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Extending health care coverage in social security systems

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Introduction

The participants in this Regional Social Security Forum are mainly directors of social security systems, most of which have not yet introduced health care benefits. Considerations to introduce health care benefits are however undertaken in numerous countries, and provide a great challenge in the current reforms or changes that are underway in the social security systems in Africa.

The major issues are covered by reviewing the following questions:

1. Is health care important?
2. What is the added value of health care in a social security system?
3. Why has health care not been integrated into social security systems so far?
4. What are the options for increasing funding for health care?
5. What has happened in the meantime?
6. How can we proceed?

1. Is health care important?

There is no question that health is important - to the individual, the family, the community, the nation and at global level. Social security systems recognize the concept of entitlement to a benefit "in his or her own right". In the absence of a mechanism to protect the health of the individual, we see the lack of this right already at the individual and family levels. A parent may forgo seeking care in favour of medical attention of a child, or an elderly dependent parent. Yet at national level, we find incompatibility in the importance given to health and the resources allocated to protecting health.

At global level, there is tremendous concern when an infectious disease emerges - or re-emerges - to become a threat beyond the national borders, as we have seen with the attention and resources given during the recent SARS (Severe acute respiratory syndrome) and Avian flu crises. Through the large international donors such as the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and the Bill Gates Foundation, millions of dollars are available to prevent the spread of HIV/AIDS, malaria and tuberculosis - all infectious diseases which spread beyond borders through global activities. In Africa, more women die as a result of complications of pregnancy and childbirth than from these three diseases but far from enough funds are allocated by international and national sources to deal with pregnancy and childbirth - which do not pose threats beyond borders.
Coming back to the regional context, health status and the health care systems in Africa are significantly behind the rest of the world. Life expectancy is lowest in countries in the African continent. In a list of estimated years of life expectancy prepared by the CIA Government Library for 2008, the last 38 countries are in sub-Saharan Africa. Four of these countries have a life expectancy of less than 40 years, and another 20 have life expectancies between 40 and 50 years. At the other end of this spectrum, 20 countries, including Japan, Singapore, Canada

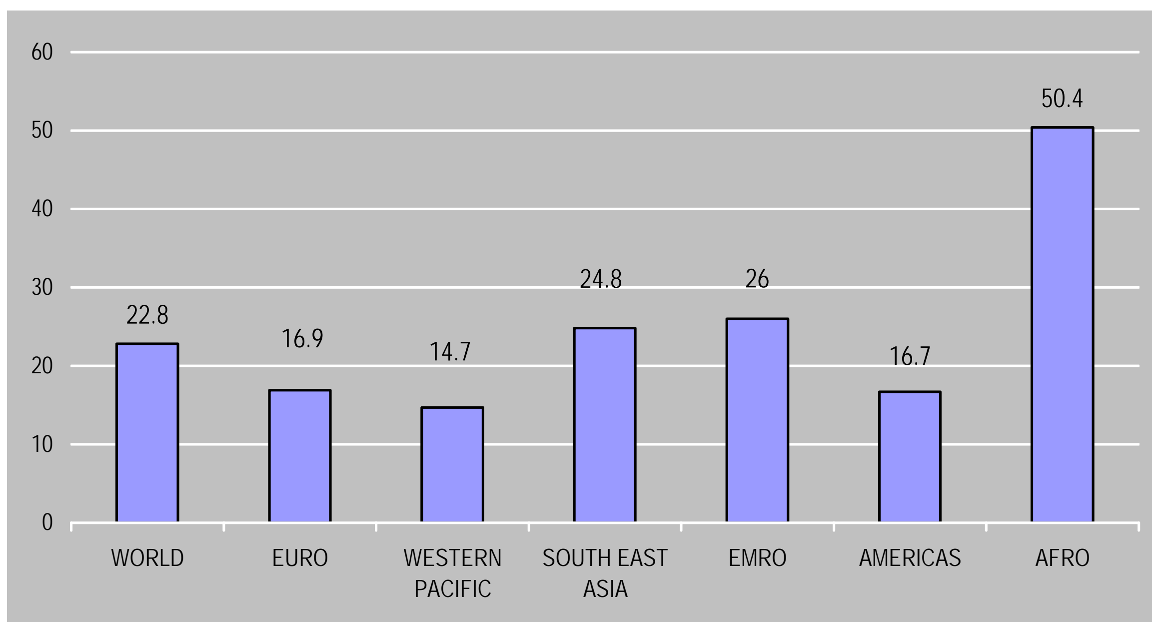
and France, have life expectancies of between 80 and 83 years, which is 30 to 40 years longer than in most African countries.

A more significant indicator for us is the DALY - Disability Adjusted Life Years. This is a health gap measure, representing years lost due to premature mortality and to years of disability due to disease. The total years lost therefore reflects the productive and healthy years lost due to disease. One DALY represents the loss of one year of equivalent full health. Chart 1 below demonstrates the very significant health gap in Africa, compared to other regions of DALYs, or years lost through disease, per 1,000 population. Table 2 shows the percentages of DALYs due to three main groups, reflecting the burden of disease (BOD) in each group:

- Communicable. maternal, perinatal and nutritional conditions, which includes infectious and parasitic diseases.
- Non-communicable diseases (NCDs), which includes chronic diseases such as cancer, heart disease and diabetes.
- Injuries, including unintentional injuries such as road accidents and work accidents, and intentional injuries, such as self-inflicted injuries, violence and war.

In this case, the data are compared by the World Health Organization (WHO) Region, so that "AFRO" includes the countries mainly in Sub-Saharan Africa, while some African countries are in the Eastern Mediterranean Region ("EMRO").

Chart 1. ***Disability adjusted life years/1,000 population by region, 2005***



Source: DALYs by age, sex and cause for the year 2005, Health Statistics and Health Information Systems, World Health Organization, *www.who.int/healthinfo/boddaly*

Chart 1 shows us that in the 44 countries in the AFRO Region; just over 50 years per 1,000 population are lost. This figure is more than double the global rate, and double the rate in countries in the South East Asia Region, which includes India.

This situation in the mainly sub-Saharan African countries cannot all be blamed on HIV/AIDS, although its burden is enormous. If we look at Table 1, we see that in the AFRO countries, 71.5 per cent of the DALYs are due to the first group - communicable, maternal, perinatal and nutritional conditions. The figure again is double the global percentage and significantly higher than the percentage in the South East Asian countries. HIV/AIDS, which is part of this first group accounts for 16.3 per cent of all DALY's, and we need to ask what other conditions in the first group account for the rest of the burden. Here we find tuberculosis and malaria as well as the childhood diseases that are preventable by immunization: whooping cough, poliomyelitis, diphtheria, measles and tetanus.

Table 1. ***Per cent disability adjusted life years/1,000 population accounted for by disease/condition group, 2005***

WHO region	All Group 1 Communicable maternal, perinatal nutritional conditions (%)	HIV/ AIDS (%)	Malaria (%)	Maternal causes (%)	Group 2 Non-communicable diseases (%)	Group 3 Injuries (%)
AFRO	71.5	16.3	8.6	3.2	19.2	9.0
Americas	7.4	2.4	0.8	1.1	69.4	13.9
EMRO	43.7	0.9	1.0	2.9	43.4	12.9
South East Asia	39.0	3.0	3.5	2.3	47.1	13.9
Western Pacific	17.3	1.1	1.6	0.9	68.3	14.4
Europe	9.5	2.0	0.1	0.4	77.2	13.3
World	38.5	5.6	2.3	2.0	49.0	12.5

Malaria accounts for 8.6 per cent of the burden of disease in the AFRO countries. This is 2.5 times the burden in South East Asian, and 5 times that of the Western Pacific countries, which include countries with high prevalence of malaria. With timely access to appropriate care, there is no reason for so many Africans to die from malaria. Through the input of several international agencies, such as the Global Fund, effective drugs are provided. The question is whether they are distributed to the health centres, and whether the patients face financial barriers in reaching these health centres.

Maternal conditions account for 3.2 per cent of all DALY's in AFRO countries, and only 0.4 per cent in the EURO countries, which demonstrates that most of this cause could be prevented. EURO countries are not all industrialized nations of Western Europe, but include Eastern Europe and the Central Asian Republics that were part of the former Soviet Union.

The conditions in the first group are largely preventable, some through public health measures such as the provision of clean water and sanitation, and others through appropriate personal health care, which means effective preventive measures and timely use of appropriate medical technologies. The lack of access to care due to under-funding of the health care system and to financial barriers to seeking care are major impediments in dealing with this group of health conditions in many countries in Africa.

Studies and documentaries note that late or delayed care is the major reason for complications and death due to causes in the first group. We cannot disregard the issue of physical accessibility to health care in many parts of these countries. Distance, travel time and cost are real concerns, but more pressing problems are the potential costs of care. Even if the care is given free at the end of a day's walk to a district hospital, the fear of loss of salary or income during the two or more days involved is also a serious deterrent to seeking care.

Table 1 shows that Non Communicable Diseases (NCDs) account for 19.2 per cent of the DALY's in the AFRO countries. With the increase in NCDs, these countries therefore face a "double burden" of disease. The chronic conditions are not necessarily the results of childhood diseases. They are more likely to be the results of changing lifestyles as societies, or parts of them, become more affluent. There are more and more of these conditions in African countries, linked to greater prevalence of risk factors such as obesity, smoking and the lack of physical activity. Assuming the current members of the social security systems in many African countries are the better paid workers in the country, and that disability benefits are provided, then health care is crucial to prevent an increase in NCDs, particularly diabetes, heart disease and cancer, and the disability that goes with these. The complications of high blood pressure and diabetes can be prevented if the risk factors, including obesity, are controlled at an early stage.

Table 1 also shows the tremendous lack of equity in health through an indicator that reflects the impact of premature mortality and disability on working life and productivity, which are the core of social development, and of the sustainability of social security systems.

2. What is the added value of health care in a social security system?

Health care is a short-term benefit, and most of the members and their dependents will use that benefit at least once each year: about 85 per cent of them are likely to visit a doctor or nurse as out-patients, and about 5 - 8 per cent may need hospital in-patient care. The

previous section looked at health status and the burden of disease in Africa. Underlying these figures is a huge amount of unmet need for health care and an average of at least two visits to doctors and nurses a year for all the population would be a significant achievement.

A 30-year old working mother is likely to be more concerned about having health care for her family than having a pension in 30 years time, even if she was guaranteed employment during the entire period till retirement, and even if the value of that pension would be guaranteed and not subject to inflation and decreasing purchasing power. Individuals would be particularly concerned if they had to face unpredictable financial burdens, over which they have no control of the type, volume of service or the cost, at the time of illness.

For a social security system, introducing health care benefits could therefore provide an attraction to membership, and to compliance in contribution payment, as members will want to be sure that they are and remain covered. The relationship between contributions and need is important in this context. In a pension system, payment is according to means (as a percentage of salary), and so is the benefit. Members are likely to be unhappy when the reported salary is less than actual salary. In health insurance, payment is according to means while use is according to need. One could assume that members will not mind if the employer under-reports salary. If the two are linked, the contribution base will be the same - so while health care encourages compliance in registration and maintaining entitlement, the long term benefits, such as pension and disability allowances, encourage compliance with the reporting of salary or income.

The second added value of health care is health, and the productivity and development that come with good health. Adults who are ill reach a stage where their productivity is negatively affected - they have more sickness absenteeism, more disability claims and eventually stop working, which means that they also stop contributing. Young mothers who die in childbirth will leave widowers and orphans with more needs for caring in the home. Schoolchildren who cannot concentrate on studies because of poor nutrition will not go on to higher education and qualification for the skills needed in developing countries. And children who die before they reach school age will significantly deplete the workforce in the next generation. And all these will deplete the extension of coverage of the social security system, while creating new demands on cash sickness benefits and disability allowances, as well as on unemployment benefits where these exist.

A third added value is the process of improvement in the health services system. Contracts between social health insurance systems and the providers directly bring predictable revenues into the provider system, which should promote improvement in the quality of care. A social health insurance scheme has far more strength than the individual patient as the purchaser of health care benefits. The insurance scheme is also committed to ensuring the quality of its health care benefits, while the providers, as well as the insurance scheme, quickly understand that failure to increase patient satisfaction will lead to the refusal of members to pay regular

contributions. Therefore, the commitment between members who prepay for health care, the scheme and the providers should serve to improve and maintain the quality of care.

3. Why has health care not been integrated into many social security systems in Africa?

Before looking at this question, we need to review the current scope of health care as a benefit in the social security systems in this Region.

A review of "Social Security Programmes Throughout the World: Africa 2007" shows that of the 44 countries covered, all have work injury programmes, 41 have old age, disability and survivors' benefits and 20 have family allowances. But only 20 have "medical care" in addition to the cash benefits for workers during absenteeism due to illness. Of the 20 countries with health care benefits, five are the North African countries: Algeria, Egypt, Libya, Morocco and Tunisia. Five countries have limited health care benefits under family allowances and others have health care benefits only for maternity. In nine of the 44 countries, workers and in some cases their dependents, have limited medical care under the prevailing labour laws. Three countries have contributory schemes for civil servants (Burundi, Burkino Faso and Gabon).

A report prepared for the Eleventh African Regional Meeting of the International Labour Office (ILO) in Addis Ababa, in April 2007, noted that almost 90 per cent of the population of sub-Saharan Africa is not insured against the risk of illness or accident. The report emphasized that "in order to help the most disadvantaged and vulnerable groups cope with life's contingencies; social protection is a powerful means of reducing poverty.

The importance of health care is clear and the next question therefore is: if health care is so important, then why has it been integrated into so few social security systems in Africa. Is it because of a delay in catching up with the reality or denial of the consequences of the changes in health care financing over the past two decades?

In the past, governments were responsible for developing health care facilities, operating them and for financing health care for their populations. This responsibility was generally confirmed in basic health laws, stipulating free care in government health care facilities. In many countries in Africa, private care meant clinics and hospitals run by charitable non-profit and usually religious institutions - the mission health services - and these also provided care free of charge or applied nominal fees. Through a chain of events linked to broader economic rather than social policies, government responsibility has shifted from financing health care to defining, legislating and implementing alternative health care financing mechanisms.

The most dramatic change was the application of user charges for public health services, which means out-of-pocket payment for health care at the time of illness and without any

reimbursement. Even at the risk of political opposition, most governments have *de facto* stopped the free delivery of care to all but its poorest citizens and to civil servants. Free health care is now limited to what governments can or want to pay for, and severe reductions in public expenditure have resulted in far lower health budgets from general taxation revenues. Until the application of user charges, these public facilities were usually the only source of care without financial barriers for most of the population.

On the positive side, the application of user charges has forced Ministries of Health to develop budgeting and pricing mechanisms, leading to improved financial management at central government and at hospital provider level. However, user charges have many potentially negative effects. Applying user charges at the time of illness, when earnings may be reduced, can lead to irrational health behaviour by the patient, through delays in seeking care, decisions on which family member should have priority and decisions on what services to purchase beyond the initial consultation.

Within a very short time, health care providers realize the potential to increase revenues by generating demand for care, including unnecessary services. In developing countries, this is not limited to overuse of high technology. The more common manifestation of unnecessary services is the high proportion of patients who receive unnecessary prescribed medicines, very often by injection, at the primary health care level. One result is a new area of negative health outcomes; it is now accepted that resistance to effective medicines has been impaired by the over-prescribing of antibiotics, let alone the increased risk involved in using injections. An individual paying patient is not protected by any mechanism, such as a social security scheme, to assure the appropriateness and the quality of the care provided.

4. What are the options for stable and equitable health care financing?

There are several options for increasing the funds available for health care in a country, from a greater government allocation for health, to various forms of user charges and to the social protection option. Obviously, these are not equal in terms of stability, sustainability, the rational use of household income and the ability to assure the quality of care.

4.1. Increase in government allocation from tax revenues

A national health services system, funded through taxation revenues, and covering the entire population is perhaps the simplest way of achieving universal health coverage. However, the tax base in most developing countries is weak, as these countries are generally characterized by small formal labour sectors and large informal sectors, and by weak tax collection systems.

The amount spent by governments on health is indeed very low in many developing countries. If indeed more tax revenues could be raised there would still be at least two problems to be faced. First is whether more public funds should be spent on health, given the needs of other social services, such as basic education and housing. Second is that the additional amount for health from tax revenues would still have to be negotiated each year, resulting in a lack of stability in the amount available each year.

4.2. User charges

The introduction of user chargers in public health facilities was discussed in the previous section. The willingness of patients to pay these charges will depend not only on how high the charges are but also on whether they have the cash at the time of illness, and their perception of the public services, which is generally low in an under-funded system.

The poorest and most vulnerable sectors of the population are usually exempt from paying the charges. However, government hospitals generally do not receive specific payment for the health care provided to patients who are exempt from fees. The treatment of these patients has become a source of resentment and also a financial burden for the hospitals. In the absence of financial compensation for the exempt patients, there is obviously a tendency to give more favourable treatment to patients who pay, including those who give under-the-table patients directly to the staff, than to those who are exempt. Problems of exemption, instability, unpopularity and low yield have already shown that user charges are not the optimal way to achieve stable and adequate funding for health care.

4.3. Drug revolving funds

Drug Revolving Funds (DRFs) are basically user charges for drugs, aimed at assuring availability, in a public non-profit health care delivery system. Patients are charged prices that are cost plus a set percentage for administrative overheads, which are basically purchase costs and incentives for the local health workers. The mechanism was first introduced by UNICEF in 1987 in Mali, and termed the Bamako Initiative and initially system seen as a plan to assure availability of essential drugs in the faltering health care services in many countries in Sub-Saharan Africa. This mechanism was also the first attempt to give up the ideal of free health services in the public sector.

Many countries in Africa now have DRFs at local village level and much has been written about the impact of the system. The most positive aspect was that the system demonstrated that patients are willing to pay for visible goods and services. In terms of the appropriateness as a stable health care financing mechanism, the major criticisms are that DRFs still constitute out-of-pocket payment at the time of use, and even small amounts may present a financial burden in very low-income populations. However, the most interesting finding at local level is the absolute amount of money collected in this way. The amount often reflects recognition

by the local health workers that more drugs sold will generate more incentive payments. It is difficult not to assume some unnecessary prescribing under the circumstances. If such a high amount can be generated among the same target population, we should be able to collect the appropriate amount on a prepayment basis and use the funds for a range of health care benefits, beginning with the initial examination and not only drugs.

4.4. Health equity funds

Health Equity Funds (HEFs) are a relatively new mechanism to cover health care for the poorest. These are generally not state social assistance allocations to cover the poor, but funds provided through the international development partners. International and local non-government organizations (NGOs) are contracted to implement these funds in specific poor populations, rather than as a national policy. The amounts spent on identifying the poor each year and the administrative costs of the HEF's seriously reduce the actual amount left available for health care, and these funds are often limited to covering only in-patient care. The funding is inadequate to cover all the poor families and continuation of the method also discourages the development sustainable health care financing mechanisms by national ministries of health in the low income countries. Governments realize that the international development partners are not, and indeed should not, guarantee health care funding for the poor on a long-term basis.

4.5. The social health insurance option

For all these reasons, the protection against the hazards of paying for health care requires a broader base than payment at the time of use coming from scarce family resources or borrowed at high cost or in the worst case, from the sale of family assets that provide income. This can be accomplished by insurance with its core elements of prepayment in the form of regular affordable contributions and broad social pooling; the same elements in place for other social security benefits.

In fact, health care was the first formal branch of social solidarity or mutual assistance, as we see in the first legislation in Germany in 1883, through Bismarck's Sickness Insurance Act, which defined social security as:

> "The protection which society provides for its members through a series of public measures, against the economic and social distress that otherwise would be caused by the stoppage or substantial reduction of earnings resulting from sickness, maternity, employment injury, unemployment, invalidity, old-age and death."

The legislation stipulated that (a) workers in defined industries earning less than a specified amount should be affiliated with a sickness fund and (b) the fund would be financed through

compulsory contributions of workers and of their employers. Other countries followed with similar legislation, as compulsory health insurance was seen as the appropriate response to the expectations of workers and their families. However, this trend has been very slow in sub-Saharan Africa.

In the national context, governments are keen to introduce social health insurance to obtain additional funding for health. Health care providers in the public sector are generally under-funded, resulting in low salaries, low levels of technology and even lower satisfaction by both the public and the health professionals.

Private providers spring up where the money is, and attract the already scarce health professionals away from the public system. In a short time, revenues into the private sector grow, while the quality of care may not improve to the same degree. The result is increased out-of-pocket payment by those who can afford such care, but not increased funding of the public sector - which still remains the main provider for the vast majority of the population.

Employers are increasingly looking for insurance mechanisms for work injury programmes, and for non-work related health care in countries where labour laws require the employer to cover health care, and health care is not covered by the social security system. Individual employers no longer want to bear all health risks of their employees and look for mechanisms to share these risks. When they cannot afford to provide this protection through commercial for-profit insurance companies, they become extremely interested in social health insurance.

As for the formal sector population now covered by social security systems, health care has become a significant issue. Health care is the benefit used by all family members throughout the life cycle and is the benefit used most frequently, compared to maternity, invalidity, old age and death benefits. The experience with the Drug Revolving Funds in Africa has shown that people are willing to pay for health care when the availability of services is guaranteed. An important development over the last two decades is the evolution of community-based or micro-health insurance by the population excluded from the formal salaried sector systems. As will be described later, these voluntary initiatives are growing in number and in strength as both health protection and health care purchasing mechanisms.

From the social protection viewpoint, we can summarize social health insurance as the optimal and sustainable mechanism to enable:

- affordable, fair and progressive contributions by households and other partners;
- optimal pooling levels to reduce risks and foster solidarity among different populations (young and old, low and high income, urban and rural);
- increased efficiency and quality assurance in the purchase of health care;
- relationships between the social health insurance scheme, providers and members that discourage moral hazard and abuse and promote rational use of health care;

- improvement in the delivery of health care through increased financial resources and more appropriate allocation of these resources;
- provision of health care with greater consideration for patient preferences and increased satisfaction among health professionals; and
- a significant step in the extension of social security benefits for the population which enriches the concept of social protection while improving health and productivity and reducing poverty due to ill-health.

5. What has happened in the meantime?

In terms of coverage through insurance, the private insurance sector looks for every opportunity to attract individuals and groups to purchase health insurance policies. For the most part, health coverage is offered by general insurance companies rather than health insurance schemes, through the private commercial for-profit insurance sector. These life and non-life insurance companies are willing to take some loss on health care, to attract employers paying high salaries. The premiums are high and often linked to the risk of the individual unless employers purchase policies for groups. Private for-profit health insurance usually covers less than 2 percent of the population, and creates yet another inequity in access to health care.

In South Africa and Zimbabwe, a different form of private health insurance has evolved. This is based on the traditional mutual aid system, where medical non-profit insurance companies have developed, and have made efforts to cover low as well as high and middle-income workers and their families. This is a form of voluntary insurance, and employers and individual families are not obliged by law to enroll. Coverage remains low, reaching 7 percent of the population in South Africa, and essentially the higher income population. However, the traditional concept is eroded as premiums are rising since these schemes increasingly rely on the private for-profit provision of health services and use commercial third party companies for financial management.

Another and increasingly popular form of voluntary insurance is community based health insurance, or micro-insurance schemes, initiated by local institutions such as community associations or cooperatives, or by health care providers. Community-based health insurance (CBHI) aims to provide protection against health care costs for families in the self-employed or informal economy - usually those who are excluded from formal sector social security schemes.

The pioneer in this area of community based or micro-health insurance is the Bwamanda scheme launched in 1986, when the Bwamanda district hospital in a rural area of the Democratic Republic of Congo offered the population in its catchment area membership in a prepayment scheme in order to obtain its health services without having to pay at the time of use. The well documented reviews of the Bwamanda scheme reported on willingness to pay

and the substantial and predictable revenue to the hospital through the scheme. The number of such schemes has since grown considerably in Africa, mainly in the francophone countries. Most are in rural areas, and are linked to community associations rather than health care providers.

Although there is increased interest in community-based or micro-health insurance, this form of financing health care is not well understood and is currently more criticized than supported. Some health economists claim that small health insurance schemes are not sustainable, and that the proliferation of such schemes leads to chaos rather than controlled and stable expansion of coverage. Weak management capacities, the lack of a framework for coordination between schemes and limited health care benefits have all been noted as major reasons for slow expansion.

Admittedly, it is difficult to reach over 50 per cent coverage of the population at local level through these voluntary and small schemes. The main components, such as contribution levels and collection mechanisms, as well as benefits, vary from scheme to scheme, making mergers and portability of entitlement very difficult. The schemes often lack the management capacity to ensure steady extension and financial viability.

Despite the difficulties and fragility of these schemes, their importance should not be underestimated. They prevent many people from falling into poverty because of health care costs, and they spread awareness of the concept of solidarity and the need for affordable social health protection mechanisms for all. With political commitment, and a national policy which implements regulations and guidelines for the controlled expansion and merging of schemes, universal coverage can be a reality. This needs a policy of linkage, whereby eventually the formal sector social security system can assist or take on coverage of the self-employed and informal economy population. Case studies of this linkage have been carried out by the ISSA, working with the STEP programme of the ILO and the International Association of Mutualities (*Association internationale de la mutualité* (AIM)), and the documentation provides excellent material for consolidation of the process.

Rwanda is an excellent example of this process, and indeed one of the case studies describes this experience. As a major part of the reform of Rwanda's health system after 1994, a country-wide independent community health insurance scheme was launched in 1999. The Mutual Health Insurance (*Mutuelles de santé*) now covers over 70 per cent of the target population in all provinces and the use of health care has increased significantly compared to the user charge periods. Contributions to cover the entire household are relatively low, administrative costs are kept below 8 per cent of revenue and a central reserve fund has been created for emergencies. Apart from providing the policy, technical assistance and monitoring, central government boosts the process through a grant to each district. The immediate aim is to strengthen pooling through merging with the scheme for civil servants and the Military Medical Insurance.

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6. How can we proceed?

The addition of health care to the social security package can bring about the changes we need. As noted in the very beginning of this paper, the social security systems in most African countries have not seen health care as a priority until recently. The integration of health care is not an easy task, particularly since the social security systems may not have the medical or health care expertise. Dealing with the medical aspects of work injury programmes is certainly not as complex as a comprehensive health care insurance system for all workers and their dependents.

The development of social health insurance should not be seen as the sole responsibility of Ministries of Health, as initiators or implementers. We have already noted that Ministries of Health are now very interested in the health insurance option, but they do not have the essential institution capacity to register populations and collect contributions, which are at the core of extension of coverage and viable financing. The necessary tripartite governance is also difficult to achieve in social health insurance systems managed by a Ministry of Health. An additional point is that it is far easier for social security systems than a Ministry of Health to contract with providers in both the public and private sectors.

The call here is to social security organizations to take initiative, identify the partners, beginning with the Ministry of Health and to launch a serious and continued process of integration of health care into the social security systems. This should be seen as an opportunity for social security systems to attain the added value discussed earlier, as an opportunity for enhancing national growth through social protection and not just achieving growth of a social security system. It is also an opportunity for the Ministry of Health to carry out responsibilities to develop the optimal health care financing methods for the population with a strong and reliable partner. With the political commitment of the government, clear national policy and appropriate steering of the stakeholders to get them to work together, the series of difficult issues or questions can be handled. The main questions in the process are outlined below:

6.1. Are there any pre-requisites?

The urgency of reaching stable health care financing in most countries in Sub-Saharan Africa precludes lengthy studies and much of the necessary data already exist through work carried out in recent years. Rather than carry out new studies, it is more important to train a core group of people to understand the nature of social health insurance. There are many misconceptions, beginning with the claim that the contribution amount to cover dependents and a comprehensive range of benefits would be so high that labour costs would be negatively affected. Social security schemes that have integrated health care as a benefit have done so with a moderate contribution level. The trained group, including senior government officers

who will be involved in the process, should then have the capacity to identify essential gaps in available data and use all the sources to first develop the appropriate ideology, policy and legislative and regulatory tools. This group will also be able to deal with the expected opposition to the integration of social health insurance which comes from the private insurance and private health care providers sectors and is usually expressed early in the debate.

International development partners, including the ILO, ISSA and WHO, are ready to provide technical support in the area of social health insurance. However, the development process has to be a national process from the very beginning, led by a national multi-sectoral team and not one or two individuals.

The team may be guided by external advice, but acceptance of the product, analysis of each of the proposals and subsequent decision-making can only be done by nationals who acquire cumulative knowledge on the major issues involved. The ultimate success of the scheme depends on the extent to which informed nationals contribute to the process, and take on the responsibilities involved.

Another pre-requisite is obviously the existence of a health services system which can deliver the benefit to which the insured are entitled through their regular prepayment. Very few countries have such a system in place, and it would take far too long to develop the ideal situation. However, through increased government investment in the health care infrastructure and training of adequate human resources for health, and cooperation between the social health insurance system and health care providers, steps can be taken to assure the initial provision of care, and to plan for improvement with the commitment of increased funding from health insurance revenues. Often the key issue is flexibility in enabling use of the health insurance revenues at the provider level, to allow for increased income for the staff and improved patient conditions that increase satisfaction.

6.2. What legislative tools are required?

Both compulsory and voluntary health insurance need legislative tools, including laws and regulations, to assure effective implementation. Existing labour laws may need revision, as employers will not want to continue with liability to pay for non-work related health care in addition to new health care contributions. Social security organizations may not need the entire process of drafting and passing legislation to integrate health care as existing social security laws in many countries enable the addition of new benefits and new populations (such as workers in small enterprises and the self-employed) through simple amendments. Changes will probably be needed in the oversight and governance to assure appropriate expertise and health professional involvement. The addition of knowledge and skills in this area can only benefit the existing social security systems. Two points are important here:

- if universal coverage is the stated policy, the legislation should include or be linked to social safety nets for the very low income and vulnerable populations who cannot contribute themselves; and
- the legislative tools are essential but should not necessarily take years to put in place. The law should cover the principles and commitments while the components which may need periodic adjustment should be put into regulations.

6.3. What health care benefits should be provided?

There is a tendency to favour a "minimum package of benefits" in a new social health insurance scheme, or to limit benefits to cover "catastrophic costs" which usually means hospital in-patient care. There are several underlying issues here. First, an insurance scheme offering benefits that will be used by all members of the family at least once every year can be very attractive to potential members. In-patient hospital care which may be used by only 5 to 8 percent of the covered population each year is far less attractive. Experience has shown that limiting benefits to hospital care leads to irrational use of the service: members will delay seeking care until indeed the severity of their illness requires hospitalization. Or the scheme will be abused when patients have to be admitted as in-patients to benefit from services that can be provided on an out-patient basis.

Second, limiting benefits to a minimum package of essential primary care in community facilities is unfair. Just as all over the world, Africans have a growing expectation of the results of medical science and modern technology. The preferences of the insured regarding comfort and dignity in receiving care should also be considered. Africans deserve a balanced range of health care, to suit their health, medical and cultural needs.

The benefit package does not have to include every available and safe medical technology. It can achieve the cost control needed for an affordable contribution level through emphasis on health promotion and prevention, efficient referral mechanisms and appropriate purchasing of health care. The inclusion of preventive services does not mean that the Ministry of Health relinquishes its responsibility for the prevention of disease to the insurance scheme. On the contrary, it means that government is better able to fulfill its responsibility for public health, in coordination with the responsibility of the health insurance scheme to promote healthy behaviour and prevent disease at the individual and household levels.

There is a tendency to exclude services that are considered high cost technologies. Again, efficient administration of the scheme can find ways to limit the use of a defined list of high cost services through referral mechanisms and the management of reasonable reserves dedicated to this purpose.

The main mechanism to control costs is through the provider payment mechanism. Firm contracts with accredited health facilities and provider payment mechanisms that are not

based on the volume of care provided are essential for this. That is, the provider payment mechanism should assure the quality of care while avoiding unnecessary services to the insured population simply to increase provider revenues. Many social health insurance schemes are moving from fee-for-service to capitation and other payment methods for this reason. Every social security scheme has limited funds, which depends on the pool of insured persons and compliance in paying an contributions, and the latter cannot simply be increased because of inefficiency or overuse of the benefits covered.

A pertinent question in defining benefits is whether HIV/AIDS should be covered, since the current high prevalence of HIV/AIDS can pose serious challenges to the financial viability of providing comprehensive benefits. It would be grossly inappropriate to exclude preventive or acute care for inter-current infections of insured persons who are HIV sero-positive or have been diagnosed as having HIV/AIDS. The real high costs of care for HIV/AIDS patients are for the anti-retroviral drugs (ARVs) which if effective, may be required for long periods. Today the Global Fund and other international donors provide these drugs through grants to the high burden countries. However, as with the provision of drugs to cure tuberculosis and malaria through the Global Fund, these drugs will only be given after the diagnoses have been made. The lack of access to primary health care and delay in the detection and diagnosis of both diseases leads to three very undesirable trends:

- an increase in severity of the disease in the individual;
- spread of the disease to other persons; and
- an increase in disability and premature mortality due to these diseases.

The social health insurance schemes therefore have to seek partnerships with the agencies now dealing with HIV/AIDS, tuberculosis and malaria. Apart from the funding of prevention and the ARVs, it would be useful to seek a form of pooling of at least some of the resources of these agencies as support for the contributions of families living with HIVAIDS who may not be able to afford the contributions.

6.4. How long will it take to cover the entire population?

It is not possible to cover the entire population immediately, or in a short-time, even when the stated policy and legislation call for universal coverage. In an existing compulsory social security system, it will obviously be easier to begin with those already covered by pension and other benefit branches. The integration of health care can in fact trigger extension of this population in a very significant way, when, for example, coverage is extended to workers in smaller enterprises than currently covered. If there is a scheme for civil servants, the extension could be to the salaried workers in the private sector. If the social security system now only covers the private sector, this could be the opportunity to negotiate with government to cover civil servants. In any event, the health care benefit should cover the worker and his/her dependents. Governments sometimes state they will retain the

responsibility for financing the health care of children. In an under-funded health system, this means that the care of children will continue to be under-funded. It is neither possible nor desirable to cover only the workers, and universal coverage cannot be achieved by covering each individual as a separate entity.

The extension of coverage to the self-employed and the informal sector is more complicated. If voluntary social health insurance, through community-based on micro-health insurance schemes has already been started in the country, the challenge will be to strengthen these schemes and increase awareness of the advantages of membership. This process can take many years, or can be shortened by central support, including technical support from the existing social security schemes, until the entire population can be covered through the compulsory system. Universal coverage also requires the government to commit to a safety net mechanism to cover the non-economically active population and other vulnerable individuals and families. The process to achieve universal coverage also needs a clear policy on the target stages and time frame to cover each specific population group, which could be type of employment, affiliation with civil society groups and cooperatives, or geographic area.

Conclusions

The ILO report entitled The Decent Work Agenda in Africa: 2007-2015, stated:

> "The main challenge for social protection in Africa is to extend coverage of social security to ensure that people have access to health care and enjoy at least a minimum level of income security. Only in this way will it be possible to make the right to social security, as embodied in Article 22 of the Universal Declaration of Human Rights, a reality on the African continent. Stepping up efforts to provide basic social protection is thus a viable way to reduce poverty and insecurity for countries in sub-Saharan Africa."

We have seen that health care in Africa is way behind - and this is not all because of HIV/AIDS, tuberculosis and malaria, and the statement in the Decent Work Agenda sums up what needs to be done.

The smooth development and integration of health care require both political and technical components and need to consider the current and potential role of each of the stakeholders. The concept and objectives need to be well understood, and political and socio-economic stability should ensure that the policy will be pursued even with changes in government. Increased funding for health care through social health insurance does not mean that governments, through ministries of health, should spend less on health care. On the contrary, ministries of health need to increase resources for health, including funding, in almost every country in Africa.

We do not have the tools to achieve equity in health. We do have the tools to achieve equity in access to health care through social protection, including social health insurance, so that Africa does not have to stay behind in health, and can come out of the cycle of poverty and ill-health. Social security systems are among the most powerful organizations in any country - they have the political backing and the institutional structures to add health care to the range of benefits, and even to extend - or begin extending - this benefit to the self-employed and informal economy.

References

Abel-Smith, B. 1992. Health insurance in developing countries: Lessons from experience", in *Health Policy and Planning,* Vol. 7, No. 3, pp. 215-226.

Abel-Smith, B.; Rawal, P. 1992. "Can the poor afford "free" health care: A case study of Tanzania", in *Health Policy and Planning,* Vol. 7, No. 4, pp. 329-41,

Arhin, D. C. 1995. "Health insurance in rural Africa", in *The Lancet*, No. 345, pp. 435-444.

Atim, C. 1998. "The contribution of mutual health organizations to financing, delivery and access in health care in West and Central Africa: Synthesis of research in nine countries" in *PHR Reports*, No. 18.

Carrin, G.; Desmet; Basaza, R. 2000. "Social health insurance development in low-income developing countries: New roles for government and non-profit organizations", in X. Scheil-Adlung, International Social Security Association, *Building social security: The challenge of privatization.* Piscataway, NJ, Transaction Publ. <http://www.wpro.who.int/NR/rdonlyres/02A6ADBE-FF59-4640-A1DE-3304A00AF5C9/0/buildingsocialsecutiryXeniaScheilAdlung.doc> (accessed on 18.05.2009).

Castillo-Riquelme, M.; McIntyre D.; Barnes, K. 2008. "Household burden of malaria in South Africa and Mozambique: Is there a catastrophic impact?", in *Tropical Medical International Health*, January, No. 13, pp. 108-122.

Chaora, M. 1997. *Health insurance development in Zimbabwe* (Case study). Harare, CIMAS Medical Aid Society.

CIA. Undated. *World Fact Book*. Washington, DC, Central Intelligence Agency.

Criel, B.; Van der Stuyft, P.; Van Lemberghe, W. 1999. "The Bwamanda Hospital insurance scheme: Effective for whom? A study of its impact on hospital utilization patterns", in *Social Science & Medicine*, No. 48, pp. 897-911.

Gbossa, L.; Gauthe, B. 2002. *Social protection and crises in the Congo: From humanitarian aid to sustainable development* (ESS Paper, No. 12). Geneva, ILO – SOCPOL.

Geest, S. van der. 1992. "Is paying for health care culturally acceptable in sub-Sahara Africa?", in *Social Science & Medicine*, Vol. 6, N° 32, pp. 667-673.

Gilson, L.; Mills, A. 1995. "Health sector reforms in sub-Saharan Africa: Lessons of the last 10 years", in *Health Policy,* No. 32, pp. 215-243.

Gilson, L. 1997. "The lessons of user fee experience in Africa", in *Health Policy and Planning*, Vol. 12, No. 4, pp. 273-285.

Gilson, L.; McIntyre, D. 2007. "Post-apartheid challenges: Household access and use of health care in South Africa", in *International Journal of Health Services*, No. 37, pp. 673-691.

Ginneken, W. van. 2002. *Extending social security: Policies for developing countries* (ESS Paper, No. 13). Geneva, ILO – SOCPOL.

International Labour Office. 2002. *Micro-assurance santé: Guide d'introduction aux mutuelles de santé en Afrique*. Geneva, ILO – STEP.

—. 1999. *Health micro-insurance: The Abidjan platform*. Geneva, ILO – STEP.

—. 2007. *The decent work agenda in Africa: 2007-2015* (Report of the Director-General, 11th African Regional Meeting, Addis Ababa, April). Geneva, ILO. <http://www.ilo.org/global/What_we_do/Publications/Officialdocuments/Director-Generalsreports/lang--en/docName--WCMS_082282/index.htm> (accessed on 18.05.2009).

Logie, D. E.; Rowson, M.; Ndagije, F. 2008. «Innovations in Rwanda's health system: Looking to the future», in *Lancet*, No. 372, pp. 256-261.

Mathers, C.; Loncar, D. "Projections of global mortality and burden of disease from 2002 to 2030", in *PLoS Medicine*, Vol. 3, No. 11.

McIntyre, D.; Mooney, G. 2007. *The economics of health equity*. Cambridge, Cambridge University Press.

Moens, F. 1990. "Design, implementation and evaluation of a community financing scheme for hospital care in developing countries: A pre-paid health plan in the Bwamanda health zone", in *Social Science & Medicine*, Vol. 30, No. 12.

Musango, L.; et al. 2006. "Rwanda's health system and sickness insurance schemes", in *International Social Security Review*, Vol. 59, No. 1.

Nyonator, F.; Kutzin, J. 1999. "Health for some? The effects of user fees in the Volta Region of Ghana", in *Health Policy and Planning*, Vol. 14, No. 4, pp. 329-341.

Ron, A.; Abel-Smith, B.; Tamburi, G. 1990. *Health insurance in developing countries: The social security approach*. Geneva, ILO.

Ron, A.; Scheil-Adlung, X. (eds): 2001. *Recent health policy innovations in social security* (International Social Security Series, Vol. 5). Piscataway, NJ, Transaction Publ.

Russell, S.; Gilson, L. 1995. *User fees at government health services: Is equity being considered?* (PHP Publication, No. 15). London, School of Hygiene and Tropical Medicine.

SSA; ISSA. 2007. *Social security programs throughout the world*: *Africa*. Washington, DC, Social Security Administration.

Waddington, C.; Enyimayew K. 1989. "A price to pay: The impact of user charges in Ashanti-Akim District, Ghana", in *International Journal of Health Planning and Management*, No. 4, pp. 17-47.

Weaver, M.; et al.. 1994. "Prospects for reform of hospital fees in Sub-Saharan Africa: A case study of Niamey National Hospital in Niger", in *Social Sciences & Medicine*, Vol. 38, No. 4, pp. 565-574.

World Health Organization. 2000. "Who pays for health systems?", in *World Health Report 2000: Health systems: improving performance.* Geneva, WHO. <http://www.who.int/whr/2000/en/whr_00_ch5_en.pdf> (accessed on 18.05.2009).

World Health Organization. 2005. *Social health insurance: Selected case studies from Asia and the Pacific*. WHO South East Asia and Western Pacific Regional Offices. <http://www.wpro.who.int/NR/rdonlyres/8EE02A82-B0EF-4EE3-B635465A7C67794D/0/searpno42.pdf> (accessed on18.05.1009).