



SOCIAL HEALTH INSURANCE IN GFF COUNTRIES:

OPPORTUNITIES AND PITFALLS



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ABSTRACT

Several lower-income countries are considering Social Health Insurance (SHI) as a method to mobilize and pool additional resources for health. However, labor market constraints and low enrollment among informal sector groups limit how much additional revenue governments can leverage through contribution payments. To increase coverage, donor and government-financing has become a prominent revenue component for health insurance in countries where the Global Financing Facility (GFF) is active. Additional challenges faced by health coverage include providing coverage to a substantial share of the population, contracting with quality providers, and a weak governance environment. Based on a review of the literature, this paper examines (i) the merits and demerits of SHI to finance health systems in LICs and MICs when compared with other coverage schemes; (ii) the likely challenges for a country that tries to move forward with SHI; and (iii) potential solutions. The analysis shows that even where countries have almost reached universal coverage, mandatory insurers manage a relatively small share of national health finances. This may be sobering for governments who hoped to increase revenues through health insurance. Insurance revenues tend to be lower than expected due to a small formal

sector, low contribution payments, contribution evasion and low enrollment rates. High expenditures caused by high service use, provider-induced demand for unnecessary care, generous benefits, and high administrative costs, further endanger the financial situation of these schemes. In addition, narrowly defined benefits packages, insufficient consumer information, inadequate quality of care and skimping behavior by providers are all pitfalls that contribute to low utilization rates and high out-of-pocket payments among individuals with coverage. The paper finds that except for the equity and labor market distortions created by enrollment and contribution payments, these pitfalls affect all coverage schemes. Solutions to prevent and handle them exist in membership and revenue management, provider contracting and payment, benefits management, and in administration. Coverage schemes who do not use these tools are simple disbursement agents who transfer funds collected from government and households to the health sector at high administrative cost. The paper also argues that SHI performs better in countries with strong government commitment to finance universal coverage and higher government effectiveness.

1. INTRODUCTION

This paper examines the experience with Social Health Insurance (SHI) and compulsory health schemes in selected countries to help inform the policy dialogue with governments. The purpose of this paper is to assess country experience with SHI and identify lessons for countries where the Global Financing Facility (GFF) is active. The paper examines (i) the merits and demerits of SHI to finance health systems in LICs and MICs when compared with other coverage schemes, (ii) the likely challenges for a country that tries to move forward with SHI and (iii) potential solutions. The paper is not meant to be a guideline to advise governments on SHI; rather, it aims to build a common understanding about SHI to inform the health policy dialogue with governments.

Several lower-income countries are considering Social Health Insurance as a method to mobilize and pool additional resources for health. Most countries supported by the GFF (13 of 23) do not have SHI for their population (Annex Table 1). Instead they finance and provide automatic health coverage through the government health sector. However, an increasing number of low-income countries are interested in SHI. Madagascar's national policy for universal health coverage from December 2015 aims to develop national health insurance that pools contributions from taxes, external donor grants, and other sources (Garchitorena 2017). In 2015, Burkina Faso passed a law for universal health insurance (assurance maladie universelle) that will fully subsidize coverage for the poor and partially for low-income groups (Wright 2016). In Cameroun, the government is considering universal coverage to be financed from contributions paid by employers, employees and retirees, as well as the informal sector population¹. Myanmar plans to develop a new social health insurance law². These countries strive to provide health coverage for the entire population through national health insurance.

Government employees tend to be the first to be covered. In most low- and middle-income countries, government employees already have government-funded

health insurance coverage through the Social Security System (ILO 2008; Wagstaff 2009). This is the case in countries ranging from Benin and Burkina Faso to Tanzania, Namibia and India. The Central Government Health Scheme in India, for example, started in 1945; it provides comprehensive medical care to central government employees, including pensioners and their families. Kenya was the first African country to introduce compulsory health insurance for salaried workers in 1966. In some countries including Benin and Zambia, public sector employees are now promoting the move from Social Security to SHI to gain access to private sector health care. As a result, government employees will have better access to care than the rest of the population who cannot afford enrolling with private health insurance.

SHI has been introduced for different reasons. Several low- and middle-income governments, including Tanzania, Benin, South Africa and Namibia, are proposing SHI as a method to ensure access to a universal benefit package for the population and to mobilize additional revenues from different sources to finance health care. The former socialist countries in Eastern Europe introduced SHI systems for different reasons. Their motivation was to use SHI as a third-party payer to improve efficiency in health care, contain costs, increase transparency, and put constraints on politicians who redirect funds away from health to other sectors (Rechel 2009). Some Eastern European countries created SHIs to isolate healthcare spending from the vicissitudes of the annual budgeting process, to ensure a guaranteed source of funding for health as well as to set a ceiling on health care spending (World Bank 2005). Political pressure advanced the reform in Indonesia and Peru. Indonesia's single-payer started in 2014 after citizens brought legal actions to hold the government accountable for the 2004 law on the National Social Security System with uniform benefits for all. Similarly, the transition to a democratic government in Peru resulted in Comprehensive Health Insurance for poor and uninsured groups in 2002 (Atun 2015).

¹ Ministry of Public Health République du Cameroun (2017): Point de presse conjoint sur la couverture de sante universelle. <http://www.minsante.cm/site/sites/default/files/Point%20de%20presse%20CSU.pdf>

² https://www.philhealth.gov.ph/news/2018/delegates_learn.html

How much additional resources governments can raise through SHI will be constraint by the labor market. SHI in higher-income countries raise substantial revenues from members' payroll taxes and contributions. For lower- and middle-income countries, revenues from payroll taxes will not be a relevant source for SHI financing. These countries have a small share of their workforce active in the formal sector economy and expanding SHI coverage to informal sector workers is difficult as their labor income is not easy to tax. Haiti, for example, does not consider SHI a viable option as more than 90 percent of the workforce is in the informal sector (World Bank 2017). Labor market constraints thus limit how much additional revenue governments can leverage for SHI through contribution payments. They also highlight how important it is for governments to raise alternative revenues sources to finance coverage for defined groups.

In addition to revenue constraints, provider and institutional readiness and political changes affect government decisions on SHI. In Afghanistan, national health insurance has not been launched because of concerns about insufficient political and constitutional support, low quality of care, lack of public awareness about health insurance, limited management capacity to run health insurance, and insufficient fiscal space and willingness to pay for health insurance (Zeng 2017). Burkina Faso just launched a SHI program; however, the main constraints that had to be addressed during the ten-year development process included: how to convince the population to pay insurance contributions when people expect "free care", the services the government will continue to finance for the entire population, the financial viability of SHI given the large informal sector population, how to integrate and collaborate with existing community-based health insurance systems, and how to finance the enrollment of the poor and ensure equal access to a minimum benefit package for all members³. Some countries abolished SHI. When socialist governments came to power in the second half of the last century, Brazil, Iceland, Portugal and Spain reverted from SHI to tax-financed systems (Saltman 2004; Wagstaff 2009).

Previous findings about the feasibility of SHI in low- and middle-income contexts have been sobering. The main difficulties encountered by SHI include (i) inequity in SHI financing and the need for social solidarity through government financing, (ii) ensuring the availability of adequate health services and provider compliance, (iii) low enrollment among informal sector groups, and (iv) insufficient political commitment to social insurance (Carrin 2002). Similarly, it was found that poor regulation of SHI hamper quality of care and increase cost. High collection costs, collection evasion, the exclusion of non-poor informal sector workers and the adverse effect of contribution payments on the labor market raise major concerns about the additional value of SHI. Instead of SHI, a tax-financed system was proposed as it has the advantage of covering the entire population and ensures equity in financing; it also avoids labor market distortions (Wagstaff 2009).

This paper expands on previous studies by taking stock of an increasing body of literature from lower- and middle-income countries to examine how health insurance has performed in GFF countries, common pitfalls and how they have been addressed. The next section defines social health insurance using the system of health account framework and presents selected country experience to exemplify how SHI differs from other health financing schemes. Chapter 3 presents evidence from GFF countries on the financial sustainability of SHI and other coverage schemes; whereas Chapter 4 examines challenges that affect financial protection for insurance members. Some countries have addressed these issues through specific mechanisms, which are presented in Chapter 5. The paper concludes with four main lessons.



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³ <http://www.sidwaya.bf/m-20056-les-sept-defis-de-l-assurance-maladie-universelle-.html>

2. SOCIAL HEALTH INSURANCE IN BROADER HEALTH FINANCING CONTEXT

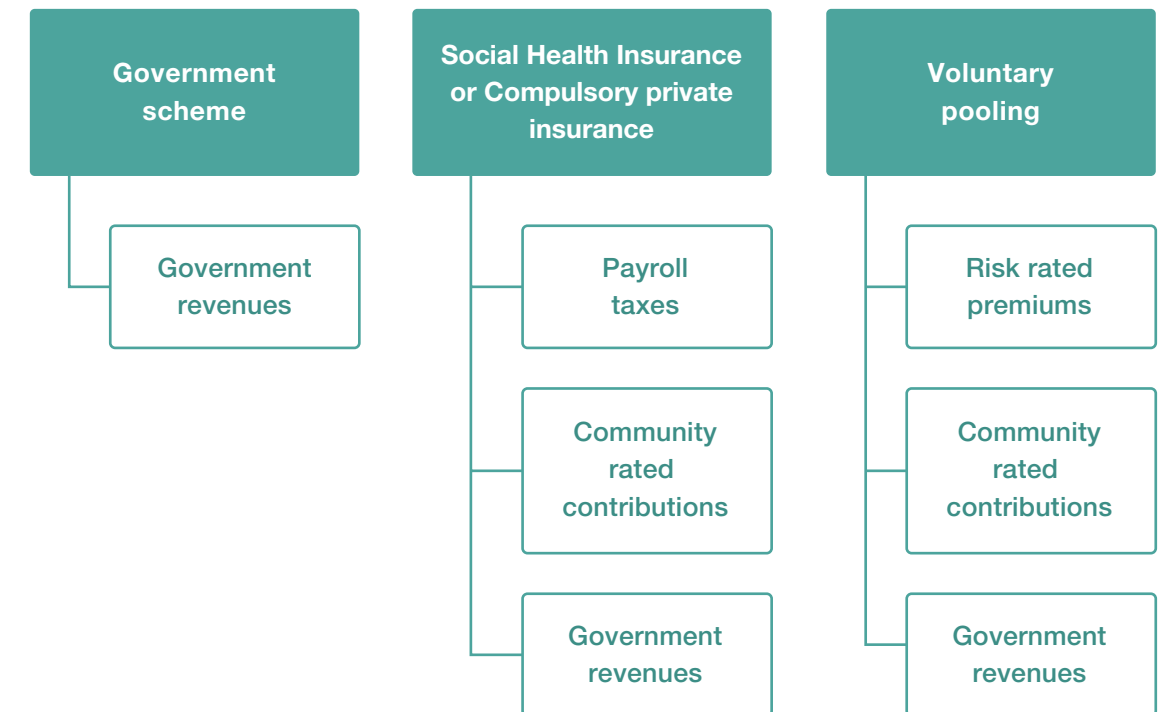
There are multiple ways to finance health care and most countries use a mix of financing methods. The Systems of Health Accounts identifies three sources of health revenues that are pooled: (i) government revenues, (ii) compulsory contribution payments (payroll taxes and contribution payments) and (iii) voluntary contribution payments. These sources finance different coverage schemes as depicted in figure 1 (page 7). Contribution payments to compulsory schemes are not risk-rated based on individuals' health risk, as this is the case for voluntary payments to health insurance. Rather, to enhance solidarity across socio-economic groups, compulsory contributions are income-dependent payroll taxes or community-rated based on the financial risk of a community or a geographic area. Voluntary pooling is financed through risk-rated premiums reflecting the financial risk of illness for an individual or a group of individuals. Contribution payments and premiums tend to be regressive with poorer households paying a higher share of their income on contributions than wealthier groups. To prevent regressivity in health financing, several governments subsidize contribution payments for lower-income groups, including OECD countries. Governments also finance insurance benefits and deficits. In addition, patients pay (non-pooled) user fees directly to health care providers (OECD 2017). Table 1 provides an overview on how the main coverage schemes are financed and managed.

Government schemes provide automatic coverage to all or specific groups and can be administered differently. Government schemes are managed by the Ministry of Health, some lower-level of government, or by a third-party public entity in countries with a "payer-provider-split" (table 1). Some governments transfer health funds to lower levels of government to finance care for specific groups. The Seguro Popular⁴ in Mexico, for example, is an intergovernmental revenue transfer within the national health system from the center to the states to co-finance health care for registered uninsured individuals in the public and private sector. The transfer is defined based on

the number of individuals enrolled with Seguro Popular. Several governments have introduced a payer-provider-split to keep the public payer organizationally separate from public providers. The Latvian health fund is a government scheme that is fully government funded and managed by a public entity who contracts with public providers (OECD 2017). The Thai government has established the tax-funded Universal Coverage Scheme (UCS) to provide health coverage for uninsured individuals (Tangcharoensathien 2018). Cambodia created a health equity fund (HEF) who manages subsidies for eligible groups (Jacobs 2018). The difference between these government schemes and SHI is that they provide automatic coverage to a population through tax-funding whereas SHI provides mandatory coverage for members.

Mandatory coverage requires participation in a health insurance scheme by law for the entire population or for a specific group. Mandatory coverage schemes can be administered by a social health insurer or by compulsory private insurance schemes (table 1). Several European countries provide Social Health Insurance for the population, including Germany, Austria, France, Hungary, Poland, Serbia. In a few high-income countries such as Switzerland, the Netherlands, Saudi Arabia, and Slovakia, private health insurance companies administer mandatory coverage for the population or specific groups. Different entities can manage SHI, including a public or quasi-public entity, or private health insurers. SHI are regulated by the government supervisory and legislative framework, which sets the rules for financial and operational management of SHI (Normand 2009). The Tanzanian National Health Insurance Fund (NHIF) for instance is a public agency under the Ministry of Health, Community Development, Gender, Elderly and Children who provides health insurance to government employees and private sector workers. The Tanzanian Social Security Regulatory Authority regulates and supervises the NHIF. SHI members generally have access to the same benefits offered by contracted providers in the public and private sector.

FIGURE 1: COVERAGE SCHEMES AND THEIR FUNDING SOURCES



Source: Based on OECD 2017

In some countries, health insurers manage different coverage schemes for specific groups. The Mandatory Health Insurance Fund (HIF) in Kyrgyzstan manages the government scheme (payer-provider split) and the SHI scheme for formal sector workers (table 1). The Slovenian health insurance institute is a public entity that provides coverage as a SHI for the population and it also sells complementary voluntary health insurance coverage (OECD 2017). Since 2009, the Tanzanian NHIF also administers the voluntary Community Health Funds (CHF) which in 2016 provided access to a smaller benefit package for about 9.6 million individuals in the informal sector in rural areas. CHF enrollment is co-financed by

donors⁵. The Rwanda Social Security Board provides SHI for public sector employees, while it also administers the mandatory community-based health insurance (CBHI) scheme which covers informal sector groups. Before joining RSSB, CBHI was managed by local associations and provided mandatory coverage for informal sector groups in Rwanda. In Turkey, subsidized coverage through the tax-funded Green Card Program increased to 85% of the poorest by 2011. In the meantime, the Program has been incorporated into the public health insurer (Atun et al. 2013).

⁴ <http://www.seguropopular.org/>

⁵ <http://nhif.or.tz/pages/profile#gsc.tab=0>

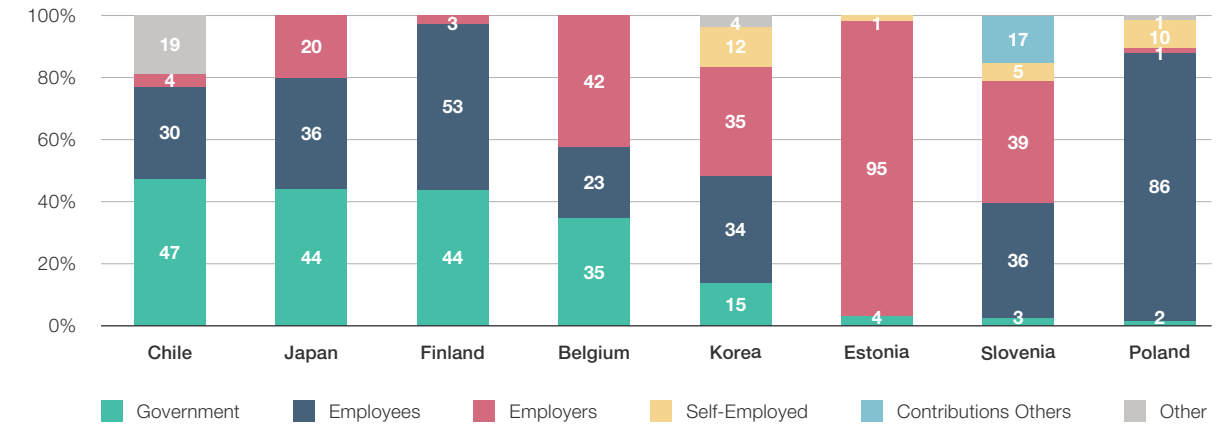
TABLE 1: COVERAGE SCHEMES AND THEIR CHARACTERISTICS

COVERAGE SCHEMES	GOVERNMENT SCHEMES	SOCIAL HEALTH INSURANCE	COMPULSORY PRIVATE INSURANCE	VOLUNTARY POOLING
Participation	Automatic for population or sub-group (enrollment)	<ul style="list-style-type: none"> Mandatory for population or sub-groups Requires enrollment 		<ul style="list-style-type: none"> Voluntary Requires enrollment
Financing	Government revenues	<ul style="list-style-type: none"> Non-risk rated contributions <ul style="list-style-type: none"> – payroll taxes – community-rated contribution Revenues from government and donors 		Contributions rated by: <ul style="list-style-type: none"> individual risk community Government revenues
Administrator	Government or Public entity (provider-payer-split)	Public entity (off-budget)	Private entity	Private or Public entity
Examples	Population-based: <ul style="list-style-type: none"> Public coverage NHS UK Latvia HIF Sub-group: <ul style="list-style-type: none"> Cambodia HEF HIF Kyrgyzstan UCS Thailand Seguro Popular Mexico 	Population-based: <ul style="list-style-type: none"> SHIs in OECD EHIF Estonia Ghana NHIS HII Slovenia Sub-group: <ul style="list-style-type: none"> HIF Kyrgyzstan NHIF Tanzania UEBMI China RSSB Rwanda 	Population-based: <ul style="list-style-type: none"> Netherlands Switzerland Slovakia Sub-group: <ul style="list-style-type: none"> Saudi Arabia for private sector workers 	Private administration: <ul style="list-style-type: none"> Private health insurers Some CBHI Public administration: <ul style="list-style-type: none"> HII Slovenia CBHI managed by local governments in Ethiopia UBHI and NRCMS in China

Source: Author based on OECD 2017.

Note: NHS = National Health Services; UCS = Universal Coverage Scheme; UEBMI = Urban employees basic medical insurance; NRCMS = new rural cooperative medical scheme; UBHI = Urban basic health insurance.

FIGURE 2: FINANCING SOURCES OF COMPULSORY INSURANCE IN SELECTED OECD COUNTRIES, 2015



Source: OECD Health Statistics 2017.

Social health insurers manage contribution payments made by or on behalf of eligible persons. In several OECD countries, governments finance a large share of SHI revenues, including in Chile, Japan, Finland and Belgium; whereas SHIs in Eastern Europe are predominantly financed by contributions from employees and employers (figure 2). SHI contributions are mostly levied as payroll taxes and paid by employees, employers, and the self-employed (OECD 2017). To ease pressure on labor costs, some countries have reduced payroll taxes and increased government funding to SHI. Germany reduced SHI payroll taxes from 15.5% to 14.9% of gross salary in 2010 and increased government funding through general tax revenue to SHI. The German government also fully subsidizes SHI coverage for the unemployed and assumes responsibility for SHI deficits⁶. As a result, SHI manage revenues from different sources including an increasing share of government tax-financing for non-contributing member groups.

Voluntary enrollment tends to be insignificant where not subsidized. Voluntary pooling mostly takes place through private voluntary health insurance and other voluntary prepayment schemes, such as mutuelles or CBHI (table 1). Private insurers in lower- and middle-income countries mainly insure coverage for private sector care. In South Africa about 16% of the population — mainly higher-income groups — are privately insured. Voluntary community schemes are catering to lower income

groups. In Ethiopia and China, these voluntary schemes are managed by government entities. The two public voluntary schemes in China receive substantial government subsidies to keep premiums low (OECD 2017). Bangladesh adopted a healthcare financing strategy in 2012 that recommends voluntary CBHI for low-income informal workers. CBHI are managed by the Labor Association for Social Protection under the Ministry of Local Government and Rural Development (Ahmed 2018). However, enrollment in voluntary pools tends to be low where enrollment fees are too high for households (Adebayo 2015).

The goal of any coverage scheme is to provide financial protection and access to quality care in a financially sustainable manner. To achieve this goal, schemes will have to provide coverage to a substantial share of the population, raise reliable revenues, contract with quality providers, and operate in a governance environment that is supportive of the schemes. The two main reasons why schemes could fail to meet these health policy goals are that: (i) their financial sustainability is endangered by higher expenditures than revenues and (ii) members are not financially protected as evidenced by high out-of-pocket payments and low utilization of care. The following two sections identify several challenges that can trigger these situations. Thereafter, evidence is presented on how they have been managed in different countries.

3. FINANCIAL SUSTAINABILITY

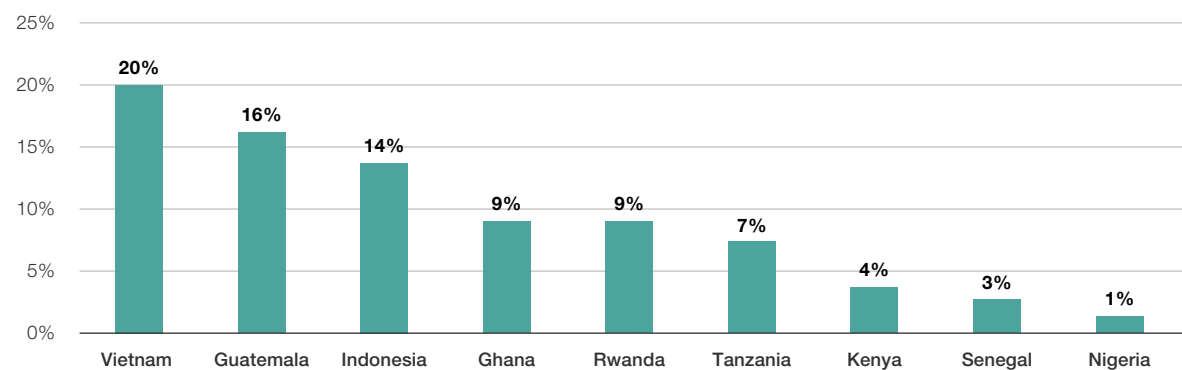
The financial sustainability of SHI is threatened if revenues are insufficient to pay for members health care expenditures. Several SHIs in the Africa region are financially solid. Between 2012 and 2016, the NHIF in Tanzania achieved annual surpluses from its formal sector members ranging from 37% to 50% of total insurance revenues. Similarly, the NHIF in Kenya reports an operating surplus of 4% of total revenues⁷ for its formal sector plan for 2018. The Ghana NHIS however has been running an annual deficit since 2009 (Wang 2017). This was also the case for the JKN scheme in Indonesia. European SHIs including in France and Hungary have faced large deficits that led them to introduce measures to manage expenditures (Mossialos 2016). Financial sustainability is a threat for any coverage scheme including for governmental schemes.

3.1 INSUFFICIENT REVENUES

Health insurers manage a relatively small share of total health expenditures. Although governments launch health insurance to raise additional revenue for the health sector, Vietnam, Guatemala and Indonesia are the only countries where health insurers manage more than 10% of total current health expenditures (figure 3). Despite reaching almost universal coverage, the Rwandan RSSB manages only 9% of the country's total health expenditures. As shown in figure 4 (page 11), a substantial part of these insurance funds is financed from government tax-revenues. Compulsory and voluntary schemes raise a negligible share of revenues for health through household contributions. Not many insurers in low-income countries publish their revenue situation. Those who do show

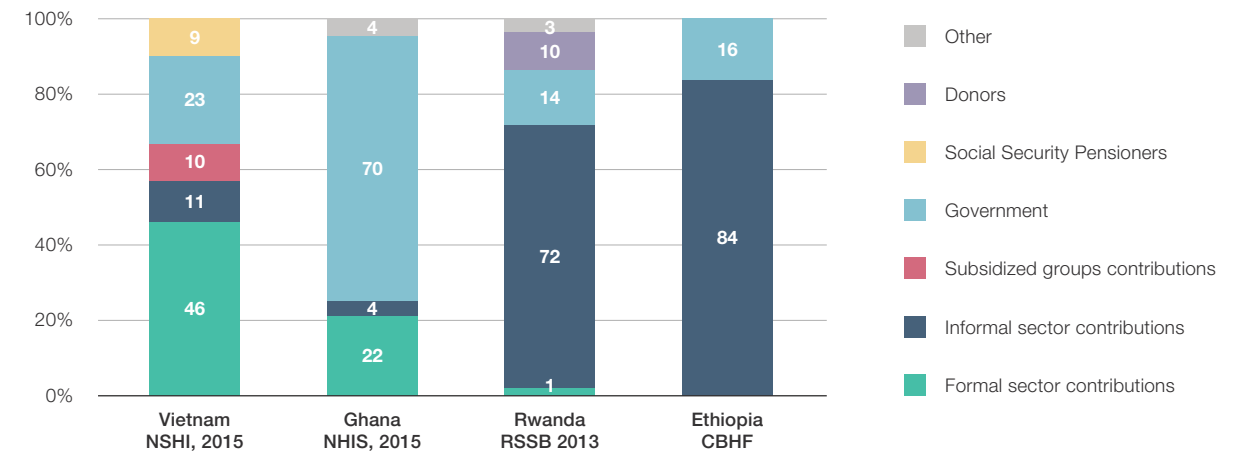
substantial government funding. The Vietnamese government subsidizes about 50% of total SHI revenues⁸. Of the revenues managed by the NHIS in Ghana, 22% are additional revenues from formal sector contributions and 4% from informal sector contributions; whereas the government through its VAT contributes 70% of total insurance revenues to subsidize enrollment of non-contributing groups (NHIS 2018). As a result, the financing structure of the NHIS Ghana is not that different from a governmental scheme. The voluntary community-based schemes in Ethiopia raise about 84% of its revenues from informal sector contributions and 16% from subsidies (figure 4). Revenues from contributions tend to be lower than expected because of a small formal sector, low contribution payments, contribution evasion and low enrollment.

FIGURE 3: SOCIAL AND COMPULSORY HEALTH INSURANCE IN % OF TOTAL CURRENT HEALTH EXPENDITURE, BY COUNTRIES SUPPORTED BY THE GFF, 2015



Source: WHO Global health expenditure database: <http://apps.who.int/nha/database/Select/Indicators/en>

FIGURE 4: FINANCING SOURCES OF COMPULSORY AND VOLUNTARY HEALTH INSURANCE IN GFF COUNTRIES



Source: Country documents

i. LOW CONTRIBUTION PAYMENTS

To manage labor costs and ensure affordability, there is pressure to keep contribution payments low. All SHIs in GFF countries raise payroll taxes for formal sector workers (table 2). The level of payroll taxes differs across countries and ranges from 2.5% in Ghana to 10% of gross salaries in Guatemala. In most countries this tax is shared between employers and employees. Those active in the informal sector pay a fixed amount to the insurer when signing up. Employers and workers in all countries are keen to keep payroll taxes and contribution payments low to ensure affordability and prevent adverse effects on the labor market.

Governments and donors are financing coverage for informal sector groups. In the Philippines and Ghana, tobacco taxes and VAT have been increased, respectively, and earmarked to subsidize SHI coverage for the poor. In 2017, about two-third of members of the Ghanaian NHIS are subsidized by the government. Some donors finance coverage for specific population groups. The German donor agency for example pays contributions for all pregnant women to the NHIF in Tanzania and to the Community Health Fund for family members⁹. Rwanda also requests private insurers to transfer 1% of their total revenues to CBHI as a solidarity transfer (table 2). As

a result of subsidized enrollment, some large member groups contribute a small share to total insurance revenues. In Ghana, informal sector groups constitute 30% of all members but their contribution amounts to 4% of total NHIS revenues with government co-financing their enrollment (NHIS 2018). Government funded schemes such as the USC in Thailand do not require contribution payments; however, individuals may have to pay a copayment when seeking care similarly as the insured.

Financing enrollment for the poor is challenging for governments as fiscal constraints limit the number of poor with subsidized insurance coverage. Government-subsidized enrollment reaches a small share of the poor in some countries causing donors to step in. In Ghana and Ethiopia, only about 2% of the poor have been enrolled in SHI (Fenny 2018). The national health insurer in Kenya covers a small number of poor households, whereas in Tanzania the poor are covered under the CHF or by the donor-funded program for pregnant women (table 2). In Rwanda, the GFATM co-finances premiums and co-payments for 2 million poor CBHI members (The Global Fund 2017). As this is also the case in governmental schemes such as the UCS in Thailand, government and donor financial commitment is essential in ensuring enrollment for low-income groups.

⁷ http://www.nhif.or.ke/healthinsurance/uploads/notices/NHIF_Performance_Report_2018_08.08.2018.pdf

⁸ https://www.healthpolicyproject.com/pubs/7887/Vietnam_HFP.pdf

⁹ http://health.bmz.de/events/In_focus/Ensuring_mothers___and_babies___health_in_Tanzania/index.html

TABLE 2: FINANCING OF COVERAGE SCHEMES IN COUNTRIES WITH GFF SUPPORT

COUNTRY (YEAR)	MEMBER CONTRIBUTIONS	GOVERNMENT FINANCING	DONORS / PRIVATE
Ghana NHIS (2017)	<ul style="list-style-type: none"> • 2.5% of social security on payroll for formal sector • Premium for informal sector members 	<ul style="list-style-type: none"> • 2.5% VAT for poor, children <18, elderly >70 years and pregnant women 	
Guatemala IGSS ^{10 11}	<ul style="list-style-type: none"> • 10% of gross salary (7% employer and 3% employee) 	<ul style="list-style-type: none"> • Subsidy of 3% of the total value salaries of contributors 	
Indonesia JKN (2018)	<ul style="list-style-type: none"> • About 5% of gross salary • Rp.25,500 – Rp.59,500 per month per informal sector member 	<ul style="list-style-type: none"> • Rp.19,225 per month per subsidized member 	
Kenya (2018)	<ul style="list-style-type: none"> • Fixed amount increases with income 		<ul style="list-style-type: none"> • Poor households
Rwanda RSSB (2017) ¹²	<ul style="list-style-type: none"> • RSSB 5% of formal sector salary • CBHI Premium 2000 RWF per person per year 	<ul style="list-style-type: none"> • Government fully subsidizes premium for two poorest categories 	<ul style="list-style-type: none"> • Poor households • Solidarity transfer: 1% of private health insurance revenue
Tanzania NHIF (2016)	<ul style="list-style-type: none"> • 6% of gross salary • \$3-\$6 per CHF member 	<ul style="list-style-type: none"> • Local government match CHF member contribution 	<ul style="list-style-type: none"> • Pregnant women
Vietnam (2017)	<ul style="list-style-type: none"> • 4.5% of gross salary (formal) • 4.5% of minimum salary (informal) 	<ul style="list-style-type: none"> • US\$30 for poor • US\$21 for near-poor & students 	

Source: Country documents

High contribution payments and subsidized coverage for low-income groups can have an adverse effect on the labor market. High SHI contributions lead to higher labor costs for employers and can push formal sector employees into informality where individuals have access to the governmental system. In Eastern Europe, the expansion of SHI has been associated with higher unemployment and declining employment ratios (Wagstaff 2007). In Mexico, the government-subsidized Seguro Popular incentivized informality. While Seguro Popular

improves access to care. But it was also associated with a 3.1 percentage point increase in informal sector workers, as low-income individuals can avoid having to pay SHI contributions by moving into the informal sector and receiving coverage under Seguro Popular (Aterido et al. 2011). The effect of health insurance on the labor market has been mainly studied in OECD-countries, highlighting the need for more analytical work in lower-and middle-income contexts.

ii. CONTRIBUTION EVASION

Contribution evasion can reduce health insurance revenue substantially. Contribution evasion happens when employers underreport the number of formal sector employees or the base salary on which the SHI contribution is levied. In Indonesia, two health plans managed by JKN (for informal sector and public-sector workers) reported substantial deficits of US\$480 million in 2017 caused by contribution evasion and high utilization rates. Embezzlement of contribution payments by local agents also leads to evasion and lower revenues (HPP 2018). The World Bank found in South-Eastern European countries that SHIs suffer from large noncompliance caused by pervasive contribution evasion and poor collection amounting to an estimated 40% of expected revenues. As a result, SHI regularly must be bailed out by general government revenue transfers as contribution revenues are falling short of legal entitlements for members. In Lao PDR, social health insurance enrolment is mandatory but less than half of private sector firms enroll all employees which points to large contribution evasion (Alkenbrack 2015). Contribution evasion was estimated to cost 2.75% of GDP in Colombia. In Kazakhstan, forgone revenue due to evasion during local collection was substantial and estimated at 40% of expected revenue (Wagstaff 2010).

iii. LOW ENROLLMENT

Only four countries supported by the GFF — Rwanda, Vietnam, Indonesia and Ghana — provide compulsory health insurance coverage to a substantial share of the population. SHI agencies in GFF countries administer different coverage schemes (figure 5). In 2017, the Vietnamese SHI covered about 80% of the population (Nazzareno 2018). Half of them are low-income and their enrollment is subsidized by government (Nguyen 2017). Rwanda has almost reached universal insurance coverage through CBHI. Rwanda is the only country with a compulsory CBHI scheme managed by the Social Security Agency; it covers about 82% of the population. However, the Tanzanian NHIF manages health coverage for only 7% of the population active in the formal sector, and 20% of the population through the voluntary CBHF scheme. In Kenya, about 80% of the population remains uninsured as enrolment is most difficult among informal sector groups (Kazungu 2017). In these GFF-supported

countries, SHI enrollment is low because a small share of their workforce is active in the formal sector, and contribution payments are difficult to enforce among informal sector workers. In Guatemala, about 30% of the workforce is in the formal sector. As a result, only about 18% of the population is insured with the Instituto Guatemalteco de Seguridad Social (IGSS) (Avila 2015).

Progress with enrollment has been affected by affordability and administration. PhilHealth in the Philippines is one of the largest insurers and reported 91% population coverage in 2016 (PhilHealth 2016). In 2015, the state-owned Myanmar Insurance and 11 private domestic companies begun enrolling customers (aged 6 to 65 years) at a premium of approximately 50 USD (Latt 2016) which was not affordable for low-income groups¹³. During the first seven months only about 2,100 subscribers enrolled¹⁴. In Lao PDR, despite mandatory enrollment, limited capacity of the insurer kept enrollment low (Alkenbrack 2015). Thus, in addition to affordability, administrative barriers matter too.

Despite subsidized enrollment into SHIs, informal sector groups and the poor remain a small share of total members in some schemes. The insurers in Guatemala and Kenya mainly cater to the formal sector. However, most insurers started to enroll informal sector groups which resulted in very heterogeneous membership distributions (figure 6). In 2018, the Indonesian national health insurer Jaminan Kesehatan Nasional (JKN) covered about 75% of the country's population (figure 5). More than half of them are classified in the bottom-40% income groups and fully subsidized by the government (figure 6). Still, informal sector groups report lowest enrollment as monthly premium payments to JKN are unaffordable or not a priority for them (Dartanto 2017). The Philippines and Vietnam partially subsidize SHI enrollment for informal sector workers but without much success (figure 6), and enrolment rates are lower in rural areas (Wagstaff 2016). Despite a 25% premium subsidy and promotion campaigns, inability to pay remained the main reason for low take-up among informal sector workers in Vietnam who constitute only 12% of total members. Similarly, a 50% premium subsidy in the Philippines increased insurance take-up by only 3 percentage points among informal groups (O'Donnell 2016). In 2016, they represented only 8% of total PhilHealth membership. While the poor are large member groups in the Philippines (36%) and Vietnam (45%), they represent a small share of 6% of all NHIF members in Ghana (figure 6).

¹⁰ <http://www.ghspjournal.org/content/5/3/382#T1>

¹¹ https://www.usaid.gov/sites/default/files/documents/1862/Guatemala-HSA%20_ENG-FULL-REPORT-FINAL-APRIL-2016.pdf

¹² <https://www.sciencedirect.com/science/article/pii/S0305750X18300330>

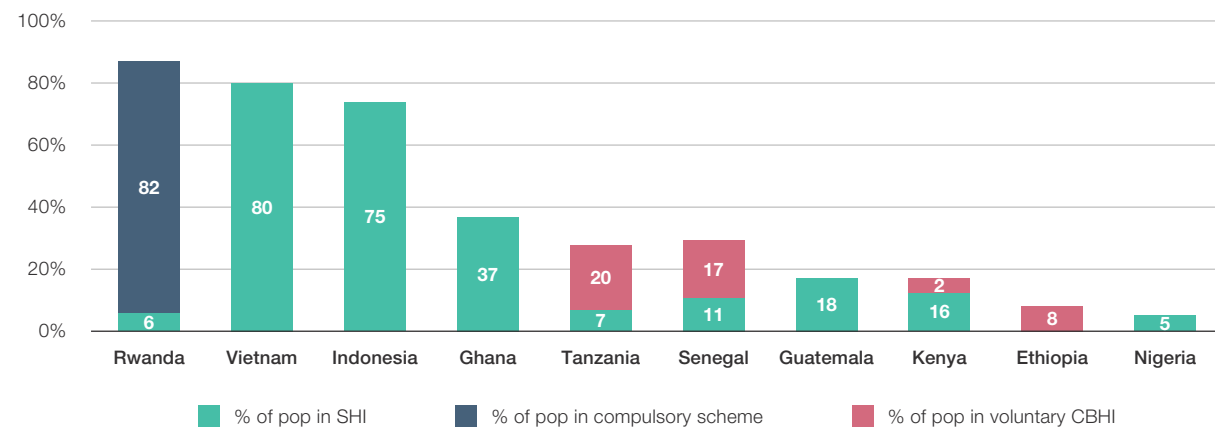
¹³ Myanmar Times: Health insurance coming. June 28, 2018. <https://www.mmimes.com/special-features/204-insurance-2015/13169-health-insurance-coming.html>

¹⁴ Myanmar Business Today: Health insurance companies struggle to find business. February 17, 2016. <https://www.mmbiztoday.com/articles/health-insurance-companies-struggle-find-customers>

In sum, this section shows that even where countries have almost reached universal coverage, mandatory insurers manage a relatively small share of national health finances, which may be disappointing news for governments who aim to raise additional revenue for health through insurance. This is because revenues from contribution payments from formal and informal sector groups

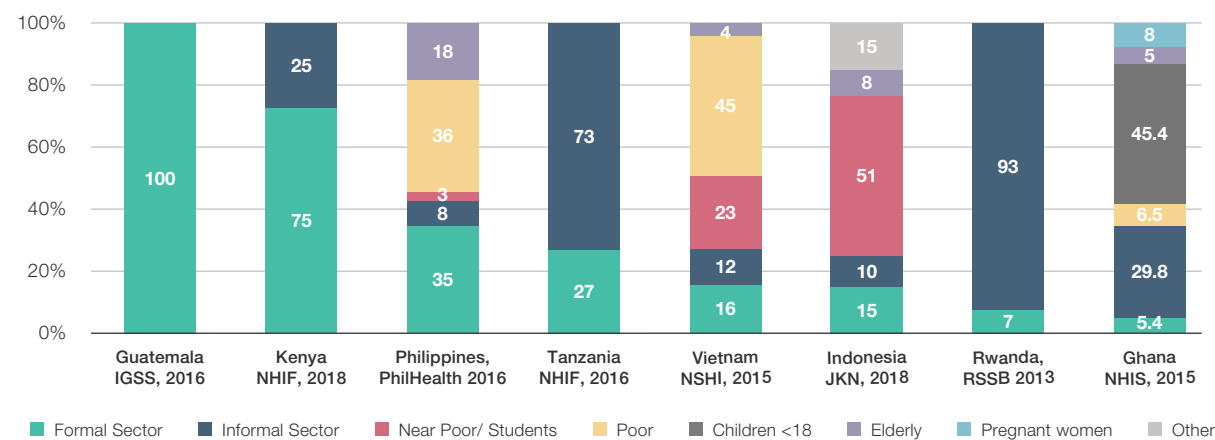
are small, and informal sector groups are most difficult to reach even with subsidized enrollment. Governments and donors remain important financing sources to cover lower-income groups and pay health and administrative expenditures. Financing through government tax-revenues requires continued government commitment to universal coverage and fiscal space to finance health care.

FIGURE 5: PERCENTAGE OF POPULATION ENROLLED IN DIFFERENT SCHEMES IN GFF COUNTRIES, LATEST YEARS



Source: Country documents

FIGURE 6: MEMBERSHIP DISTRIBUTION IN NATIONAL HEALTH INSURANCE, BY COUNTRY, LATEST YEARS



Source: Country documents

3.2 HIGH EXPENDITURES

Insurers around the world are challenged by growing health expenditures. High expenditures are a problem in SHIs in higher-income countries. In Hungary, SHI expenditures have exceeded revenues since the fund's inception. The resulting deficit amounted to 1.6% of GDP by 2003 (World Bank 2005). When insurers repeatedly occur high expenditures, the government will have to step in to tax-finance the insurance deficits and to prevent an increase in contribution payments for members. In Ghana, high expenditures have resulted in annual NHIS deficits since 2009. The deficit was first financed by withdrawals from the NHIS investment fund. Since 2012 the National Insurance Authority took out loans to finance the annual NHIS deficit (Wang 2017). Several factors contribute to high SHI expenditures including high service use, provider-induced demand for unnecessary care, generous benefits; and high administrative costs. If insurers do not manage their expenditures they become simple disbursement agents.

iv. HIGH UTILIZATION BY COVERED MEMBERS

The goal of any coverage scheme is to ensure access to quality care which can increase service use to an efficient level. In Ghana, Rwanda, and Indonesia, health insurance has significantly increased maternal health care utilization (Wang 2017). In Ghana, access to care improved substantially for pregnant women with fully subsidized NHIS enrollment. They report higher utilization rates for prenatal care, assisted deliveries, postnatal and preventive care, which combined had a positive effect on health outcomes, including lower maternal and infant mortality (Alhassan 2016). In Rwanda, compulsory CBHI coverage led to improved child and maternal care coverage, and under-five child mortality, infant mortality and maternal mortality declined drastically (Lu 2012). Health insurance coverage has substantially improved access to care for insured children in Vietnam (Palmer 2015). These findings suggest that overall health insurance coverage has improved access to care and health outcomes.

Governmental health funds and voluntary schemes are equally effective in improving access to care. In China low-income seniors who participate in a voluntary scheme that is funded and managed by the local government report better health outcomes (Cheng 2015). The governmental USC scheme in Thailand reduces the likelihood of illness, especially among the elderly (Wagstaff 2012). USC members are more likely to have an annual check-up. Members also report higher hospital admission rates and outpatient visits (Ghislandi 2015). Peru's Sistema Integral de Salud (SIS) provides tax-financed public coverage without charge to informal sector households who live below a defined income threshold. SIS covers both preventive and curative services and providers are reimbursed by fee-for-service payments, which sets an

incentive to deliver more services. Compared to the uninsured and focusing on urban areas, SIS does increase service use of curative services including hospital care but has a less pronounced effect on preventive care (Bernal 2017). Compared to poor adults already covered through employment-based insurance, SIS improves access to ambulatory care and medication mainly for the elderly and the poorest and it substantially increases the likelihood of being able to afford treatment (Neelsen 2017). Hence, utilization also increases when people join a government-funded voluntary or automatic coverage scheme as they will have to pay less when seeking care.

Utilization can increase to an inefficient level if there is unnecessary service use, which is detrimental for any coverage scheme. Individuals are more likely to use care if they pay lower co-payments than those who pay user fees. In the extreme case, this can lead to moral hazard when people with coverage use unnecessary care. This can be problematic for any health insurance and public coverage scheme. The Thai USC program charges a co-payment to members when seeking care to prevent moral hazard (Tangcharoensathien 2018). The formal and informal sector segments covered by the Indonesian JKN report very high utilization rates in the absence of co-payments (HPP 2018). Ghana reported high utilization rates for NHIS members who visited several health providers in search for better quality care (Alhassan 2016). Moral hazard behavior and fraud has also been identified among NHIS members in Ghana who frequently visit health facilities for care not needed, ask for drugs for other individuals not covered by insurance, or lend their membership cards to uninsured individuals to use care (Debpuur 2015). Such moral hazard behavior is inefficient and creates unnecessarily high expenditures.



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Adverse selection of severely-ill members who need costly treatment could be problematic in the initial phase of SHI when enrollment is still low. Adverse selection is not an issue in schemes with compulsory enrollment for large population groups. However, some SHI explicitly introduce adverse selection for health policy reasons by subsidizing insurance coverage for higher-cost groups such as pregnant women as this is the case in Ghana and Tanzania (table 2). Some small membership segments, such as informal sector groups, are more likely to suffer from adverse selection as high-risk individuals and those with chronic illness will be the first to enroll which leads to higher average expenditures in their membership category.

v. PROVIDER-INDUCED DEMAND FOR UNNECESSARY CARE

Provider payments can set incentives to increase the number of services delivered beyond levels of efficient service delivery. Providers are generally paid by line-item budget under automatic government schemes. Health insurers and public funds reimburse providers differently. Diagnostic Related Groups (DRG) payments to hospitals dominates in higher-income countries but is less common with insurers in low-income countries. DRG pays hospitals a bundled amount for all services needed to treat a diagnostic case. The Ghana NHIS pays DRG to public and private hospitals and for outpatient specialist care. Higher DRG rates are paid to private providers, and

fee-for-service for drugs in community pharmacies. The UCS in Thailand also pays DRGs to hospitals and sets a global budget ceiling. DRG payments generally lead to shorter hospital lengths of stay and an increase in the number of hospital admissions. It can also lead to premature discharges and costly readmissions as shown by the experience from high-income countries.

Fee-for-service payment is costly to administer and sets an incentive to increase the number of services. Primary care providers in Ghana and in Thailand are paid by capitation. The RSSB in Rwanda and CBHI in Ethiopia pay fee-for-service to hospitals and outpatient. Fee-for-service (FFS) payment can lead to over-prescription of medicines and the use of more expensive diagnostics which will increase health expenditures. Fees tend to be calculated based on historic expenditures and do not set incentives to increase efficiency. FFS also creates substantial administrative cost for providers who must submit detailed information to insurers for claims payment. FFS requires verification systems in hospitals and health centers to control bills and prevent fraudulent billing. This can be costly to administer and lead to delayed reimbursement which negatively affects the financial sustainability of providers. Hence, health insurers with FFS payment to providers are financially more at risk.

vi. GENEROUS BENEFITS PACKAGE

A generously defined benefits package can drive expenditures. Few SHI offer a benefit package that is defined based on cost-effectiveness criteria. In Guatemala the IGSS benefit package covers advanced diagnostics in the for-profit sector and care in the private sector, which causes the IGSS to spend about five times more per insured member than the MOH does for automatic coverage of the uninsured. In Ghana, the basic package is generous as it covers all services in the public and private sector, except for services on the exclusion list (e.g. dialysis, cancer treatment etc.). However, the NHIS is considering narrowing the benefit package to improve the Fund's financial stance. The voluntary CBHI in Ethiopia provides a generous package in health centers and district and regional hospitals.

Countries supported by the GFF face changing demographics and disease burden which will increase future demand for a more expensive treatment to be included in the package. As people live longer they are more likely to suffer from chronic conditions such as diabetes which requires more expensive treatment. Non-communicable diseases (NCD) are often under-detected. With better access to diagnostics for the insured, they will be more likely to be diagnosed and require additional treatment options to be covered in the benefit package. Expanding the package can be costly and contribute to future growth in health expenditures.

vii. GENEROUS BENEFITS PACKAGE

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Financial sustainability in any coverage scheme can be endangered by factors that affect revenues and contribute to growing expenditure. Governmental schemes do not face the same pitfalls on the revenue side such as low contributions, evasion and low enrollment. However, fiscal space can hamper government financing for public sector schemes; and they are equally challenged on the expenditure side as health insurers. These pitfalls need to be managed carefully to prevent financial deficits, which will be presented after the following chapter.



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4. FINANCIAL PROTECTION

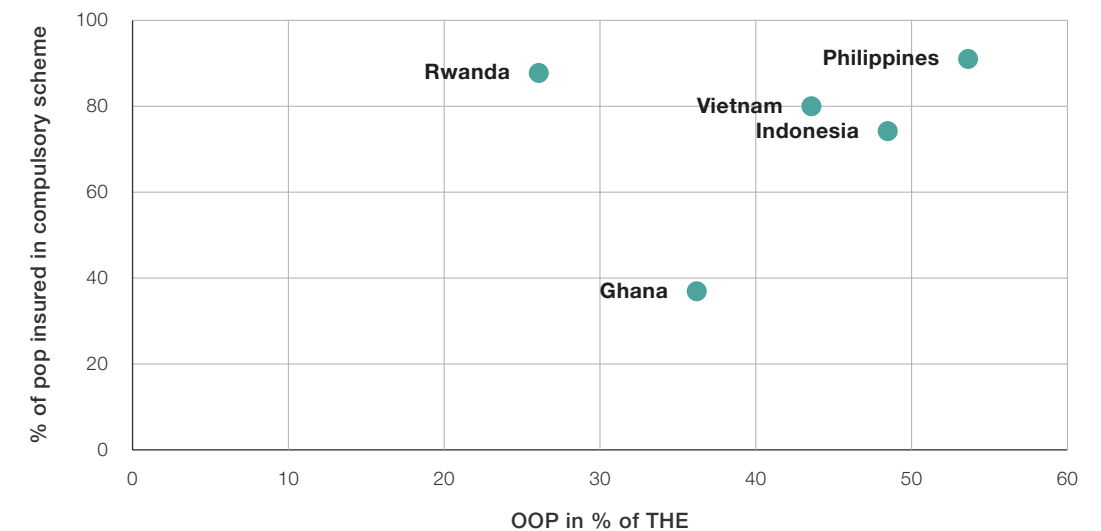
Another important health policy goal for any health financing scheme is financial protection against the financial risk of illness. If utilization rates in health facilities remain low for insured individuals and their out-of-pocket (OOP) payments high, then their scheme is not providing the necessary financial protection. The same applies for government-funded schemes.

4.1 HIGH OUT-OF-POCKET PAYMENTS

In many countries with substantial SHI coverage, the level of out-of-pocket payment as a share of total health expenditures is still very high. Despite a large share of the population enrolled in a compulsory scheme, out-of-pocket payments by patients is still a major financing source as a share of total health expenditures, with the exception of Rwanda. In the Philippines, for example, although 91% of the population is insured with PhilHealth, more than half of total health expenditures is still financed by out-of-pocket payments from patients. Vietnam and Indonesia show similar results. This suggests that

government-subsidized insurance coverage is not providing the expected financial protection against high out-of-pocket payments for insured households (figure 7). Thailand managed to lower out-of-pocket payments to 12% of total health expenditures by 2015; whereas Mexico, despite the government-funded Seguro Popular, still reports high out-of-pocket payments of 41 percent. Poorer individuals will likely not seek care if they continue to pay high fees despite coverage.

FIGURE 7: OUT-OF-POCKET PAYMENTS IN % OF TOTAL CURRENT HEALTH EXPENDITURES IN SELECTED COUNTRIES WITH HIGHEST HEALTH INSURANCE COVERAGE, 2015



Source: World Development Indicators

i. NARROWLY DEFINED BENEFIT PACKAGE

A narrowly defined benefit package with high copayments can keep utilization rates low for the insured and their out-of-pocket spending high. Some compulsory schemes provide coverage for a limited benefit package which causes insured patients to co-pay for services when seeking care. In Rwanda, insurance enrollees in the poorest quintile had significantly lower utilization rates and experienced higher catastrophic health spending than the better-off as the copayment may still be too high for the poor and prevent poor enrollees from seeking needed care (Lu 2012). In India, members of the RSBY scheme report higher OOP payments as providers prescribed care not covered by the narrowly defined RSBY benefit package (Karan 2017). In Peru, out-of-pocket spending for insured households has increased as patients pay user fees for

services not covered by SIS (Bernal 2017). Because of the small benefit package and limited availability of providers in low-income areas in Peru there appears to be no nationwide impact on inpatient care use and out-of-pocket health expenditure for the insured (Neelsen 2017). Similarly, enrollment in the governmental Seguro Popular in Mexico does not affect out-of-pocket spending which was explained by lower government spending (Nikoloski 2018). Some insurers, including in China and Tanzania offer different benefit packages across health plans which leads to unequal access to care and contributes to higher out-of-pocket payments for lower-income groups who are insured with smaller benefits plans. An underfunded benefit package can lead to waiting lists and providers charging additional fees to patients.

4.2 LOW UTILIZATION RATES

If insured members report low utilization rates, then health insurance does not meet its purpose of improving access. Low utilization is often caused by members being inadequately informed about their rights and benefits, insufficient care in facilities and providers skimping care on patients. These issues can be equally problematic in government-funded schemes.

ii. INADEQUATE CONSUMER INFORMATION

Insufficient information about member benefits negatively affects utilization in particularly for poor households. Health insurance is a complex concept and not easily understandable for insured low-income individuals who may be illiterate. They may not know what benefits are covered and how high the co-payment is which may prevent them from seeking care although they are insured. In Indonesia, subsidized low-income members are less likely to use care than formal sector members due to a lack of understanding about benefits (HPP 2018). Similarly, service use among members of the Medical Insurance Program in Georgia was low because the program provided too little information on the benefit package (Bauhoff 2011). Some NHIS members in rural areas in Ghana were not able to access care as they did not receive membership cards to prove their membership to providers (Alhassan 2016).

iii. INSUFFICIENT AVAILABILITY AND QUALITY OF CARE

Insured individuals will not seek care if health facilities and staff are not available, services and drugs not provided, or quality of care is inadequate. Insurers have a responsibility to contract with providers who can deliver the insured benefit package. However, access is often hampered because providers are not ready to treat an increased number of insured patients. This was the case in Ghana where low quality of care and lack of drugs covered by the NHIS has led to complaints among NHIS members. In addition, the lack of infrastructure and health staff causes longer waiting times and providers to charge fees above the reimbursement limit agreed with insurers. As a result, utilization rates remained low and OOP increased for the insured (Alhassan 2016). The small number of contracted providers in rural and low-income areas in Indonesia kept utilization rates low for subsidized low-income members. Poor quality of care in the public sector can cause patients to seek private sector care and pay out-of-pocket. JKN subscribers who work in the

private formal sector in Indonesia report lower utilization rates in JKN facilities as they can afford seeking better-quality care with private providers that are excluded from JKN coverage (HPP 2018). Similarly, in Georgia medical insurance did not improve utilization of care as quality of care remained inadequate (Bauhoff 2011).

iv. SKIMPING CARE

Providers may have a financial incentive to deliver substandard care to the insured. Most insurers reimburse health facilities by paying fees for services (FFS) provided. However, administratively, FFS is difficult to handle and can create adverse incentives. In India, delayed FFS reimbursement by the RSBY scheme to providers has led hospitals to refuse admission of RSBY members (Karan 2017). Ghana introduced capitation payment to providers in 2010. Capitation pays providers based on the number of individuals enrolled with them and independent of their care-seeking behavior. To keep their cost low, providers may have an incentive to skimp care on insured patients. Findings from Ghana suggest that capitation has negatively affected quality of care and increased the probability of referrals to other providers (Gyamfi 2016).

The above examples show that narrowly defined benefits packages, insufficient information, low levels of quality care and skimping behaviors by providers are all pitfalls that can cause low utilization and high out-of-pocket payments among individuals with insurance or public coverage. To prevent these pitfalls, insurers and public funds manage their membership, revenues and expenditures, which is the focus of the following chapter. The above country experience also highlights the importance of readying the provider-side to ensure that providers are prepared to deliver the contracted benefit package to a growing number of patients. Regular monitoring and evaluation of any coverage schemes will help identify and address issues that negatively affect financial sustainability and how well a scheme ensures financial protection to its members.



5. HOW PITFALLS HAVE BEEN MANAGED

Social health insurers and other coverage schemes are complex systems. If weak, they are simple disbursement agencies who transfer funds collected from government and households to the health sector at a high administrative cost. To prevent this fate, any coverage scheme in the public and private sector uses its management tools to avert and manage pitfalls. These “tools” include membership and revenue management, provider contracting and payment, benefits and insurance administration. A strong governance environment with political commitment to finance universal coverage is crucial for insurers to perform and contribute to policy objectives. Other factors that facilitate the performance of SHI include a higher level of population income which increases ability to pay contributions, and administrative capacity to manage funds.

5.1 MEMBER ENROLLMENT AND MANAGEMENT

Eliminating administrative barriers and information campaigns targeted to low-income groups are effective tools to increase enrollment. Information campaigns can be conducted through medias predominantly used by the poor such as the radio or community meetings. A client-centered approach in Ghana includes community education and participation, and increased autonomy for local NHIS offices to build relationships with members (Alhassan 2016). Member education about benefits covered under RSBY and their eligibility for RSBY coverage has been recommended in India (Karan 2017). In the Philippines, local government employees were instrumental in informing low-income households about their health insurance coverage (Bredenkamp 2017). Where available, technology - mobile phones and m-Health initiatives — are tools that can be used to inform members. The most effective intervention to

increase insurance enrolment by almost 30 percentage points among low-income informal sector groups in the Philippines was assistance with completion and submission of application forms (Capuno 2016).

Membership cards make it easier to access providers and treatment. In 2013, the NHIS in Ghana introduced biometric registration and instant issuance of membership cards to facilitate contribution collection and membership management (Alhassan 2016). The Vietnam Social Security is issuing electronic health insurance membership cards which includes member’s medical information¹⁵. In Taiwan, each member has an NHI card with a memory chip that stores personal information, including the past six visits to health care providers, diagnoses, prescriptions, and allergies; and public health and insurance data (Cheng 2015).

5.2 REVENUE MANAGEMENT

Governments finance a large share of SHI revenues from taxes to subsidize coverage. Governments, even in high-income countries increasingly use tax-funding to subsidize contribution payments and reduce payroll taxes to diminish labor cost. The French SHI for instance receives 64% of its revenues from payroll contributions, 16% are raised from a national earmarked income tax, 12% from taxes levied on tobacco and alcohol, the pharmaceutical industry, and voluntary health insurance companies, 2% from government subsidies, and 6% from transfers from other branches of Social Secu-

urity (Mossialos 2016). Switzerland and the Netherlands subsidize household contribution payments to compulsory private insurance for lower-income groups. The government of the Philippines increased the cigarette tax by 341% which led to a 114% increase in annual excise revenue. Of this extra excise revenue, 85% is used to subsidize insurance enrollment for 14 million low-income families with PhilHealth and to upgrade medical facilities (Goodchild 2016). Rwanda, Indonesia and Vietnam made insurance enrollment mandatory and subsidized enrollment for low-income groups.

Contribution evasion can be reduced by modernizing collection and tax-administration. To limit evasion, contribution payments should be cashless either through bank accounts or mobile money. In Rwanda, people can pay insurance contribution directly to the bank account of the RSSB at the local Bank, or through Mobile Money

payments. In Ethiopia, tax collectors (elected by villagers) collect voluntary CBHF contributions from members. Contribution compliance can be improved by strengthening administration and by tasking a single collection and enforcement agency with collection, such as the tax authorities or the social security institution.

5.3 PROVIDER CONTRACTING AND READINESS

Countries substantially invest in the provision of care to ensure providers are ready to deliver the benefit package. To strengthen availability and quality of care in Ghana, the focus has been on infrastructure expansion for accredited health facilities and improving material and human resource capacity to reduce workloads in health facilities (Alhassan 2016).

Insurers conduct member surveys and provider performance analysis to contract with providers. Insurers use claims data from providers to monitor and evaluate provider performance in contracted health facilities.

Results are used during contract negotiations with providers to negotiate for better quality and services, and in rate adjustments. Results from member surveys can support client-centered care in health facilities. Client Call Centers have been set up in Ghana for the insured to provide feedback on their experience with providers and help identify issues on the availability and quality of care. Results are shared with providers and the Ministry of Health, and can be used in contract negotiations, accreditation, and quality supervision.

5.4 PROVIDER PAYMENT

Mixed payment methods are used to manage expenditures. In most higher-income countries, there has been a shift away from FFS to risk-adjusted capitation for outpatient care. Hospitals are paid disease-specific payment (such as diagnoses related groups DRG) often within budget ceiling. Ghana pays by DRG. The Universal Coverage government scheme in Thailand has applied strict global budget constraints for hospitals to manage cost increases that can be triggered by DRG payments (Annear 2018). The NHIF in Kenya pays fee-for-service for inpatient and capitation for outpatient care (Munge 2015), which sets an incentive to treat patients in hospitals instead of outpatient settings. Capitation payment is being tested in Ghana (Depuur 2015). Vietnam’s SHI switched from fee-for-service to capitation payment for district hospitals which led to reduced hospital costs and drug expenditures, and an increased admission rate for uninsured patients who pay fee-for-service (Nguyen 2017).

Reliable information systems and technology facilitate data collection and payment. Insurers and providers have invested in data collection on patient diagnostics and treatment procedures, such as ICD-10 and CPT coding systems in hospitals, and in financial management systems to facilitate billing and financial transfers. The NHI in Taiwan has a strong IT system and all claims from providers to the insurer are filed and processed electronically (Cheng 2015). In India, smartcards have been used to reduce fraud and administrative costs related to patient verification and claims processing. Ghana plans to implement electronic patient health records for insured patients which will be linked to the financial management system (IFMIS) to prevent billing for services not provided.

5.5 BENEFITS MANAGEMENT AND SERVICE USE

Basic benefit packages with cost-effective treatment choices will help manage expenditures. Most basic packages cover preventive care, maternal and child health care and limited curative care. Formal sector members tend to have access to a more comprehensive package including in the private sector than subsidized member groups. Some countries identify in their health insurance law explicit criteria to define treatments covered in the benefit package. Such criteria can include cost-effectiveness, efficacy and equity. In Vietnam, the Ministry of Health defines the benefits package together with the Vietnam Social Security (VSS) and health providers. Clear criteria for what is covered have not been established but the benefit package is comprehensive and is currently being updated based on the health needs of the population and affordability. The Thai package is comprehensive for the poor and covers high-cost treatment like transplants (Bredenkamp 2015). Thailand uses a Health Intervention and Technology Assessment Program to decide which procedures, drugs and vaccines are included in the UCS benefit package and to negotiate for reduced prices. The Technology Assessment Program also serves to prioritize medicines to be included in the national list of essential medicines (Tangcharoensathien 2018).

Benefit packages are regularly revised to ensure access and include gatekeeper criteria to manage expenditures. The benefit package is determined by the financial resources available to SHI and needs to be revisited regularly. To manage expenditures some SHIs cover generics instead of higher-cost drugs. Ghana and Ethiopia both

have negative lists to identify the services not covered. In Rwanda the benefits package covers all services in the public sector for insured patients conditioned they follow the referral system. Insured members who seek care at a higher level without referral will not be covered. In Ghana it was recommended to narrow down a generous benefits package and introduce co-payments for members to manage expenditures and the financial sustainability of the health insurer (Alhassan 2016).

Utilization management can help control volume and manage cost. Utilization management aims to control the factors that contribute to growing health expenditures including excessive use of drugs or surgery, unnecessary intensive care and lack of care coordination between providers. Utilization management includes increased copayments, gatekeeper system, a cap on the benefit package, information campaigns to increase preventive service use, the use of generics over branded name drugs, and managing specific high-cost diseases-categories. Some insurers analyze their members burden of disease to identify and control cost-drivers. These management tools are commonly used in higher-income countries where universal coverage through health insurance has contributed to higher health expenditure. Similarly, in lower-income countries, national insurers could play a key role to support efficient health spending by promoting the use of generics and biosimilars and addressing supply shortages and delivery delays through more efficient procurement.

5.6 INSURANCE ADMINISTRATION AND GOVERNANCE ENVIRONMENT

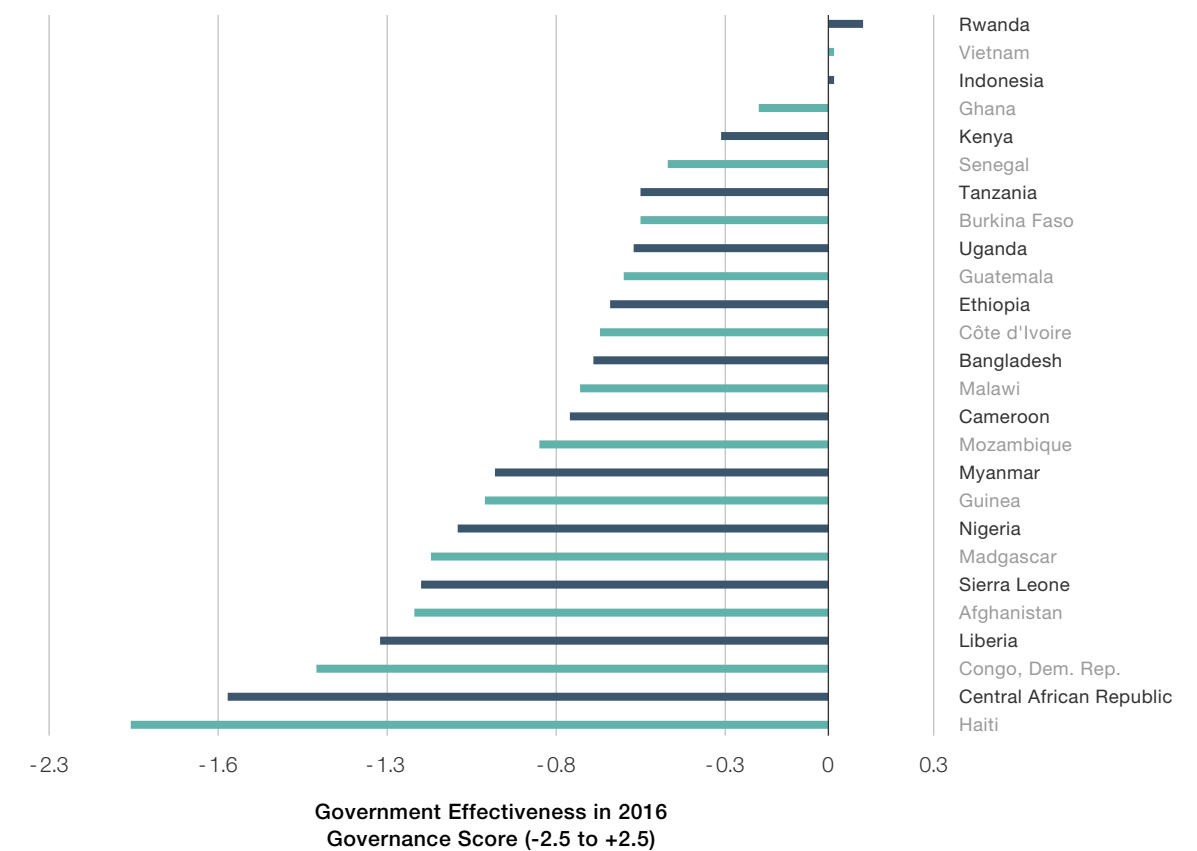
Efficient health insurance operation adds value greater than its costs. SHI adds costs to a health care system as it is an extra actor in the system. Any health insurer must thus design its operations to add value greater than its costs, and it must build efficient and effective operations with health providers. Several measures can help manage administrative expenditures. These include SHI adherence to standard business requirements in accounting, financing, and auditing; and standard-

izing insurance forms to simplify billing and payment to providers. Governments have set up supervisory authorities for health insurers who conduct solvency tests and annual audits, as well as consumer protection agencies for members to voice their complaints. Ghana recognized that political interferences could affect the effectiveness of the insurer and started to de-couple politics from routine management activities of the NHIS (Alhassan 2016).

Health insurers tend to perform better in GFF countries with higher government effectiveness. Some factors help SHI perform better including a large and growing formal sector. Strong economic growth and political commitment by the government matter too. Strong governance arrangements, political leadership for universal coverage, and mature health systems that can adjust to changing demand and rising costs were found to be enabling factors in countries with universal coverage (Reich 2016). In Rwanda, universal coverage through health insurance was achieved with strong political and ideological

support by the government (Chemouni 2018). Governments with a commitment in their health strategy to expand SHI coverage — among them Rwanda, Vietnam, Indonesia and Ghana, — have reached highest insurance coverage. These countries also score higher in government effectiveness as expressed by better quality public and civil service, more independence from political pressures, better policy formulation and implementation with stronger credibility of government commitment to such policies (figure 8).

FIGURE 8: GOVERNMENT EFFECTIVENESS SCORES IN COUNTRIES WITH GFF SUPPORT, 2016



Source: Kaufmann, Daniel, Kraay, Aart and Mastruzzi, Massimo, The Worldwide Governance Indicators: <http://info.worldbank.org/governance/wgi/index.aspx#reports>

6. CONCLUSION

One of the main lesson of this review is that SHIs in low-and middle-income contexts do not contribute a significant size of revenues through member contributions to the health sector, which may be disappointing for policy makers who expect to raise additional funds through SHI. This is because in most countries the formal sector is small and salaries relatively low which results in a limited contribution base. In addition, enrollment rates are low among informal sector populations who are difficult to tax, and among the poor who cannot afford paying contributions. As a result, health insurance contribution payments do not contribute a substantial part of health revenues and SHIs even in higher-income countries, rely on substantial government funding. This is also the case in GFF countries such as Ghana, where the VAT contributes about 70% of total SHI revenues. Tax-funding is essential to subsidize enrollment of low-income groups and guarantee a steady revenue stream for health insurance. Governments have increased taxes on unhealthy products such as tobacco, alcohol, and sugar to help subsidize insurance enrollment. Private insurers are being taxed too, including motor vehicle insurance.

The main difference in the features of mandatory insurers such as SHI, and government funded schemes is ownership, automatic or compulsory enrollment, and their revenue composition. Some countries including Thailand and Mexico have opted for government-financed schemes to cover lower-income groups, which requires continued political commitment and fiscal space to allocate the necessary health funding. The main difference in their features between these funds and SHI is their ownership, membership and contribution financing. Both systems use similar tools to manage their revenues and members, contract and pay providers, and administer benefits. Depending on how they are governed, managed and funded, SHI and tax-funded systems can be equally effective in improving financial protection for their populations.

Investing in health facility infrastructure, staffing, medical products and pharmaceuticals are prerequisites to ensure providers are effective partners. Accredited health facilities must be available to deliver quality services to insured and uninsured patients. Regular provider performance analysis can be used to inform providers and exclude lower-quality providers from contracts. The Ministry of Health plays an important role in quality assurance and delivering a mature health system that can adjust to changing demand and increasing costs.

Health insurance are complex systems to manage. Insurers in Rwanda, Vietnam and Indonesia cover a large share of the population. These countries also report higher government effectiveness as measured by the governance score, including reliable insurance supervision and legislation, political commitment and effective management. Effective insurance coverage requires reliable management of benefits and expenditures, and partnership, with providers such that members will benefit. Professional insurance managers are essential for success, and political interference must be avoided. IT systems ensure connectivity with providers and members, financial management, and data collection. Better data will allow insurers to conduct regular financial and performance analysis and use results in contracting with providers, revenue management and rate setting, and in adjusting the benefits package. Because of their complexity, new health financing systems take time to design and implement, and regular analyses and adjustments are needed to continuously strengthen system effectiveness.



ANNEX

ANNEX TABLE 1: COUNTRIES SUPPORTED BY THE GFF 2015

COUNTRIES SUPPORTED BY GFF	SHI	% POP COVERED	SHI AS % OF THE*	CHI AS % OF THE**	GFA AS % OF THE***	SHI IN COUNTRY'S HEALTH STRATEGY?
Rwanda	Yes	87.6%	3%	9%	40%	Yes
Vietnam	Yes	80.0%				Yes ¹⁶
Indonesia	Yes	75%	14%	14%	18%	Yes ¹⁷
Tanzania	Yes	27%	7%	7%	40%	Yes
Senegal	Yes	25-30%	3%	3%	40%	n/a
Guatemala	Yes	17%	16%	16%	18%	No
Kenya	Yes	14%	4%	4%	35%	Yes ¹⁸
Ethiopia	Yes	7.5%	0%	0%	33%	Yes ¹⁹
Nigeria	Yes	4-6%	1%	1%	18%	Yes ²⁰
Burkina Faso	Yes	0%	0%	0%	53%	No ²¹
Afghanistan	No					
Bangladesh	No					
Cameroon	No					
Côte d'Ivoire	No					
Central African Rep	No					
DRC	No					
Guinea	No					
Haiti	No					
Liberia	No					
Mozambique	No					
Madagascar	No					
Malawi	No					
Myanmar	No					
Sierra Leone	No					
Uganda	No					

Source: WHO Global Health Expenditure Database.

Note: * Social Health Insurance (SHI) in % of Total Health Expenditure (THE);
 ** Compulsory Health Insurance (CHI) in % of Total Health Expenditure (THE);
 *** Government Financing in % of Total Health Expenditure (THE).

¹⁶ [http://www.euhf.vn/upload/Strategic%20documents/82.%20MOH%205-year%20plan%20\(Eng\).pdf](http://www.euhf.vn/upload/Strategic%20documents/82.%20MOH%205-year%20plan%20(Eng).pdf)

¹⁷ https://health.bmz.de/events/In_focus/Indonesia_roadmap_to_universal_health_coverage/THE_BRIEF_EDITION_Roadmap_toward_INA_Medicare.pdf

¹⁸ <http://www.health.go.ke/wp-content/uploads/2016/03/MINISTERIAL-STRATEGIC-INVESTMENT-PLAN.pdf>

¹⁹ http://www.nationalplanningcycles.org/sites/default/files/planning_cycle_repository/nigeria/draft_nigeria_national_health_policy_final_december_fmoh_edited.pdf

²⁰ http://www.nationalplanningcycles.org/sites/default/files/planning_cycle_repository/nigeria/draft_nigeria_national_health_policy_final_december_fmoh_edited.pdf

²¹ https://www.light-for-the-world.org/sites/lfdw_org/files/download_files/country_strategy_buf_2016_2020_en.pdf



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