Support to the Health, Nutrition and Population Sector Programme in Bangladesh

BMZ-No.: 2003 66 237 / 2005 70 424

Component A:

Health Financing Component

Institutional Options for National Health Security Office (NHSO)

February 2012

Presented to:

Ministry of Health and Family Welfare
Health Economics Unit
Dhaka-1215
Bangladesh

KfW Entwicklungsbank
Abt. L I b
Palmengartenstr. 5-9
60325 Frankfurt am Main
Germany

Institutional Options for National Health Security Office (NHSO)

January 2012

Axel Weber

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List of Acronyms

DSK	DushthaShastha Kendra
GB	Grameen Bank
GK	GrameenKalya
HEU	Health Economics Unit
MHI	Micro Health Insurance
MHIB	Micro Health Insurance Bangladesh
MoHFW	Ministy of Health and Family Welfare
MSW	Ministry of Social Welfare
NHSO	National Health Security Office
SBC	ShadhoranBima Corporation
SSK	ShastyoShuroksha Karmasuchi
WEEH	Womens Empowerment and Health
WHO	World Health Organization

I. Introduction

Under the leadership of HEU/ MoHFW discussions have been conducted with key stakeholders and policy makers in Bangladesh for the identification, design and implementation of a health financing pilot in selected areas. It has been agreed that the ultimate aim of the project is to create a national health insurance scheme to be known as ShastyoShuroksha Karmasuchi (SSK: Health Protection Scheme).

The objective of the health financing pilot will be to investigate new sources of financing for the health care system in Bangladesh. Such sources may include health insurance premiums, equitable use of out-of-pocket expenditures, incorporating community financing schemes, charitable contributions, corporate social responsibility, social payroll insurance and transparent and equitable service fees. The pilot will also test mechanisms (Results Based Financing) as a tool to improve the quality of health services and increase demand as well as supply.

German Financial Co-operation with Bangladesh, through KfW Entwicklungsbank, provides support to the Health Nutrition and Population Sector Programme (HNPSP, 2005-2011) of the Ministry of Health and Family Welfare (MoHFW).

Following an international tender for consulting services, the German company GFA Consulting Group was selected to provide consulting services to the Health Economics Unit (HEU) of the MoHFW in the area of health financing.

After discussion with counterparts, the strategy adopted was to consult with national experts to get input to the design of a national health insurance scheme specifically tailored to the needs of Bangladesh. Based on this expert input, the GFA/ HEU Team will support the MoHFW in conducting a pilot in a controlled setting, aimed at testing essential features of a health protection scheme in order to determine whether the approach is feasible for scale up to a national scheme throughout the country, to ultimately cover all 150 million citizens of Bangladesh.

Throughout the developed and developing world there is recognition that a well designed national health insurance scheme, customised to be consistent with local cultural and socio-economic conditions, has the potential to improve the health of citizens, provide much needed additional funding for the health sector, and contribute in the long term to increased national productivity that promotes economic growth and prosperity.

II. Background: Institutions in Bangladesh

In Bangladesh there is no provision for health insurance schemes by the public sector and there is little in the way of private insurance. Health services, which are accessible to all, are however heavily subsidized by the Government. Public sector workers receive a small medical allowance as part of their salary but rely primarily on their savings to finance any expenditure on health care.

To address the absence of formal health insurance schemes for the poor, NGOs have developed and operate a number of micro-insurance health (MHI) schemes that target the poor. Though micro-insurance is a relatively new concept in Bangladesh, it has experienced steady growth since its commencement in 1993. MHI can be defined as a type of health insurance designed to enable access to health services by individuals and families through

affordable premiums and low prices for health services. Almost all the schemes are run in tandem with micro-credit schemes and several also include a life insurance/ savings component. Table 1 provides some summary information on the 10 of the larger schemes[1].

Table 1: Micro Health Insurance Schemes

Program	Institution/Agency	Beneficiaries*	Expenditure** (Tk. millions)
Micro Health Insurance Bangladesh (MHIB)	BRAC	33,175	0.4
Micro Health Insurance (MHI)	GrameenKalyan	230,000	2.0
Life & Micro Health Insurance Schemes	DusthaShasthoKendro (DSK)	180,000	0.03
Micro Insurance/ Emergency Fund	Integrated Development Foundation (IDF)	180,000	1.9
Customers' Security Fund	BURO Tangail	106,103	0.3
Beneficiaries Life Insurance	Society for Social Services (SSS)	502,500	0.6
Sajida Health	Sajida Foundation	50,035	8.3
Providing Primary health care service	MSW	74,108	11.1
ApatkalinTahbil	Community Development centre (CODEC)	16,105	0.4
ApatkalinTahbil	Banaful	21,830	0.05
Total		1,393,856	25

* Figures give total number of scheme members. The number of contributors is much lower as membership is generally for the whole household.** In several cases, these are estimated figures based on average contribution and number of beneficiaries. Source: ILO (2003), Micro Insurers: Inventory of Micro Insurance Scheme in Bangladesh. Numbers may have changed.

Micro-Health Insurance Bangladesh (MHIB) was initiated by BRAC in November 2001. The objective of this project is to contribute to the empowerment and improvement of the wellbeing of the poor women and their families by promoting access to quality health care through an affordable micro-insurance initiative. The project is designed for achieving three primary goals: a. contributing to woman's empowerment, b. increasing access to BRAC's health care initiatives for poor women and their families, and c. increasing awareness of preventive healthcare system. The target of the project is to cover persons of various occupations (subsistence agriculture, animal husbandry, fishing, trade and crafts etc) in the 573 villages in which BRAC operates. The project provides scheme members with primary health and pathological services. The scheme is operated with technical assistance/ co-operation from the ILO-STEP as part of their Women's Empowerment through Employment

[1] Schemes providing only life insurance, i.e. without health cover, have been excluded.

and Health (WEEH) project to empower income-poor women in Bangladesh. Details of the program are contained in the following Table.

Table 2: BRAC Micro-Insurance Program

Package	Benefits	Yearly contributions	No. of Beneficiaries
Health care: general benefit package	Discount prices for consultation: Tk, 8 for members (Tk. 10 for non-members) 50% discount on normal deliveries 10% discount on medicines Free yearly health check up Coverage of referral costs: Tk. 500 to Tk. 1,000 (Ultra poor my benefit from same services without having to pay a premium)	Tk. 100 for a family up to 6 persons (Tk. 250 for non-member) Tk. 150 for a family up to 8 persons (Tk. 300 for non-member) Tk. 200 for a family of more than 8 persons (Tk. 350 for a non-member)	30,625 (6,125 families) + 1,085 (217 families) covered without premium under the ultra-poor program.
Health care: pregnancy related care package	ANC check-up at BRAC mobile/satellite clinic Monthly supply of iron tablets and folic acid Provision of Safe Delivery Kit for home delivery Support for pre-delivery complications (miscarriage, bleeding) Normal delivery Support for post-delivery complications (post-partum haemorrhage, fever) Support in the event that newborn babies suffer from diarrhoea or pneumonia within 28 days of birth	Tk. 50 for a member Tk. 70 for a non-member	1,465 women

Source: ILO (2003), Micro Insurers: Inventory of Micro Insurance Scheme in Bangladesh. Details may have changed meanwhile.

Grameen Bank (GB)[2] initiated the "Micro Health Insurance" (MHI) program in 1997. The program is operated by GrameenKalyan (GK)[3], which is a member of the Grameen Family. The project was intended to provide primary health care services to GB members who are involved in various occupations including subsistence agriculture, animal husbandry, fishing, trade and crafts as well as other poor living within its operational areas at an affordable cost. The priority areas of the scheme are preventive and promotional health care services with special emphasis on family planning and reproductive, internal and child health care. Details are given in Table 3.

[2]http://www.grameenhealth.org/about.html

[3]http://healthmarketinnovations.org/program/grameen-kalyan-health-program

Table 3: Grameen Bank Micro-Insurance Program

Package	Benefits	Yearly contributions	No. of Beneficiaries
Primary health	Tk. 5 for Doctor/paramedic consultations-for members. Normal pathological tests at 30-50% discount. Referred consultations at 50% discount. Up to Tk. 1,000 provision for hospitalisation. Free annual check-up for head of family. Free immunization for six diseases. Free house visit by female health assistants. Free yearly medical check-up for 'head of the family'.	Yearly Tk. 120 for Grameen Bank members. Yearly Tk. 150 for non-Grameen Bank members.	230,000
School Health Card	Health awareness and regular check-ups Tk. 2 for prescriptions	Tk. 10	Data not available
Safe Motherhood	Pre and post natal care Family advice	Tk. 500-1,000	

Source: ILO (2003), Micro Insurers: Inventory of Micro Insurance Scheme in Bangladesh.

DushthaShastha Kendra (DSK)[4] started life and micro health and livestock insurance schemes in 1995 with a view to provide supports for primary health care especially for woman and children. The schemes are targeted to poor, landless, and marginal farmers - low income groups within both the informal and formal economy.

Table 4: DSK Micro Health Insurance Program

Package	Benefits	Yearly contribution	No. of Beneficiaries
Health	Consultation at subsidized rates. Essential drugs at 50% discount. Hospitalisation up to 25% discount. Awareness building and training	2.5 % of micro-credit loan (yearly)	180,000
Life	In case of death of policyholder, the outstanding loan amount is written off and nominee receives amount of already paid back loan.	1% of micro-credit loan (yearly)	45,000 (99% women)

Source: ILO (2003), Micro Insurers: Inventory of Micro Insurance Scheme in Bangladesh.

Furthermore, various innovative initiatives are being considered and piloted by various DPs. Those that need further investigation as support for, and possible inclusion in, the planned health insurance pilot are the WHO supported maternal voucher schemes, the contracting out approach of the Urban Primary Health Care Pilot, the service delivery model used by the Smiling Sun Primary Health Care Franchises, the proposed social health insurance scheme supported by Ban-HFS and WHO (that is currently on hold), the Population Council demand side financing pilot and the planned World Bank sponsored social protection programs.

In total, health insurance plan do not cover even 10% of the population in Bangladesh. The public health financing scheme on the other side is hampered by serious quality and financing problems:

[4] http://www.dskbangladesh.org/

- There are frequent under the table payments though officially there are no fees;
- There is a problem with absenteeism of staff and lack of material;
- The public financing is too little and moreover reduced stepwise.

All this leads to the political will to put health care financing on an equitable and stable footing that provides access to care to all.

Given the fact that the Bangladesh Government is not in the position to provide the necessary financing for such a plan, new sources have to be explored. One model that is gaining support is a national health insurance plan. However, to prove the feasibility of such a plan, a pilot study is envisaged. For the plan and for the pilot phase the present concept paper is providing the basics.

III. Objectives and methodology

The Objective of the study is to provide an overview of required institutional options for the National Health Security Office to enable and support pilot activities.

The purpose is to

- Explore institutional options for designing the National Health Security Office
- Examine and assess the explored institutional options with particular regard to the Bangladesh context: financial and administrative sustainability, corporate governance, etc
- Propose model of up-scaling from pilot-implementation to national roll-out
- Explore and discuss strengths, weaknesses, opportunities and threats of developed options
- Take international experience into consideration, e.g. from India and Thailand

IV. Limitations, Risks and Assumptions

Assumptions(and at the same time limitations and risks) of this paper are:

- The political will to enable certain institutions to take over tasks in a possible NHSO;
- Sufficient knowledge about the technical capabilities of all the institutions;
- A general interest in risk sharing and new health care financing mechanisms;
- Public acceptance of proposed institutions;
- Common understanding of terms and concepts.

It seems that to a certain extend terms like health insurance, risk sharing and purchaser-provider split are used as synonyms, which is not the case.

Special risks in case of health insurance models are:

- Negative risk selection (which is a serious design mistake);
- Enforcement of contribution collection;
- Moral hazard (abuse) by providers as well as patients;

V. Institutional Options for NHSO

A. Institutional Background

1. Objective

The objective is to develop and select an institutional setting that allows an effective and efficient management of the NHSO.

2. Option 1: To Establish a New Entity

This basically would mean to start from the scratch. It involves:

- To hire or purchase office buildings;
- To create an infrastructure;
- To select, hire and train staff;
- To create a new image;
- To establish office rules and regulations;

3. Option 2: To Run a Call for Tender

This would mean that an existing institution is elected to take over the task of NHSO. HEU or another Unit is developing tender documents including TOR and selection criteria and runs a call for tender. Among the applying institutions the one with the best score is selected. The selection may be valid just for the pilot and may be extended to the whole nation later on. The Question that arise are:

- Who runs the call for tender?
- Who selects the applicant?
- What will be the legal procedure to install the new institution?
- What are the selection criteria?

The call for tender could be run by the MoHFW. Technical tasks could be outsourced to HEU.

The politically more interesting question is who selects the candidate. There again are several options:

- MOHFW or another Ministry;
- Parliament;
- A multi-ministerial task force;
- A committee composed of political stakeholders (civil and public representatives)

Suggested selection criteria are for example:

- An existing nationwide network of offices;
- Experience with financial products, best would be insurance background;
- Solvency;
- Legal background;
- Public reputation;

4. Option 3: APublic Institution

Possible candidates are:

- A public pension institution;
- A public insurance company;
- A public bank;

The vast majority of old age people have no old age income, except those who are supported by own families. To partly alleviate the situation, as of 1998, Old Age Allowance Program under MSW was introduced. Under the program the elderly persons incapable of physical work and the destitute women are receiving an allowance from the government on monthly basis. In 2004-05, 2603.7 million taka were provided to 1,315,000 old aged persons. The allowance is given to 10 old persons (5 male and 5 female) of each ward of a union all over the country. The old age pension scheme is implemented in the rural areas of all upazilas at union level and for all wards of the municipalities of the 64 districts of the country. The Ministry of Social Welfare of the government shoulders the responsibility of the scheme.

The banking system of Bangladesh is dominated by the 4 Nationalized Commercial Banks of which 3 are totally controlled by government and 1 (Rupali Bank) bank is controlled by both government and private sector. Together they control more than 54% of deposits and operated 3388 branches (54% of the total) as of December 31, 2004. The nationalized commercial banks are:

Nationalized Commercial Bank of Bangladesh:

- Sonali Bank
- Agrani Bank
- Rupali Bank
- Janata Bank

The Insurance Market in Bangladesh consists of two state-owned corporations, forty three and seventeen private sector general & life insurance companies respectively, a total of 62 insurance companies. Thus the insurance sector in Bangladesh has grown up substantially and deepened remarkably with number of companies in both life and general segments.

SBC[5], the state owned general insurance company, is entitled to 50% of public sector business. Insurance Corporation (Amendment) Act 1990 provides that fifty percent of all insurance business relating to any public property or to any risk or liability appertaining to any public property shall be placed with the SBC and the remaining fifty percent of such business may be placed with this corporation or with any other insurers in Bangladesh. But for practical reason and in agreement with the Insurance Association of Bangladesh SBC underwrites all the public sector business and 50% of that business is distributed among the existing 43 private general insurance companies equally under National Co-insurance Scheme.

5. Option 4: Existing Social Insurance

In Bangladesh, the only formal pension scheme is for public sector employees. The pension issues are governed according to the rules of the Public Servants (Retirement) Act of 1974. There are four categories of pensions.

[5] See http://www.sbc.gov.bd/current_market.php

MSW also has an old age allowance program. The program provides old age allowances to the 10 oldest poor persons, at least five of whom must be women, from each ward (comprising of three villages) of every Union Parishad at the rate of monthly Tk. 125 per person. About Tk. 749.5 million was distributed in 2002-2003 as allowances for 499,662 old and helpless people as against the target of 500,000 people. This program has been highly appreciated for extending social services in the rural areas. During 2003-2004, the number of beneficiaries increased to 1 million with a higher rate of allowances of Tk. 150 per person.

Available information on these schemes is summarized in Table 5.

Table 5: Pensions and Assistance to the Poor Elderly (data from 2003)

Program	Institution/ Agency	Beneficiaries (Number)	Expenditure (Tk Million)
Pensions and family pensions for the retired government/semi-government employees	Ministry of Finance	179,886	8,802.0
Medical Allowances to pensioners	Ministry of Finance	179,886	800.0
Old age allowance	MSW	499,662	749.5

Source: Ministry of Finance: Budget Database

6. Option 5: A Private Insurance Company

There are several health and non-health private insurance companies in Bangladesh. However, there are just a few with a nation-wide network.The privatization policy adopted in the 1980s paved the way for a number of insurersto emerge in the private sector. This resulted in a substantial growth of premiumincomes, competition, improvement in services, and introduction of newer types of business in wider fields hitherto untapped.Up to 2011, the government has given permission to more than 20 general insurance companiesand over 10 life insurance companies in the private sector. Insurers of the country nowconduct almost all types of general and life insurance, except crop insurance andexport credit guarantee insurance, which are available only with the ShadharanBimaCorporation (SBC).[6]

7. Option 6: A Private Bank

There are several large private Banks with nationwide networks in Bangladesh. Private banks are the highest growth sector due to the dismal performances of government banks (above). They tend to offer better service and products. Some examples are:

- United Commercial Bank Limited
- Mutual Trust Bank Limited
- BRAC Bank Limited
- Eastern Bank Limited
- Dutch Bangla Bank Limited
- Dhaka Bank Limited
- Islami Bank Bangladesh Ltd
- Uttara Bank Limited

[6] See http://www.scribd.com/doc/20131763/overall-insurance-company%E2%80%99s-problems-and-prospects-in-Bangladesh

- Pubali Bank Limited

8. Option 7: A Micro Insurance Network

In 1980, Grameen Bank of Bangladesh started lendingto poor people without collateral security, therebyrevolutionising finance and banking. Inspired by thisscheme, a lifeinsurance company – Green Delta of Bangladesh– came forward in 1988 to providefinancial security to the poor in the formof microinsurance at a small amount ofmonthly premium.After its introduction in Bangladesh, microinsurance spread among other lifeinsurance companies at a rapid pace. Todate, almost every life insurance companyin Bangladesh operates at least more thanone microinsurance project. For eight life insurance companies,more than 50% of premium income comes from microinsurance. For others, microinsurance constitutes anaverage of 30% of total premium income premium.In 2008, about two million new policies were soldunder microinsurance, compared to a million under ordinaryindividual life. Total microinsurance premiums in2008 amounted to around half of ordinary and other lifepremiums.For the last few years, microinsurance portfolio of differentcompanies have grown at an average rate of morethan 20% per annum. This spectacular growth of microinsurancein such a short period reflects the necessity andacceptability of microinsurance among the masses in thecountry. Given that this trend is expected to continue inthe years to come, premium income under the microinsuranceportfolio will likely overtake ordinary life premiumin about five years' time.

9. Option 8: Post offices

Bangladesh Post office is a govt. owned department dedicated to provide wide range of postal and banking products and public services. It is the premier national postal communication service holding together a vast country with a large population. It has a large network of outlets. Like in other countries, it would be a good candidate to collect contributions and to provide basic claimsprocessing.

10. Option 9: Mobile Phone Networks

Bangladesh has various nation wide operating mobile phone companies: Aktel, Banglalink, Citycell, Grameen Phone, Teletalk, Warid Telecom. Mobile phone networks in other countries are use to administer health insurance. Kenya was the first country in the world to use mobile phones for cash transfers. The service, called M-PESA, was developed by Safaricom Limited. Other countries use mobile phones for contribution collection.

11. Option 10: A Competitive System

One alternative that can for example be found in Colombia is a competitive system incorporating a number of different public and private carriers.

It is composed of a public accreditation and supervision authority, which at the same time could collect the contributions (which is not absolutely necessary), and a number of companies that ally to be part of the network. These companies, like the public pension fund, public and private insurance, banks etc. have to comply with certain minimum standards concerning benefits, contributions and membership, and otherwise can have their own packages.

In case there is compulsory membership and compulsory contribution payment according to affordability, there may be a need to leave these two tasks to the public umbrella institutions. However, it may be enough to prove that one is member of one of the participating companies.

12. Evaluations of Alternatives

The following Table 6 evaluates the different options according to various criteria. It can be seen that private insurance companies and especially micron insurance companies achieve the best scoring. It is evident that weakness of private insurance companies is the poverty orientation and the administration costs, which include profit margins.

Table 6: Evaluation of Options

	Professionality	Client Orientation	Independency	Technical Capacity	Regional Presence	Admin Costs	Poverty Orientation	Average Score
Public Entity	3	3	4	3	2	2	2	2,7
Public Pension Fund	2	3	3	3	3	2	2	2,6
Private Insurance	1	2	1	1	2	3	3	1,9
Private Bank	1	2	1	3	2	3	3	2,1
Micro Insurance	2	2	1	2	2	1	1	1,6
Post Offices	2	2	3	3	1	2	2	2,1
Mobule Phone Network	1	2	1	3	3	2	2	2
Excellent	1							
Good	2							
Regular	3							
Not Sufficient	4							

B. Alternative Approaches

The existing alternatives are summarized in the following table.

Table 7: Summary Table

	Centralized Structure	Competitive Structure
Compulsory	The advantage is that a public institution can exercise force easier, which would be an advantage for universal coverage.	Problem might be how to organize compulsory structure with private companies.
Voluntary	Voluntary membership has a problem with negative risk selection and social redistribution (contributions according to affordability).	A competitive market is easier to implement with voluntary membership, but this has a problem with negative risk selection and coverage.

One key question is whether the NHSO acts as a regulating body or as insurance. The following table shows advantages and disadvantages of both approaches.

Table 8: Pro and Con of Institutional Options

	Pro	***Con***
NHSO Regulating Body	It leaves space for a variety of choices and options for consumers as the system could be competitive. Les power would be concentrated in one hand.	The NHSO has less influence on the service and the quality.
NHSO Insurance Fund	Uniform quality and service standards.	Too much power in one hand. No pressure through competition. No choice for consumers.

Finally, the question is, whether NHSO should be self-governed or a branch of the state administration. The following SWOT analysis evaluates the options.

Table 9: SWOT Analysis of Self-Governed NHSO

Strengths	**Weaknesses**
Independent and self-responsible unit. Less affected by political considerations. No financial dependency from general budget.	Higher administration costs.
Opportunities	**Threats**
Political independency and own development chances.	Corruption.

Table 10: SWOT Analysis of State-Run NHSO

Strengths	**Weaknesses**
Low administration costs.	Mismatch with public finance and budget. Influenced by political considerations.
Opportunities	**Threats**
The Government will feel more responsible for the insurance.	Exploitation by public budget.

C. Management Options

The NHSO could be managed by several alternative bodies:

- By the Board and management of the selected hosting company;
- By an own management structure, which could be composed of public representatives, private representatives of insured and/or employers or selected third party professional managers.
- ILO suggests a tripartite management for social security institutions composed of representatives of the state, employers and employees.

The key question is whether the NHSO is self-governed or directly or indirectly run by the state. Self-governed means to have a certain independence from the Government, whereas a state-run or semi-state institution is more or less governed by the state.

Many countries have made good experience with self-governed institutions.

D. Supervision

In most countries, self-governed and even semi-public social insurance bodies are subject to supervision concerning conformity with the law, correctness, and even sometimes concerning efficiency and effectiveness. Supervision mostly refers to conformity with the law. Efficiency and effectiveness is a qualitative monitoring and auditing area.

In most countries monitoring and auditing is done by independent auditors, whereas supervision is done by a public agency, mostly a special supervisory agency or a ministry.

Table 11: Supervisory Activities

Legal Character	*Task*	*Institution*	*Frequency*
Public	Supervision	Authority	Permanent
Private or public	Monitoring, evaluation	Consulting Firm	Irregularly
Private or public	Auditing	Auditor	Annually

E. The Role of HEU

The existing structure, especially the HEU should have a role in the planned system. Optional tasks could be:

- HEU could become the agency that checks the qualification of candidates (institutions) and gives accreditations.
- HEU could become the managing unit of a centralized organization (not recommended).
- HEU could become the supervising agency.

F. Information and Communication

It will be important to accompany the introduction of a new scheme with a broad communication and information strategy in order to create awareness. Target would be:

- Possible candidates to manage the health insurance;
- Decision makers like Parliament and Public and Private stakeholders;
- Employers and trade unions;
- The public.

G. Legal Background

A health insurance needs a legal basis. Basically there are two options:

- A constitution can be elaborated, which will be the basis of the governance of the health insurance scheme. This constitution may be based on existing insurance legislation.
- A separate health insurance law can be enacted governing the health insurance.

Key issues that have to be regulated are:

- Contribution collection;
- Contribution utilization (for benefit package only plus x% for admin)
- Membership rules;
- Provider contracting and provider payment;

- Administration of the scheme.

Especially compulsory membership, compulsory contributions and contracting of public providers need a legal basis. They cannot be regulated by corporate rules.

H. Financing Sources

Financing is an issue that affects sustainability as well as political influence and stability. Main financing sources of a possible health insurance scheme are:

- Public funds, which mainly can be used to subsidize the poor;
- Contributions from employees, employers and self-employed; This is the main financing source of a social health insurance;
- Grants and loans from development partners. These mainly can be used to set up the scheme and to develop capacity and infrastructure. They are less suitable for permanent financing as this raises an issue of sustainability.

Table 12: Funding

	Use of Funds	***Character***
Public Funds	To subsidize the poor	Regular
Contributions	Regular funding	Regular
Development partners	Institutional development	Exceptional

VI. Suggested Inputs by Development Cooperation

KFW plans to support the start-up of the scheme with a grant of 8 Million Euro input. Possible use of these funds can be:

- Expertise to design the scheme;
- Investment in capacity building and office infrastructure;
- IT (software, smart card)
- Monitoring and evaluation.

VII. Conclusions: Further Proceeding

Further steps in the first place imply some decisions:

1. The decision how to stabilize the financing of health care. Our opinion is that financing in future should rely less on public funds and more on risk sharing. In this context it should be known that **risk sharing does not automatically mean provider – purchaser split**, but rather a way to organize solidarity (mutual support)
2. The second decision is about the model of risk sharing and financing that is chosen. Our preferred suggestion will be described below.
3. The third decision is about if, where and how to pilot the preferred model, in case a pilot is regarded as being desirable.

If the decision is taken, and even during the decision process, we suggest an implementation study. This study has to answer some core questions, like:

   a. The study has to find answers to the question whowill have the various functions.It has to be defined who manages, who controls the health plan and

how. What is the role of the Parliament? A law on health financing has to be passed by the Parliament and the Parliament approves the budget.

b. Attributes – what will the health financing plan be obliged to do and what not?
c. Legal basis (best practices from other countries)
d. What is the role of Competition & Efficiency?
e. Who exercises cost control and how?
f. Financial management – accounting framework?
g. Provider monitoring and quality control. Consequences in case of bad performance
h. Reporting requirements
i. External audits
j. Use of IT Systems and link to national health information system.
k. Avoid fraud and corruption

VIII. Recommendations

In summary and after evaluating the options, we think that the following conclusions and recommendations are valid:

1. We prefer a competitive over a centralized system. This has the advantage that people have the choice[7], that we have a broader nationwide coverage, that we have incentives to provide a good service and that we avoid the problem to chose one out of various partners that may be interested.
2. We suggest a strong supervisory and accrediting agency, the nucleus of which could be HEU.
3. We suggest to gradually transferring the existing public fund in the system into a subsidy for the poor, which may get the form of a contribution payment by the state for people who pass a means test.
4. We suggest elaborating a health insurance law and not leave the legal basis to a form of constitution.
5. We suggest to conduct a thorough technical implementation study or at least to use planned or existing studies to incorporate them into a comprehensive concept study.

[7] This is not an advantage for everybody, particularly not for the illiterates and uneducated parts of population if no special communication methods are implemented, like picture flyers etc.

IX. Annex: TOR for NHSO

The following list shows TOR for the NHSO in case it is a regulating body.

- Issuance of directives concerning accounting standards, quality standards.
- Accreditation of insurance institutions and local offices.
- Monitoring of insurance providers.
- Approval of contribution rates and tariffs.
- Registration on insured including membership with one of the competitors.
- Regulation of the market in terms of ensuring regional presence, call for tenders of local representations.
- Approval of annual accounts.
- Grievance procedures for insured.