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Expanding Coverage Through Health Insurance:
An Ongoing Process

HFG Series:
Advances in Health Finance & Governance

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About the Health Finance and Governance Project

The Health Finance and Governance (HFG) Project works to address some of the greatest challenges facing health systems today. Drawing on the latest research, the project implements strategies to help countries increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. The project also assists countries in developing robust governance systems to ensure that financial investments for health achieve their intended results.

With activities in more than 40 countries, HFG collaborates with health stakeholders to protect families from catastrophic health care costs, expand access to priority services – such as maternal and child health care – and ensure equitable population coverage through:

- Improving financing by mobilizing domestic resources, reducing financial barriers, expanding health insurance, and implementing provider payment systems;
- Enhancing governance for better health system management and greater accountability and transparency;
- Improving management and operations systems to advance the delivery and effectiveness of health care, for example, through mobile money and public financial management; and
- Advancing techniques to measure progress in health systems performance, especially around universal health coverage.

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To learn more, visit **www.hfgproject.org**

About this series

HFG's Advances in Health Finance & Governance series is designed to highlight learning and lessons from the HFG project in nine core areas: domestic resource mobilization, strategic health purchasing, health financing strategies, expanding coverage through health insurance, financial data for decision making, governance, institutional capacity building, workforce and efficiency, and building understanding for universal health coverage.

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Expanding Coverage Through Health Insurance: An Ongoing Process

Executive Summary

As countries strive to achieve universal health coverage, they must implement health insurance systems or other types of financial protection programs that protect against financial risk and improve access to quality and affordable health care. This brief articulates lessons learned by USAID's Health Finance and Governance (HFG) project in its efforts to help countries sustain and expand coverage through health insurance, with several illustrations from Ghana and Ethiopia.

Key Lessons

1. Expanding health insurance is a **POLITICAL** *and* a technical process.
2. **INSTITUTIONAL ARRANGEMENTS** and **ORGANIZATIONAL CAPACITY ARE ESSENTIAL** to expand coverage.
3. Coverage of the poor can't happen without **GOVERNMENT INVOLVEMENT**.
4. Remember the **SUPPLY SIDE**, so that increased health insurance coverage and demand for health care connects to accessible, quality services.
5. Expansion of insurance requires **INTENTIONAL, ITERATIVE LEARNING AND ADAPTATION**.

Introduction

Health insurance was conceived to protect people from unpredictable and often catastrophic spending on health care: to mitigate the financial risk of each insured person, it would pay for health care from a pool of prepaid funds, thus spreading risks and costs among the insured population. Health insurance systems have exploded across lower- and middle-income countries. Countries are now turning to the challenge of developing, sustaining and expanding public health insurance.

HFG has supported nine countries to expand health insurance in response to declining donor funds and the global move toward universal health coverage (UHC). Countries can expand the 'breadth' of health insurance when new populations are covered or the 'depth' when more services or more of the costs of services are covered.

This brief summarizes lessons from HFG's country experiences (Table 1), asking the central question: What are the some of the most important things for health system policymakers and their partners to know about efforts to expand health insurance?

COUNTRIES WITH HFG-SUPPORTED HEALTH INSURANCE ACTIVITIES

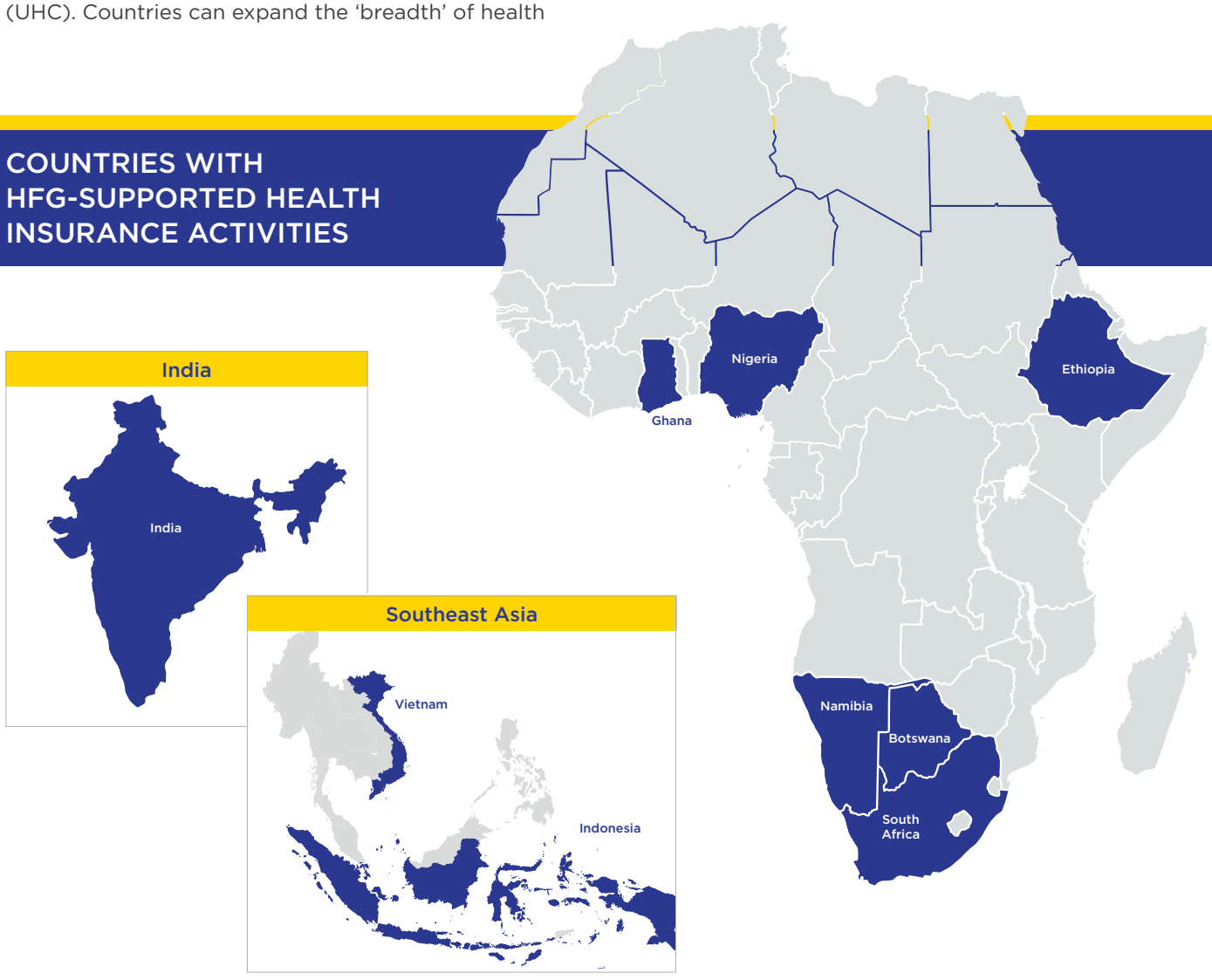

Table 1: HFG Engagement in Health Insurance

COUNTRY	HFG'S ROLE
BOTSWANA	Expansion of health insurance for the general public from fragmented medical aid schemes that cover only a small proportion of the population in the formal sector, predominantly government employees.
ETHIOPIA	Strategy for health insurance (social health insurance and community-based health insurance); pilot and scale-up of CBHI to cover 80% of Ethiopians by 2020; and preparation to launch SHI.
GHANA	Redesign of the National Health Insurance Scheme's capitation payment model for primary care providers, and use of evidence for strategic purchasing.
INDIA	Exploring options for innovative, low-cost health insurance mechanisms for the poor.
INDONESIA	Exploring the institutional arrangements for linking health financing to quality of health care.
NAMIBIA	Improving policies and systems to provide greater access to health care services for vulnerable populations.
NIGERIA	Set-up of state-supported health insurance in six states in partnership with the federal and state governments.
SOUTH AFRICA	Expanding beyond private medical schemes through national health insurance.
VIETNAM	Expanding coverage of people living with HIV/AIDS.

Photo: Gonzalo Guajardo for Communication for Development

Informal sector worker Mola Simegn displays the community-based health insurance membership card that enabled him to receive services at the Felege Hiwot Referral Hospital in Bahir Dar, Ethiopia.

Five Lessons for Expanding Coverage Through Health Insurance

Lesson 1

Expanding health insurance is a political *and* a technical process.

Health system researchers recognize that expanding health insurance and other health reforms are deeply political as well as technical processes. Cultural preferences and institutions with deep historical roots shape how political leaders and the public perceive health problems and potential solutions. Resources are always too scarce to provide every kind of health care to everyone, everywhere, so obligatory trade-offs create winners and losers—supporters and opponents—among some of society's most powerful actors. These include physicians with influence over patients, prime ministers, and parliaments; employers with allies in ministries of finance; and hospitals and other major health facilities with power over significant portions of national GDPs (Roberts et al. 2004, Glassman 1999, Walt and Gilson 1994).

The efforts of governments and their partners to scale up public insurance programs also face complex technical challenges. They require better epidemiological and economic analysis, improved management, and innovative ways of delivering care to enable access to health services and financial risk protection for the poor. The HFG project's experience, however, confirms that the design, implementation, and evaluation of health insurance expansion is (still) inherently political and that technical improvements alone are not sufficient to reach and sustain those goals. The examples below show how and why.

Ghana's National Health Insurance Scheme (NHIS) has been heavily influenced by political dynamics since its inception. In 2001-2002, technically-focused policymakers initially crafted an insurance expansion strategy—supported by external donors—that would have continued building the nascent community-based health insurance (CBHI) schemes begun under the previous government. That strategy conflicted with the political goals of the new ruling party,

which was eager to launch a fundamentally different, national-scale health insurance scheme prior to the 2004 election. The party rapidly seized a political window of opportunity. Although this action largely explains the NHIS's key successes, such as a new value-added tax earmark and national risk pooling, it also led to major operational challenges, including a financial crisis from failing to balance the NHIS's limited revenues with the near-comprehensive benefits promised to enrollees (Blanchet and Acheampong 2014).

More recently, between 2012 and 2015 a pilot program in Ghana to introduce capitation payment (where providers are paid a fixed amount per enrolled patient, rather than a fee for every service they provide) to control costs for primary care providers failed for political and technical reasons. The government chose to pilot the controversial (and poorly understood) policy change in the Ashanti region, the traditional center of power of the major opposition party. Providers and civil society groups quickly protested what they perceived to be a politically-motivated cut in funding for their region's providers and population, taking their complaints (and savvy marketing—some opponents called it "decapitation") to the vocal Ghanaian media and threatening to withdraw from the NHIS. The government also faced complex technical challenges, such as finding ways to form new networks of providers who could provide the full package of services supposed to be covered by capitated payments. Ultimately, the government was forced to suspend the program because it had failed to analyze how the problem and solutions would be perceived, how powerful players would react, and what strategies it could adopt to adjust to that political landscape. Ghana's new government is now reexamining the issue and may try a new approach. Ethiopia adopted a national health insurance strategy in 2008 that called for development of social health insurance for the formal sector, CBHI for the informal sector, and a longer-term plan to unify the two insurance schemes into a single national health insurance program. The strategy appeared technically solid—it responded to unacceptably high out-of-pocket spending (37 percent of total health expenditure), incorporated a number of global best practices for health financing reform, and recognized the difficulty of trying to cover a large informal sector with payroll-tax-funded insurance immediately. Nearly 10 years later, however, only the CBHI component of the strategy is being implemented and scaled.

Political dynamics again help explain why. Despite a great deal of technical work on designing new institutions, mechanisms for premium collection and provider payment, the launch of social health insurance has been delayed due to resistance from the employers and employees who would pay for and be eligible to enroll in it. One source of resistance from employees is that they want the social health insurance scheme to cover private health care services. To do so calls for a (so far lacking) combination of political strategy to gain support and reduce opposition and a technically strong system to accredit, contract and pay private providers to provide services to covered members.

In contrast, CBHI is scaling up nationally. CBHI has been bolstered by a combination of technical support, political analysis, and political support—most notably from the former minister of health (and current director general of the WHO), who strongly argued and advocated for CBHI with the Council of Ministers and the ruling party. This secured political support from the ruling party to first pilot CBHI and then rapidly expand it, with a target of reaching 80 percent of the eligible population by 2020. The minister also managed to galvanize technical and some financial support for implementation of CBHI from development partners, including USAID.

HFG has supported South African policymakers in the National Treasury and the Department of Health as they endeavor to launch a national single-payer health insurance program. The technical challenges of developing such a system are immense, but the politics of doing so are probably at least as important, if not more so. This explains why over a decade of design debate has not resulted in the adoption of legislation required to start the new system. South Africa's private health sector resists the replacement of private medical schemes (insurance) with a single national health insurance scheme, fearing loss of income and autonomy. Provincial governments, with powerful connections to the ruling party, are also reluctant to cede authority to a central government agency in health. Taxpayers express concern about the total costs of national health insurance and the administrative

Photo: Ayenew Hailelassie, Abt Associates

A poster on the wall of a health center in Ethiopia's Amhara region reminds visitors to become community-based health insurance members.

efficiency of a national health insurance fund. In contrast, powerful constituencies like trade unions project an uncompromising preference for a single-payer system with universal benefits, limited or no out-of-pocket payments by patients, and limited to no role for private medical schemes. Even a technically well-designed national health insurance scheme will continue to face major political obstacles to implementation. Progress will clearly require political analysis and strategy at every step.

Nigeria passed legislation creating a national health insurance scheme nearly 20 years ago in 1999, but implementation of the law did not begin until 2004, and since then coverage of the population has remained very low, limited to federal civil servants. In 2014, Nigeria's National Health Act established a Basic Health Care Provision Fund, whereby 1 percent of the federal government's budget would be earmarked to support national health insurance and block grants to states to improve the supply of basic care. Implementation of this law has also been delayed. More recently, the National Health Council passed a memorandum in 2016 to decentralize national health insurance to Nigeria's 36 state governments. Various states are now in the process of establishing state health insurance programs, such as the six HFG-supported states.

The failure of major health insurance-related legislation to move from enactment into effective implementation can be explained in large part by political dynamics and the inability of health reformers to analyze, navigate, and influence those dynamics. Powerful state governments were not effectively engaged to help design and support national health insurance at its launch, and state-level health policymakers were not supported to engage their own governments to fund schemes and subsidize the poor adequately. Additionally, there was a lack of advocacy and communications targeting the federal stakeholders who must approve and act to move funds from the Consolidated Revenue Fund into the earmarked Basic Health Care Provision Fund, as the 2014 National Health Act intended.

Lesson 2

Institutional arrangements and organizational capacity are essential to expand coverage.

Having the right institutional arrangements and organizational capacity to operate public health insurance is critical. A WHO paper stated that institutional design and organization practice are important for health financing performance and universal coverage (WHO 2010). It quoted another paper (North 1989) that defined institutions as "formal and informal rules, enforcement characteristics of rules, and norms of behaviour that structure repeated human interaction" and defined organizations as "groups of individuals bound together by some common purpose to achieve certain objectives." A World Bank working paper on the role of institutions in development underscored that "the main determinant of differences in prosperity across countries are differences in economic institutions.... Institutions are the rules of the game in a society or, more formally, are the humanly devised constraints that shape human interaction" (Acemoglu and Robinson 2008).

HFG's experience in different countries also revealed that institutional arrangements and organizational capacity influence functionality and performance of the health sector, including operationalization of health insurance. As Hsiao et al. noted, introduction of a health insurance system causes a shift in power from the supply side to the demand side. Hsiao et al. (2005) noted different options for running health insurance, and they underlined the pros and cons of running SHI under the MOH, the Ministry of Labor or by establishing a specialized health insurance agency under the MOH. They specifically underlined, "Insurance empowers the patients to demand satisfactory health services and the SHI agency should act as the wise and prudent purchaser for the insured" (Hsiao et al 2005). Ethiopia gave careful consideration to organizational arrangements and capacity for both CBHI (Box 1) and health insurance overall, including social health insurance (Box 2).

Box 1.

Ethiopia: CBHI schemes with clear organizational, governance and executive structure

In Ethiopia, a CBHI scheme by design covers a district with an average total population of over 100,000. It has informal satellite units, called sections, in each kebele, the smallest governmental administrative unit at the village level. Each scheme is staffed with three government employees, namely a CBHI coordinator, a health officer and an accountant/data management officer. CBHI scheme staff are hired by local administration, and the coordinator is accountable either to the district administrator or district health office. CBHI schemes are officially launched through a general assembly that also elects CBHI governing boards among assembly members to oversee and guide CBHI scheme management. The effectiveness of the structure was tested during piloting, adapted, and is being used for scale-up. However, discussion is under way by the government and other key stakeholders to improve the structure, staffing and incentive systems to enhance the performance of volunteers that run CBHI sections. Additionally, stakeholders are also reviewing the roles and responsibilities of the federal Ethiopian Health Insurance Agency and the regional government, especially regional health bureaus, regarding accountability of the CBHI schemes. Policy discussion is under way regarding establishment of higher-level risk pools (regional and national levels) and the organizational relationship between the higher-level pools and the CBHI schemes. Ethiopia's lesson so far is positive and it will also give more lessons from the evolving developments.

The Ghanaian National Health Insurance Authority (NHIA) was established under the National Health Insurance Act of 2003. In response to growing administrative challenges from its initial reliance on semi-autonomous district schemes, the central NHIA gained new mandates through another act passed in October 2012. That act converted district "schemes" into "offices" of the central authority, allowing the NHIA to consolidate claims processing among other functions. Beyond improving the administrative task of processing claims, the NHIA has also needed to develop new data aggregation, analysis, communications, and managerial capacities to purchase health services strategically.

The lesson here is that to successfully implement health insurance, not only do countries need to put in place the appropriate institutional arrangements and organizational capacity, they also need to evolve, learn and adapt as they grow and circumstances on the ground change (see Lesson 5).

Box 2.

The Ethiopian Health Insurance Agency: an institution empowered to set up, operate and supervise insurance

Ethiopia's MOH reviewed existing institutions and structures, including within the MOH and also at the Ethiopian Social Security Agency, to assess their appropriateness and capacity to take on the role of a health insurance agency. The review, which included consultative meetings with key stakeholders, found that both institutions were overburdened and faced significant challenges in performing their mandates. The review also determined that existing laws were not adequate to encompass health insurance. As a result, the Council of Ministers Regulation of December 2010, pursuant to the Federal Proclamation of August 2010, allowed the establishment of the Ethiopian Health Insurance Agency (EHIA) to lead SHI and CBHI, as well as to regulate all other health insurance programs.

The EHIA is led by a Governing Board of Directors and is upheld by strong managerial and operational structures. The EHIA has its headquarters in Addis and 29 branch offices throughout the country employing around 1,000 staff. Since 2006, HFG and its predecessor USAID bilateral Essential Services for Health in Ethiopia (ESHE-II) and Health Sector Financing Reform (HSFR) projects have provided technical support in the health insurance initiation, policy consultation, design and implementation, including secondment of key staff and training.

Lesson 3

Broad coverage of the poor can't happen without government involvement.

Throughout the political and technical process of expanding health insurance, government's role is irreplaceable. This point is relatively clear for government-owned and -led health insurance programs, but it is also true for attaining broad coverage through community-based health insurance (CBHI) schemes that many countries with large informal sectors have adopted. Members of CBHI schemes usually have similar demographic and characteristics; they are often all low-income, limiting the chance to collect contributions based on an ability-to-pay system (in which wealthier clients pay more than less-wealthy clients for the same benefits). CBHI schemes also typically have limited capacity to manage an insurance program. In fact, most voluntary CBHI schemes are financially unstainable without subsidy and ongoing technical support. Overall, they cover very low numbers, usually with limited benefits. It is only when governments proactively engage that CBHI schemes can play a significant role in countries' health financing and attain high levels of coverage (Wang and Pielemeier 2012).

A WHO study on CBHI concluded that very few schemes reached the vulnerable population groups, unless government or others facilitated their membership through subsidies. It further stated that government can play four important roles in

Photo: Frank Ribas for Communication for Development

Infant growth check-ups – like this one at the Ekpo Abasi Clinic in Calabar, Cross River, Nigeria — are among the primary care services typically covered by state-supported health insurance schemes.

promoting CBHI. Namely, government can (i) play an advisory role on the design of CBHIs, (ii) monitor CBHI-related activities, (iii) serve as trainer, and (iv) serve as co-financier. The paper also stated that as part of the design of CBHIs, "Government should be seen to steer C[B]HIs in the direction of a national system of universal coverage and financial protection" (WHO 2003).

In Ethiopia, the government considered CBHI as part of the overall health financing policy by specifically articulating it in its health insurance strategy and other policy documents. CBHI expanded to more than 300 districts and provided coverage to close to 17 million people, over one-fifth of whom live in poor households and have their contribution covered through a targeted government subsidy. Government played an irreplaceable role in initiating and implementing CBHI in Ethiopia. Specifically, the Ethiopian government:

- Led the design and implementation of pilot CBHI schemes in 13 districts;
- Deployed three government-salaried executive staff per scheme and allocated operational budget to run schemes;
- Allocated targeted and general subsidies to CBHI schemes;
- Developed CBHI scale-up strategy and made CBHI coverage one of the government's development targets; and
- Provided stewardship and oversight, financial audits and reinsurance in the case of a few schemes that experienced financial distress.

In Ghana, rapid expansion of health insurance to cover more than 40 percent of the population occurred only after government-led implementation of the NHIS. CBHI was piloted and launched first in Sunyani District by the Catholic Diocese there in the late 1980s. By 2002, there were more than 140 CBHI schemes, but they covered only 1-2 percent of Ghanaians with limited services. Although the central and local governments were giving limited support in the late 1990s and early 2000s that contributed to the flourishing of CBHI schemes, large population coverage increases occurred only after the enactment of the NHIS in 2003. The Ghanaian government supported this rapid expansion of health insurance by enacting the NHIS Bill in 2003; establishing the National Health Insurance Authority with the mandate to lead the NHIS; and defining contributions from formal-sector employees and non-exempted segments of the informal sector. Additionally, the Parliament passed a VAT levy earmarked to the NHIS, providing roughly 70 percent of the revenues for the scheme.

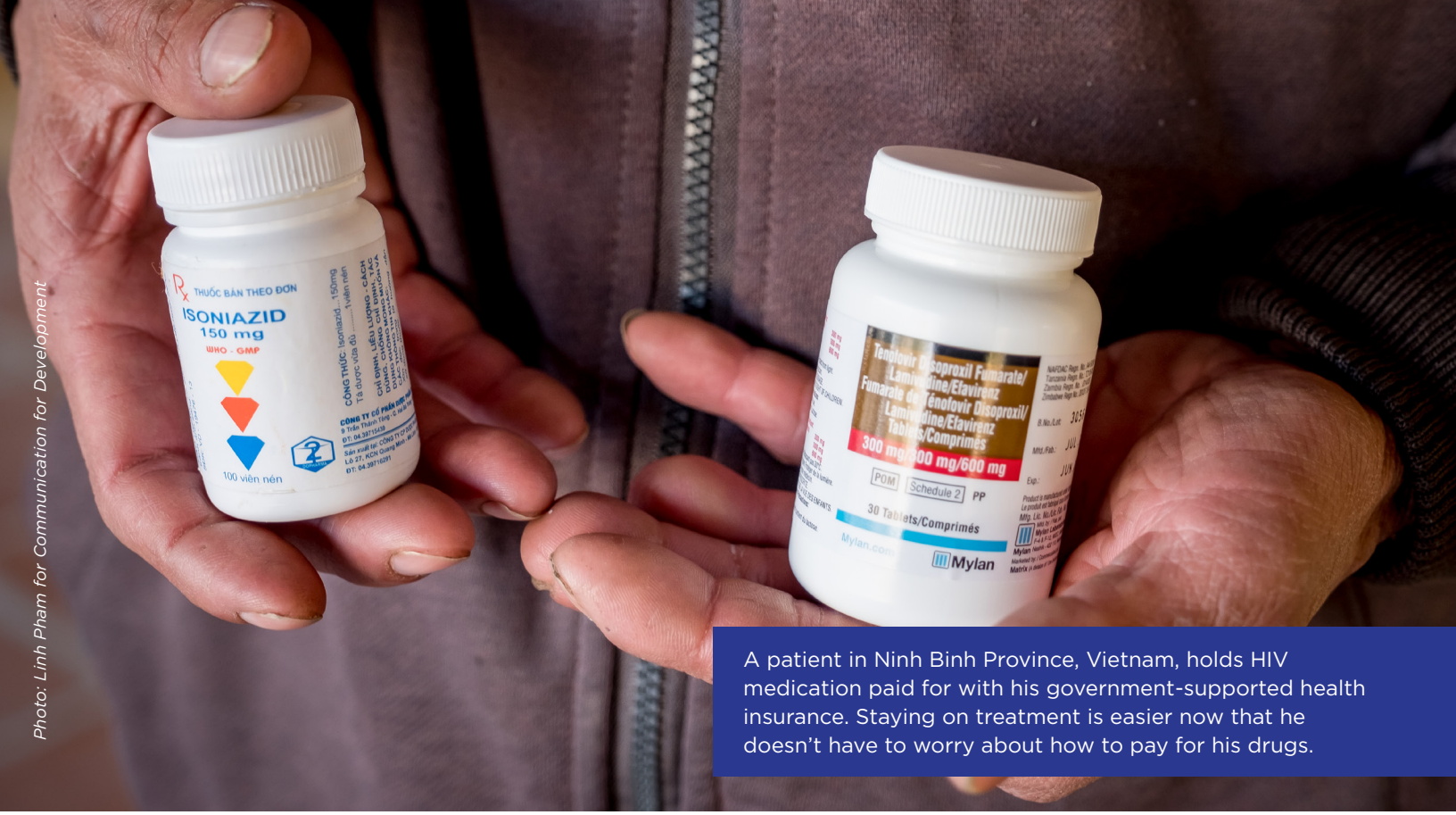

Photo: Linh Pham for Communication for Development

A patient in Ninh Binh Province, Vietnam, holds HIV medication paid for with his government-supported health insurance. Staying on treatment is easier now that he doesn't have to worry about how to pay for his drugs.

Lesson 4

Remember the supply side, so that increased health insurance coverage and demand for health care connects to accessible, quality services.

As countries work to design and expand their public health insurance programs, attention to the supply side is critical. Key supply-side factors such as infrastructure, staff, and commodities, must be in place and properly addressed (see Box 3). It is inefficient to expand coverage of mediocre or unavailable health services. Health financing arrangements put in place to expand coverage must be sequenced correctly with their corresponding supply-side considerations.

Ethiopia is a great example of a country that addressed the supply side before implementing new health financing arrangements. Leading up to the introduction of CBHI, Ethiopia enacted three reforms that improved the quality of care necessary to implement CBHI successfully. A revenue retention reform, enacted in 2005, allowed facilities to retain revenue from user fees and use it for quality improvements, instead of sending it to the federal treasury. The introduction of private wings in public hospitals improved the retention of key clinical hospital staff by enabling them to earn additional income, generate additional hospital revenue, and provide alternatives for users of private hospital services. Ethiopia also began outsourcing nonclinical services at public hospitals; this reform allowed hospital management and clinical staff to focus on delivering health care, while auxiliary services such as laundry, security, gardening, and catering were outsourced to local firms.

Box 3.

Supply-side factors

- **Access to facilities: Physical proximity of the health service provider, along with availability of transportation services, including ambulances**
- **Availability, capacity, attitude and behavior of health workers**
- **Availability of services defined in the benefit package, diagnostic services, and essential drugs**
- **Quality of care (both clinical and perceived quality)**

Lesson 5

Expansion of insurance requires intentional, iterative learning and adaptation.

Expanding health insurance is a dynamic, information-intensive endeavor. First, as populations and their health needs change and grow, insurance agencies must be able to shift subsidies to newly vulnerable groups. As health services and technologies evolve, agencies must determine which new services to start paying for and which to stop to maintain high quality of care. And as costs and prices change, agencies must dynamically respond to balance budgets. These abilities require more than the traditional approaches to monitoring and evaluation of programs. They require intentional, iterative learning and adaptation, fed by information systems, trained staff, and processes to use data for decision-making, not just bottom-up reporting.

Observations from HFG's work in Ghana and Ethiopia illustrate this lesson's relevance to health insurance expansion.

When the NHIA in Ghana started in 2003, it was largely an administrative payer of incoming claims from providers. This means it had minimal systems and staff capacity in place to aggregate information about incoming claims. It had limited ability to vet claims for medical quality, errors, or fraud. It did not have systems to flag and conduct root-cause analysis of problems in boosting enrollment and targeting the poor. In sum, it could not yet make "strategic" purchasing decisions on behalf of enrollees to maximize health or financial protection. Since 2009, the NHIA fund has been running a deficit driven by rising costs of claim payments, which have nearly tripled since 2010, stymying the ability to expand population coverage and threatening service coverage for the 40 percent of the population already enrolled. HFG worked with the NHIA to build the authority's capacity as a more evidence-based, strategic purchaser, and to use evidence to design a new round of NHIS reforms. The NHIA learned that it needed to build a learning system that establishes intentional processes and has the quality data necessary for effective learning and adaptation. The key lesson from Ghana is that it would have been ideal to build these iterative learning tools and processes into the initial design of the NHIS, rather than having to catch up after financial crises forced their creation.

Ideally, policymakers and their partners should recognize in advance that insurance expansion will require intensive information collection and analysis, and build that capacity into insurance designs from the beginning.

In Ethiopia, the government established an effective monitoring and evaluation system that is guiding health insurance expansion today. District-level CBHI schemes in Ethiopia are using routine data to manage day-to-day operations. This evidence is being gathered, compiled and analyzed at regional and national levels and used for policy decision-making at sub-national and national levels. These lessons are being used to improve the results of an ongoing expansion of CBHI to new districts and regions, as well as for policy dialogue on establishing sub-national and national-level pools.

There are major challenges in building intentional, iterative learning systems to enable health insurance expansions, especially in countries with severely limited resources for health systems. Current human resource capacity for data collection, analysis, and proactive management is limited (and tends to turn over frequently); vast amounts of data need to be digitized for better data collection, transmission, compilation, analysis, and timely use; there continues to be limited data on the quality of services; and operational processes for using data for decision-making are often lacking. As the Ghana and Ethiopia examples show, however, it is possible for those leading health insurance agencies and programs to integrate learning approaches into their operations. Ideally, policymakers and their partners should recognize in advance that insurance expansion will require intensive information collection and analysis, and build that capacity into insurance designs from the beginning.

Conclusion and Recommendations

The field of health economics and the global push toward universal health coverage have generated a great deal of theory, evidence, and lessons learned on how to expand health insurance. That body of knowledge was largely in place when HFG began work, helping guide technical choices on a wide array of core components. These include where and how to raise funds for health (revenue mobilization), how to enable the healthy and wealthy to subsidize the sick and poor (pooling), which goods and services to prioritize (cost-effective benefit package design), how to pay providers to get desired results (strategic purchasing), and more.

HFG has used and contributed to global knowledge to support nine countries' efforts to expand health insurance coverage. However, the lessons learned by HFG and its country partners go beyond that core theory and practice. They are vital additions to the pursuit of universal health coverage. These five lessons point to five recommendations for future health insurance expansion that reformers (governments, civil society groups, donors, and implementing partners) should adopt:

1. **Demand political economy analysis and strategy.** Given the array of powerful interests and potential winners and losers in health insurance expansion efforts, reformers should conduct political economy analyses to guide strategies on sequencing, strategic communications, and feasible policy choices.

2. **Require legal and organizational analysis and capacity building.** Efforts to optimize population health status or financial risk protection from health insurance coverage will be thwarted if they do not align with legal constraints and institutional abilities and responsibilities. Alongside political economy analysis and strategy, reformers should conduct governance and organizational analysis—debating and deciding which actors will (and can) do what, and enabling them to do so.

3. **Demand that the government lead and subsidize, and engage with the government to make this happen.** Community ownership and engagement of the private sector can be beneficial to health insurance expansion, but government stewardship and funding is essential for substantial and equitable progress toward universal health coverage. Reformers should resist the fast but unsustainable progress that may be attainable without government leadership. Rather, they should house their reforms—even those that envision highly decentralized governance and large roles for the private sector—with government stewards and government-regulated and -subsidized pooled funds that are the primary means of covering the poor.

4. **Align with the supply of today, invest in the supply of tomorrow.** Health insurance is a means to an end: improved population health and/or lowered chance of impoverishment from health costs. To be effective and avoid eroding public trust, however, health coverage that is promised on paper must be matched by actual availability and delivery of quality services. Governments and private-sector partners should carefully consider the existing supply of health workers and services and fund improved physical access to and quality of health care services when covering new populations or services, then continually invest in increases and improvements in quality.

5. **Monitor the never-ending path toward UHC and build systems to learn and adapt as conditions change.** Even in high-income countries that have "achieved universal health coverage," continual analysis, learning, and adaptation is required to maintain effective coverage as shifts occur in burdens of disease, health technologies, consumer preferences, provider behavior, and costs. To expand and maintain health insurance coverage, reforms must therefore build systems that do more than merely "report up" on an array of indicators. There must be systems and operational processes that quickly detect problems, rapidly investigate root causes, and ensure that analysis leads to adaptive decision-making. Timely evidence generation and use is also critical to maintain the financial health of schemes and to engage in strategic purchasing and appropriate provider payment mechanisms for efficiency and better cost containment.

References

Acemoglu, Daron and James Robinson. 2008. The Role of Institutions in Growth and Development. The International Bank for Reconstruction and Development / The World Bank. On behalf of the Commission on Growth and Development. WORKING PAPER NO. 10

Blanchet, Nathan J. and Osei B. Acheampong. 2014. *Building on Community-based Health Insurance to Expand National Coverage: The Case of Ghana*. Bethesda, MD: Health Finance and Governance Project, Abt Associates.

Feleke, Solomon, Workie Mitiku, Hailu Zelelew, and Tesfaye D. Ashagari, *Ethiopia's Community-based Health Insurance: A Step on the Road to Universal Health Coverage*. Bethesda, MD: Health Finance and Governance Project, Abt Associates.

Glassman, A., M.R. Reich, et al. (1999). "Political Analysis of Health Reform in the Dominican Republic." Health Policy & Planning 14(2): 115-126.

Health Finance and Governance (HFG) Project. (not dated). Health Insurance at a Glance in Africa.

Hsiao, William C., A. Fraker, P. Hanvoravongchai, M. Jowett, D. Pinto, and S. Ramachandra. (2005). Social Health Insurance for Developing Nations: A concept paper prepared for the Flagship Course, jointly sponsored by the World Bank and Harvard University.

Mathauer, Inke and Guy Carrin. 2010. The role of institutional design and organizational practice for health financing performance and universal coverage. WHO, Background Paper.

Rajkotia, Yogesh. November 2007. *The Political Development of the Ghanaian National Health Insurance System: Lessons in Health Governance*. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.

Roberts, M.J., W. Hsiao, P. Berman, and M.R. Reich. (2004). Getting Health Reform Right: A Guide to Improving Performance and Equity. New York: Oxford University Press.

The Federal Democratic Republic of Ethiopia. Federal Negarit Gazeta. 2010. *Proclamation No. 690/2010. Social Health Insurance Proclamation Page 5494.* Addis Ababa.

The Federal Democratic Republic of Ethiopia. Federal Negarit Gazeta. 2010. Council of Minister Regulation No. 191 /20 10 on the Ethiopian Health Insurance Agency Establishment, Page 5673. Addis Ababa.

The Federal Democratic Republic of Ethiopia. Ministry of Labour and Social Affairs. 2012. National Social Protection Policy of Ethiopia (Final Draft). Addis Ababa.

Walt G, Gilson L. 1994. Reforming the health sector in developing countries: the central role of policy analysis. Health Policy and Planning 9: 353–70.

Wang, Hong and Nancy Pielemeier. 2012. *Community-Based Health Insurance: An Evolutionary Approach to Achieving Universal Coverage in Low-Income Countries.* Journal of Life Sciences 6: 320-329.

World Health Organization. 2003. Community-based Health Insurance Schemes in Developing Countries: facts, problems and perspectives. Discussion Paper Number 1 – 2003.

Zelelew, Hailu. 2015. *Community Health Financing as a Pathway to Universal Health Coverage: Synthesis of Evidence from Ghana, Senegal, and Ethiopia.* Bethesda, MD: Health Finance and Governance Project, Abt Associates


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