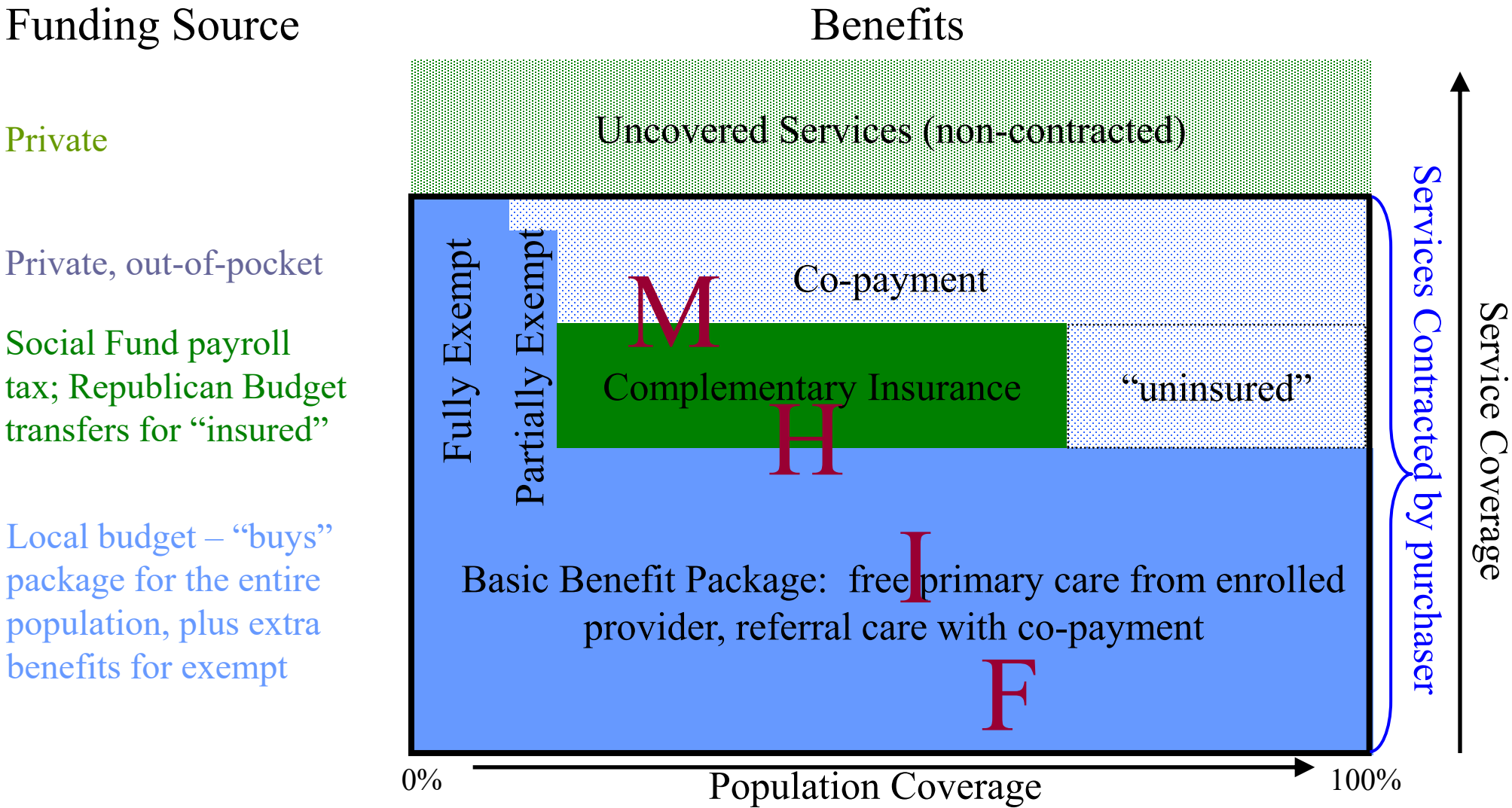
Thinking inside the box to enable SHI to move from scheme to system…whatever your starting point

Joseph Kutzin

The Role of Social Health Insurance in Financing Healthcare in LMICs

19 July 2025, iHEA Congress, Bali

Complementarity in Kyrgyzstan by thinking inside the box



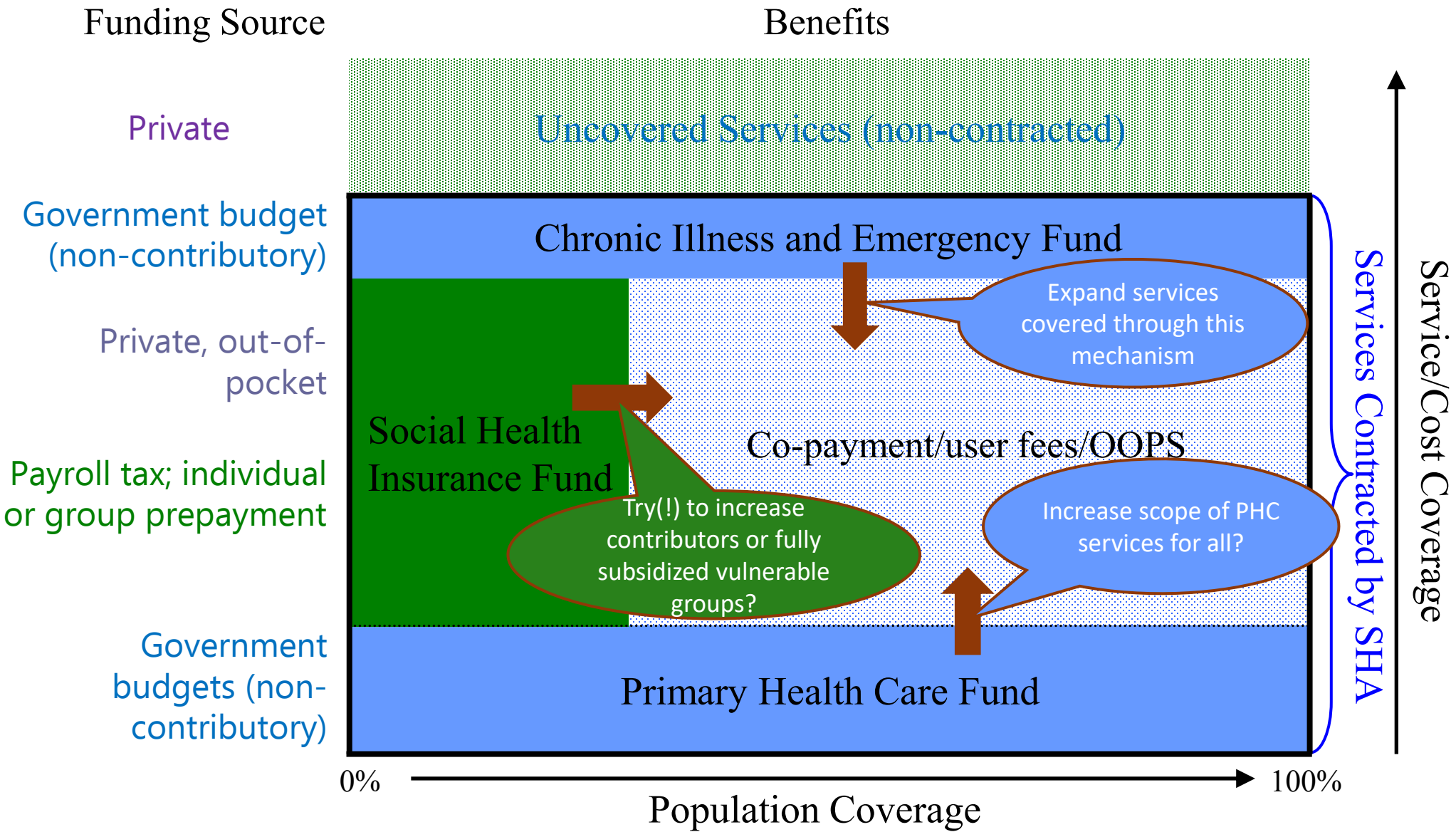
It’s about institutions and capacities, not just funding

- Design features and implementation steps matter
- “Inside the box” is not just about benefit design, but also opportunity to
  - Put in place unified/interoperable data systems
  - Progressively strengthen provider payment capacities
  - Use the data to inform decision-making beyond purchasing, e.g. as an input to quality improvement strategies
- Meanwhile, make the unfunded parts explicit so that there is at least the possibility for private funding to be complementary
  - While trying to shrink that over time

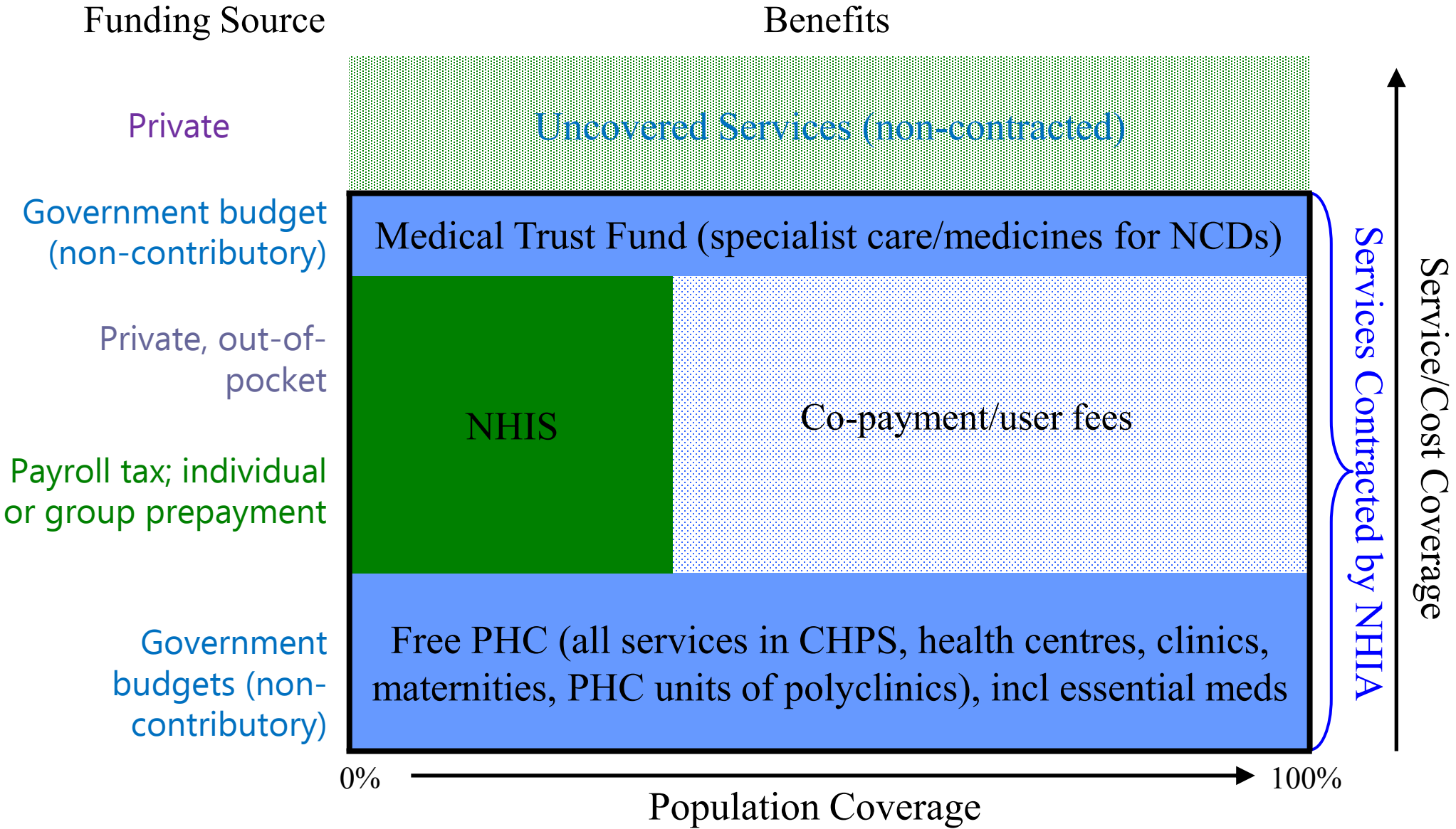
What might this look like in your country

Keeping in mind that a PPT slide is not a “reform”

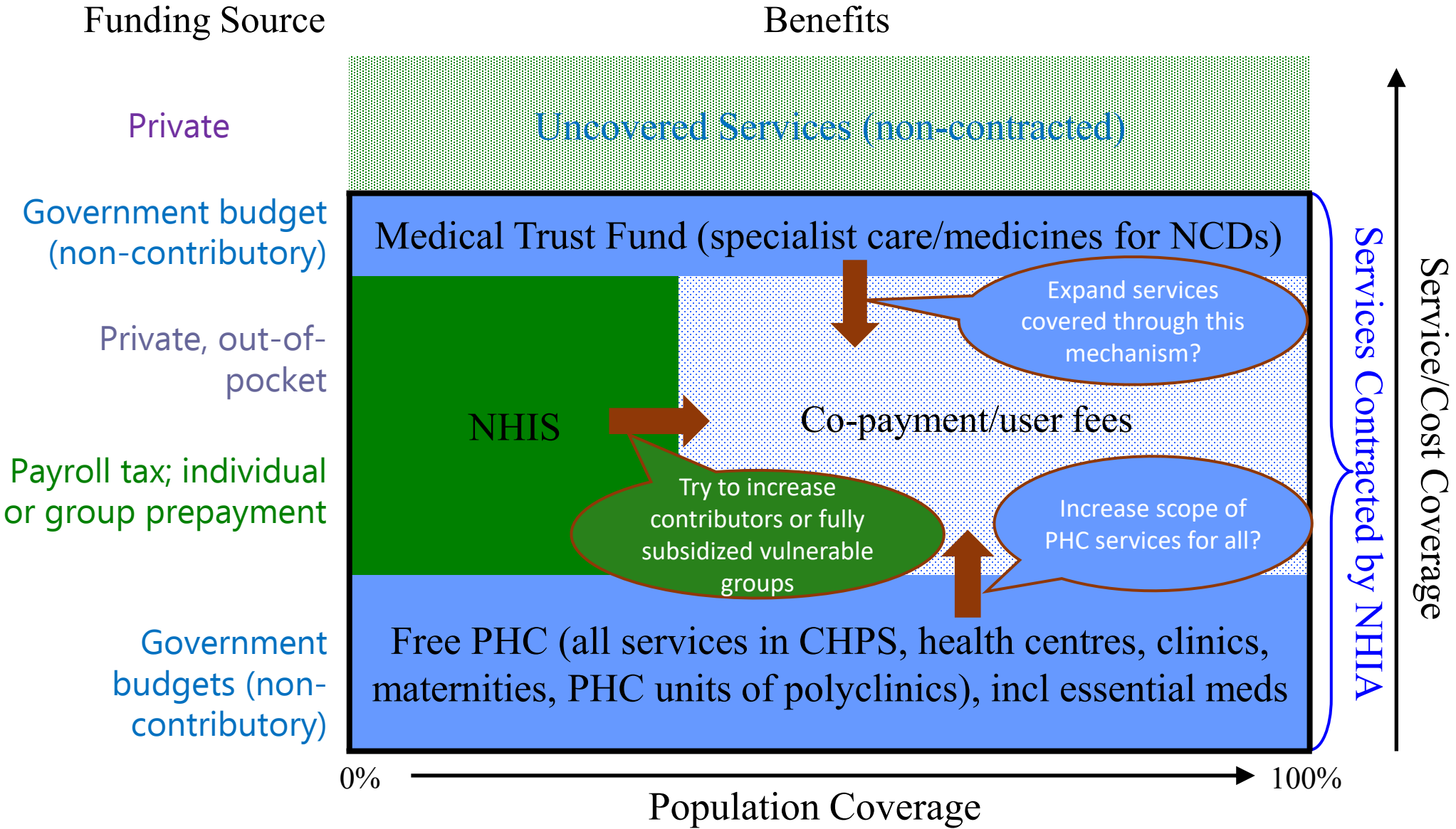
Kenya: think about the SHI scheme as part of a whole, not just separate schemes, for now and the future



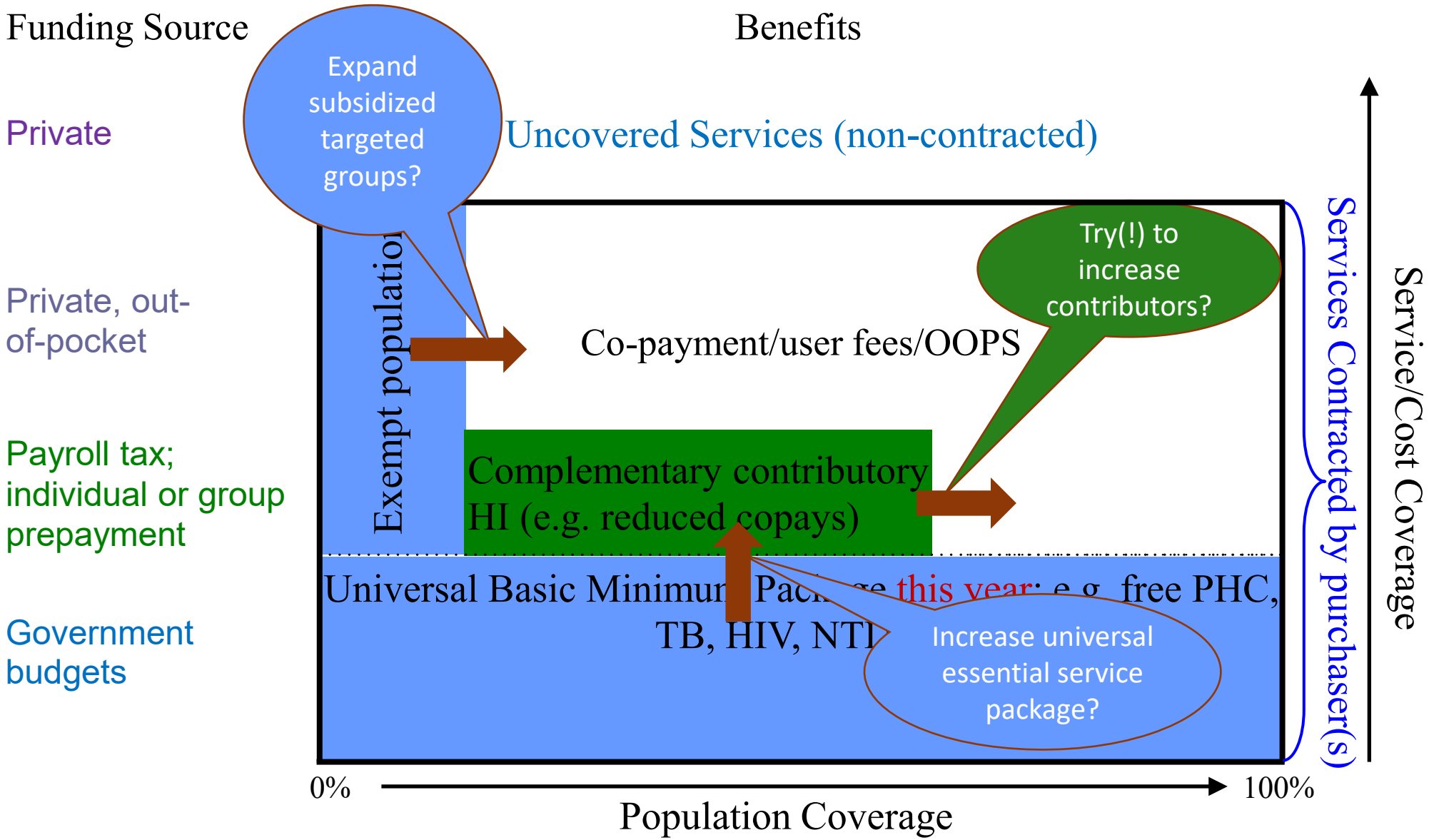
Ghana QF-FPHC in overall unified system (1 purchaser, complementary benefits)



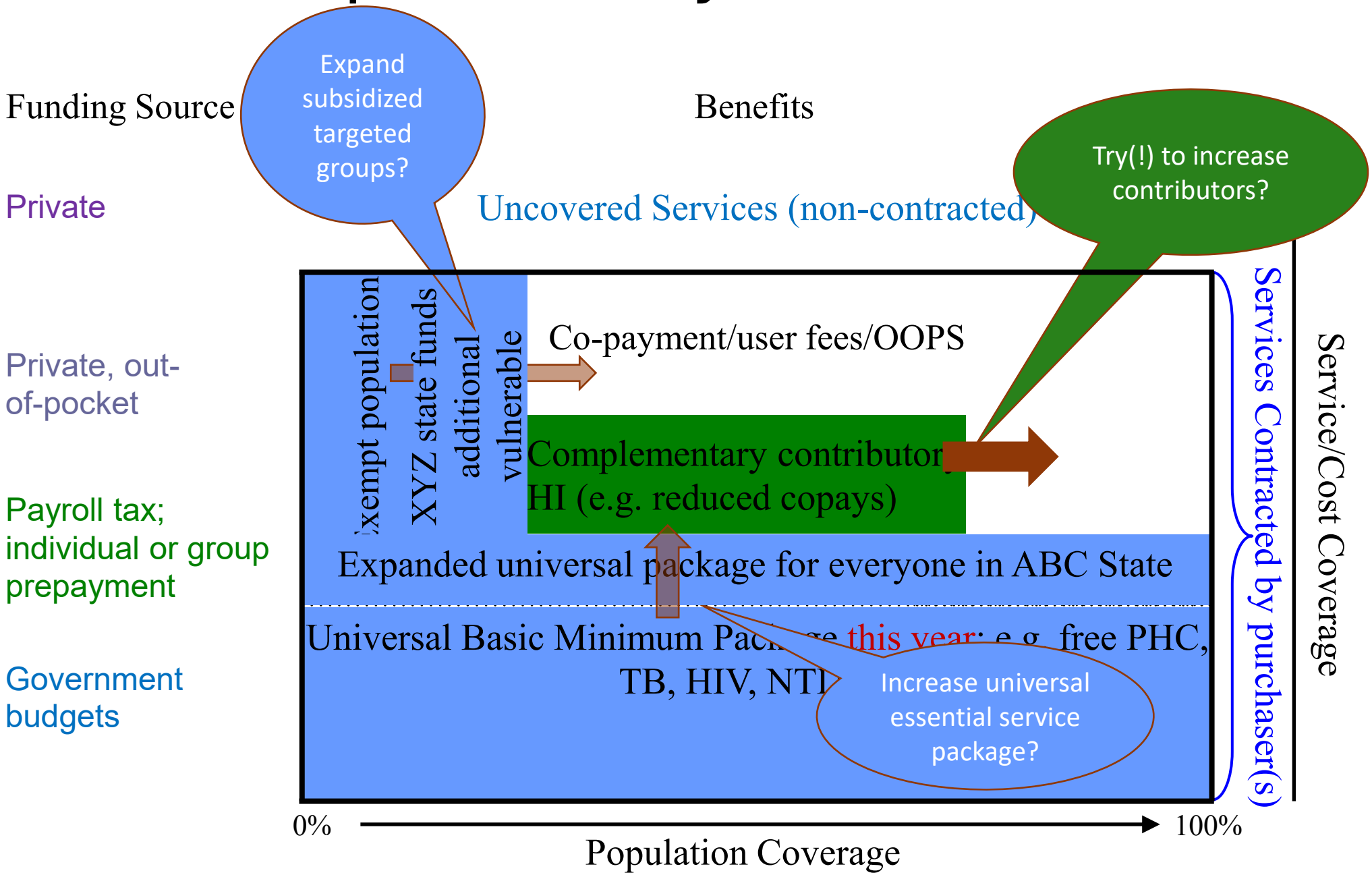
Coverage expansion dynamics over time (if / when revenues increase). Zambia?



Nothing is more complicated than Nigeria, but still a chance to think inside-the-box



State-level expansion beyond the minimum

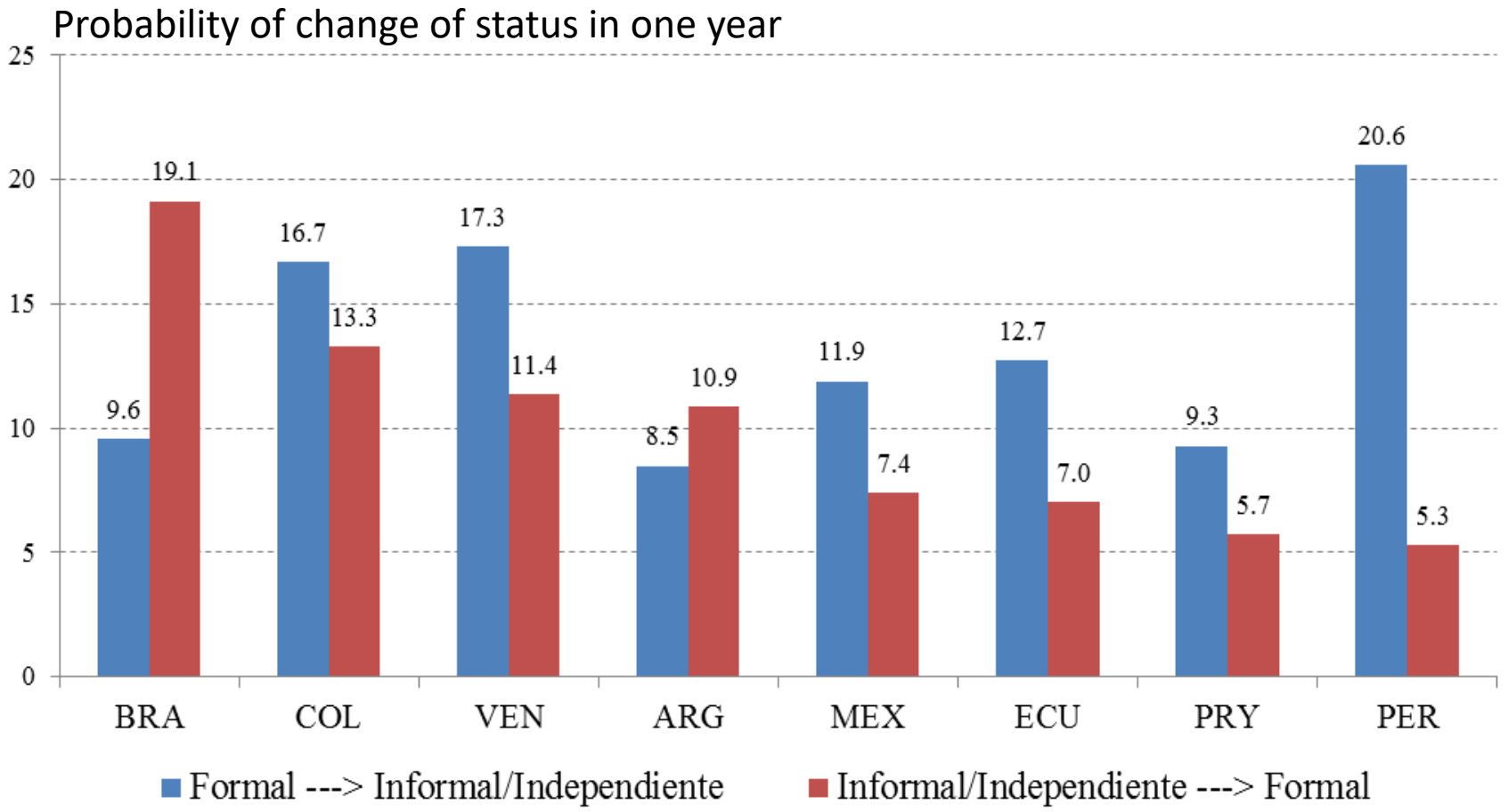


No blueprint, but signposts and ideas for how to proceed by thinking inside the box

- Design scheme as an instrument to catalyze system to progress towards UHC
  - Explicit complementarity of different funding sources (just because there are multiple doesn't mean they are complementary) to support benefits
  - Towards unified/interoperable data systems (Ghana, please) to get purchasing on behalf of entire population
  - **Progressively strengthen provider payment capacities** (helps to concentrate this capacity – this is what you can gradually improve…needs to adapt so should not be fixed in legislation)
  - Use the data to inform decision-making beyond purchasing, e.g. as an input to quality improvement strategies
  - No getting away from fact that general revenues have to play key role (but use them differently!)
  - Make the unfunded parts explicit

Try to avoid investing in this – a major diversion of attention for HIFs

- Formal job entry or exit means gain or loss of health coverage
- That's not consistent with design of systems for UHC
- And it's expensive and difficult to keep track
- Leave it to your tax agencies



Source: Santiago Levy, WIDER Development Economics Lecture, 2019

Don’t let the label constrain your options (and your thinking)!

- SHI can contribute to or detract from progress towards UHC – scheme is not an objective in itself
  - Pool general revenues in SHI to reduce fragmentation and include non-contributors
  - Bring info platforms together
  - Complementary benefits
  - Strengthen functions (especially purchasing on behalf of all) no matter what you call them
  - Leave tax policy/administration to the tax authorities
  - Can we afford it? Of course there are fiscal constraints. The real question is this: can we still try to improve the performance of our health system (whether or not we call it “health insurance”)?

Thank you