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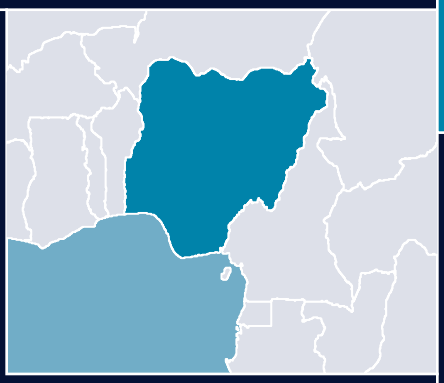
March 2013

SCALING UP NATIONAL HEALTH INSURANCE IN NIGERIA



Learning from Case Studies of India, Colombia, and Thailand

This publication was prepared by Arin Dutta and Charles Hongoro (consultant) of the Health Policy Project.

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Scaling Up National Health Insurance in Nigeria

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CONTENTS

Executive Summary iv
Abbreviations viii
Introduction 1
The Nigerian Context 1
Country Selection and Methodology 2
Considerations in Expanding Health Insurance Programs 2
Forms of Health Insurance Schemes 3
Colombia 5
Background 5
Healthcare Financing 6
Benefit Packages 6
Choice of Insurers 7
Competition and Contracting 7
Premiums and Risk Adjustment 7
Performance of the Insurance System 8
Successes *8*
Challenges *10*
Continuing Health Reforms in Colombia 11
Lessons Applicable to Nigeria 11
India 13
Background 13
Healthcare Financing 13
Structure of Health Insurance 14
Government-funded Health Insurance Schemes 16
Rashtriya Swasthya Bima Yojana (RSBY), 2008 ..... *18*
Evaluation of RSBY *19*
Health Insurance in the Achievement of UHC 21
Challenges of Implementing UHC in India 23
Lessons Applicable to Nigeria 24
Thailand 26
Background 26
Road to Universal Coverage 26
Universal Coverage Scheme 27
Evaluation of the UCS *30*
Lessons Applicable to Nigeria 31
Overall Conclusions 33
References 37

EXECUTIVE SUMMARY

Expanding access to health insurance is an important part of an overall strategy to achieve universal health coverage (UHC). UHC implies ensured access to and use of high-quality healthcare services by all citizens and protection for all individuals from any catastrophic financial effect of ill health. UHC can be a major determinant of improved health outcomes for all citizens, especially the poorest.

Nigeria is eager to achieve UHC. Since its launch in 1999, the National Health Insurance Scheme (NHIS) has been the major initiative to expand health insurance in Nigeria. However, as of mid-2012, NHIS still covered only about 3 percent of the population (5 million individuals). Policymakers in Nigeria are interested in learning from the experiences of other developing countries in achieving higher health insurance coverage. In 2013, the agenda for reform of the NHIS will pick up pace, with several different proposals being considered, including parliamentary legislation to create a "health fund" to cover the costs of health insurance for certain groups. Currently, NHIS programs exist that target the formal and self-employed sectors, with mixed success. The formal-sector program operates as a social health insurance scheme. Recently, the NHIS launched a rural community-based social health insurance program to cover more Nigerians. However, uptake has been slow.

Nigeria will need to make crucial decisions if access and financial protection in the context of health are to be expanded to cover the majority of the population. Given the likelihood of the passage of the National Health Bill (drafted in 2008) through the lower house of Parliament during 2013, Nigerian policymakers should also now consider the unfinished agenda for health financing.

To support this endeavor, the Health Policy Project conducted case studies of the experience of three countries—Colombia, India, and Thailand—as they developed government policies as a strategy to achieve universal health coverage. The lessons learned should be useful for stakeholders involved in expanding and improving the NHIS.

Colombia approved its universal health insurance scheme in 1993, creating the National Social Security System for Health, which currently covers more than 95 percent of the population. There are two insurance regimes: the Contributory Regime (CR), which covers workers and families with monthly incomes above $170 per month (those who can afford to pay), and the Subsidized Regime (SR), which targets poor or informal workers. Since 2012, both groups have been able to access the same health benefits package. A mandatory payroll tax contribution of 11 percent funds the CR. National and local tax revenues and a 1.5 percent payroll tax fund the SR.

There are several lessons from the Colombian experience for Nigerian policymakers:

- Colombia's first action was to pass Law 100, which provided the legal basis for implementing a national social security system. Establishing a legal basis for health financing reforms could facilitate implementation in a federal system such as Nigeria's.
- Colombia's fiscal capabilities allowed for a gradual expansion of coverage. A prioritization policy enacted alongside a means-testing policy would allow better targeting of spending. The key lesson for Nigeria is to plan gradual implementation as a function of available resources.
- Colombia's experience with an effective national equalization fund that pools mandatory contributions from workers and government contributions from taxation should be instructive for Nigeria, where the social health insurance scheme currently has no pooling across the contributory populations.

- Colombia's expanded SR scheme is possible through financial contributions from the federal government, local authorities at the district and municipal level, and solidarity contributions from members of the CR. Nigeria has large numbers of individuals with higher income who could also make such solidarity contributions, as well as sources of tax revenue at local government levels.
- Payroll-based funding needs a strong employment base, preferably with additional mechanisms to tax the self-employed. Self-employed people are generally not as easy to tax, especially if they are not registered taxpayers. It is important to devise other mechanisms for collecting contributions, such as the flat monthly rates or installments proposed for Nigeria's rural community-based social health insurance program (RCSHIP).
- When designing a contracting model, it is important to avoid disadvantaging public providers by saddling them with additional rules or obligations. In addition, public providers may not be competitive for service contracts. In Colombia, a modernization program was necessary to bring public hospitals up to par with private providers.
- True universal coverage may require a higher percentage of spending as a proportion of gross domestic product (GDP), so it is possible that countries such as Nigeria will need to compromise between comprehensiveness and sustainability, as Colombia did.
- Monitoring and evaluation systems are crucial to measuring performance and ensuring the efficient use of resources. Colombia invested in a database of all members, which is updated monthly. Nigeria is investing in a similar system, which needs strengthening.

India has three federal-level, government-sponsored health insurance schemes and nine state schemes, which together cover about 240 million citizens, or 19 percent of the population. With private insurance and other programs, more than 25 percent of the population has access to health insurance.

The Rashtriya Swasthya Bima Yojana (RSBY) is the premier national health insurance program established in 2008 to cover secondary care for families living below the poverty line. Contributions are very low and are required only at the time of enrollment into the scheme. The program receives funds from the federal level covering 75 percent of the total costs, with state (provincial) contributions covering the remaining 25 percent. A recent review of RSBY suggests that it is "on track" to achieving its objectives of increasing access to healthcare as well as reducing the financial risk among its beneficiaries (La Forgia and Nagpal, 2012).

As described in this report, lessons learned from RSBY's operational experience are appropriate for the NHIS:

- The successful launch and continuation of a massive health insurance scheme targeted at the poor is only possible if there is political will and fiscal commitment at all levels of government.
- Creation of a clear-cut targeting mechanism based on established lists and appropriate incentives for insurers and third-party administrators, along with the use of technology, can help lower the cost of enrollment for the poor.
- Any health insurance scheme that aims to target the very poor may learn from the foundational premises of RSBY: Make the system cashless, paperless, and portable.
- Standardization of documents and processes along with the proper use of technology helps in situations of low administrative and managerial capacity.
- The focus on secondary care (i.e., lower complication inpatient procedures) within a defined package of benefits for RSBY members has meant lower cost per family covered.

- Use of IT applications for enrollment and patient management at the provider level has benefited the scheme, beginning with the smart cards similar to those used by NHIS in Nigeria.
- Health insurance is now 24 percent of the central government budget for health (La Forgia and Nagpal, 2012). This is evidence of considerable political support and budgetary commitment. Moreover, these percentages have been achieved while keeping premiums to insurers low, thanks to competition among companies.

The debate in India about the best course toward UHC reveals the complexities that arise when governments face difficult fiscal choices. India may move to a national health insurance model, where the government uses public and private providers to allow all citizens access to a comprehensive benefit package. Such a strategy would come at significant cost. The public sector has already invested significant funds in the primary healthcare system. It has also invested in improved access to secondary healthcare and financial protection in its use of RSBY and other schemes.

Therefore, India may encounter sustainability challenges as the government expands toward UHC. In response, pragmatic proposals for India involve a mixed strategy: expand health insurance further for the poor using the existing schemes (that is, approximating a national health insurance model funded from general taxation) and consolidate other insurance schemes that use mandatory contributions for formal-sector employees.

India's choices may have important lessons for Nigeria. Nigeria can also learn from the processes and operational strategies used to expand government-funded health insurance in India. Nigeria must continue its current programs to strengthen primary healthcare and forge meaningful resource investment partnerships between states and the federal government, as India has tried to do.

Thailand introduced its Universal Coverage Scheme (UCS) in 2001, aimed at reaching the 75 percent of the population not covered by health insurance at that time. Thailand's government remains by far the biggest funder of the country's healthcare expenditures. The Ministry of Public Health is the core agency that implements the UCS scheme, which currently covers 80 percent of the population, followed by the Social Security Scheme, which covers 13 percent, and the Civil Servant Medical Benefit Scheme, which covers 7 percent. Few citizens are currently without any health insurance coverage.

High-level lessons can be drawn for Nigeria and other countries from Thailand:

- Thailand had several decades of experience with health insurance before it attempted a leap toward UHC in 2001. This past decade has seen strong political commitment to the principle of universal coverage. Access to healthcare and financial protection were seen as essential elements of an overall poverty reduction strategy. A legal framework enshrined a right to health. Different actors within the system, from civil society to government, were willing to work together to achieve the vision.
- The Thai strategy got three elements right that are necessary to achieve universal health coverage: improving fundamental access to healthcare services prior to a demand-side intervention, implementing cost containment thoroughly, and using strong purchasing mechanisms.
- In Thailand, the healthcare system was developed from the bottom up. The success of the UCS and the improvement of health outcomes are based on a strong commitment to primary healthcare as the entry point for every Thai citizen seeking health services.

- Design-related factors were important in the success of universal coverage in Thailand, including the following:
  - Use of stringent provider reimbursement mechanisms.
  - Development of strong institutions.
  - Establishment of the National Heath Commission Office, with responsibility for achieving broad participation in health policy formation.
  - A continuous process of health system research and monitoring and evaluation.

How health insurance expansion features in a UHC strategy depends on the resources available to the government via general taxation; the growth and maturity of private voluntary health insurance markets; and, most important, the state of the health system across primary, secondary, and tertiary healthcare. Our case studies suggest that pragmatic choices made by lower-middle and middle-income governments—a group where Nigeria may be placed—have involved hybrid health financing models.

ABBREVIATIONS

ACCORD	Action for Community Organization, Rehabilitation and Development (India)
ARS	Administradora de Regimen Subsidiado (Colombia)
BPL	below the poverty line
CBHIS	community-based health insurance
CGHS	Central Government Health Scheme (India)
CR	Contributory Regime (Colombia)
CSMBS	Civil Servant Medical Benefit Scheme (Thailand)
CUP	Contracting Unit for Primary Care (Thailand)
DRG	diagnosis-related groups
EPS	Entidad Promotora de Salud (Colombia)
ESIS	Employees' State Insurance Scheme (India)
FOSYGA	Solidarity and Guarantee Fund (Colombia)
GDP	gross domestic product
HCS	Health Card Scheme (Thailand)
HLEG	High-Level Expert Group on Universal Health Coverage (India)
HPP	Health Policy Project
INHS	Integrated National Health System (India)
M&E	monitoring and evaluation
MOH	Ministry of Health
MWS	Medical Welfare Scheme
NGO	nongovernmental organization
NHIS	National Health Insurance Scheme (Nigeria)
NHP	National Health Package (India)
NHSO	National Health Security Office (Thailand)
NRHM	National Rural Health Mission (India)
POS	Plan Obligatorio de Salud (Mandatory Health Plan; Colombia)
RCSHIP	rural community-based social health insurance program (Nigeria)
RSBY	Rashtriya Swasthya Bima Yojana (India)
SEWA	Self Employed Women's Association (India)
SGSSS	General System of Social Security in Health (Colombia)
SHI	social health insurance
SR	Subsidized Regime (Colombia)
SSS	Social Security Scheme (Thailand)
UC	universal coverage
UCS	Universal Coverage Scheme (Thailand)
UHC	universal health coverage
UHIS	Universal Health Insurance Scheme (India)
UPC	*unidad de pago por capitación* (capitation payment unit; Colombia)
VHV	village health volunteer

INTRODUCTION

The Nigerian Context

All countries face challenges in expanding healthcare coverage. Many countries have committed themselves to achieving equity in healthcare coverage by including healthcare goals in human rights declarations, constitutions, and health policy documents. Expanding health insurance is a strategy that countries use to alleviate the adverse health outcomes of all citizens, especially the poorest. It is one of the methods that low-income countries may consider to achieve universal health coverage (UHC). UHC implies ensured access to and use of high-quality healthcare services by all citizens, especially the poor, and protection for all individuals from the catastrophic financial effects of ill health.

Nigeria, one of the few African countries to begin expanding health insurance over the past five years, seeks to achieve universal healthcare coverage by 2015. The country's National Health Insurance Scheme (NHIS) offers programs to cover the formally employed, urban self-employed, tertiary students, armed forces, some pregnant women, children under five, and such populations as the disabled and prison inmates. Under the National Health Insurance Act of 2008, in 2010, the NHIS started a rural community-based social health insurance program (RCSHIP).

The NHIS is going through a period of evaluation to review the benefit package for its members and the different modalities for contribution of premiums. As a priority, the Nigerian government would like NHIS to cover more of the population. Currently, based on the number of identification cards issued, NHIS covers about 5 million members, or 3 percent of the population. Several proposals to increase coverage include a proposal to make NHIS registration mandatory for federal government employees. At a broader level, Nigeria needs to examine the path it will take to achieve universal health coverage and the role health insurance may play in it.

Nigeria will need to make crucial decisions if access and financial protection within the context of health are to expand to cover the majority of the population. Given the likelihood of the passage of the National Health Bill (SB 50, drafted in 2008) through the lower house of the National Assembly (Parliament) during 2013, Nigerian policymakers should now also consider the unfinished agenda for health financing. Making contributions to the NHIS compulsory for formal-sector employees is one option being considered, which could be introduced as part of the Health Bill or as a clause in the process of the review and adoption of amendments to the 1999 constitution.

Another bill,[1] widely known as the "NHIS reform bill" (tabled in the National Assembly in early 2013), proposes the creation of a "health fund" that would receive the sums from an earmarked "health tax" on the value of luxury goods (at a tax rate of 2 percent) and any other funds appropriate for this purpose. The health fund would be used to fund the health insurance contributions of a defined group of citizens: children under five, senior citizens above 65, physically challenged or disabled individuals, prison inmates, and indigent persons,[2] as well as pregnant women requiring maternity care.

If this health fund is successful, it may allow Nigeria to expand NHIS to cover a large proportion of the population. However, actual implementation will depend on the ability to capture the special tax on luxury goods and on the size of the revenue per year.

[1] Bill HB 276: "An act to amend the National Health Insurance Scheme Act, Cap. N42 Laws of the Federation, to establish a health fund to ensure access to good healthcare for every Nigerian and for other matters connected thereto" (introduced by Hon. Christopher S. Eta).
[2] This is defined in the context of the bill as individuals with an annual income below 30,000 naira, or about US$191.

The possibility of a health fund to finance health insurance coverage for key groups and the likelihood that NHIS contributions will become mandatory are all indications of a desire to expand health insurance in Nigeria beyond its current minimal state. These reforms have precedents in other countries that have also expanded health insurance in the pursuit of UHC. In this context, there is considerable interest among Nigerian stakeholders in learning from the experience of other countries that have expanded health insurance coverage. Of particular interest are the ways in which different countries have avoided the pitfalls of expanding program size while maintaining access and quality of care.

To support this endeavor, the Health Policy Project (HPP) conducted case studies of the experience of three countries—Colombia, India, and Thailand—with expanding health insurance via government-led policies as a step toward achieving universal health coverage. This document focuses only on certain aspects of the choices facing Nigeria, as appropriate for the maturity of the country's program. The lessons learned should be useful for stakeholders involved in implementing Nigeria's NHIS.

Country Selection and Methodology

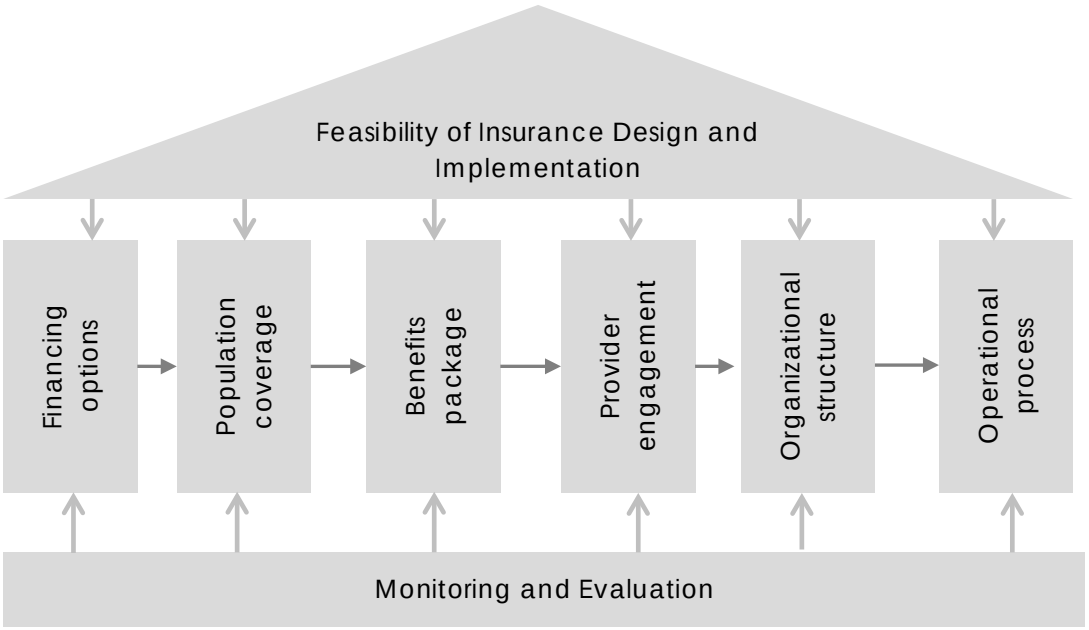
HPP identified health insurance programs in low- and middle-income countries that seem the most relevant to inform Nigeria's NHIS. At the time of this activity, the NHIS team had studied and visited Rwanda, Ghana, and India as part of its research. HPP selected Colombia, India, and Thailand largely because these three countries chose to increase coverage of health insurance—as Nigeria wishes to do—including schemes to extend health insurance to rural communities. For example, the country may have attempted expansion through some form of community-based health insurance, as has the NHIS, which is currently implementing a community-based scheme in 12 pilot states.

Before presenting the findings of the case studies and lessons learned relevant to Nigeria, it is important to review a basic framework for expansion of health insurance programming for any country.

Considerations in Expanding Health Insurance Programs

Wang and co-authors (2012) provide a practical guide for assessing the design elements that must be in place to expand health insurance coverage in a country (see Figure 1). These elements acknowledge that each country has unique economic, political, social, and institutional opportunities for and barriers to expanding health insurance. It is therefore necessary to examine each country's context before gleaning potential lessons.

Figure 1. Design Elements for the Expansion of Health Insurance



Source: Adapted from Wang et al., 2012

In the case studies from Colombia, India, and Thailand, this document will concentrate mainly on the lessons related to the first two design elements: **financing options** and **population coverage**. As Nigeria has yet to achieve significant coverage with its health insurance schemes, it may be most useful to focus on options that make progress toward universal coverage. A more detailed case study analysis may be useful at a later stage to provide insights into provider engagement, organizational structure, and operational processes once Nigeria's health insurance program gains in size and maturity. However, this document's case studies discuss these aspects only briefly.

Forms of Health Insurance Schemes

Health insurance comes in different forms, defined mainly by the source of financing for the insurance premiums. A country may choose several different forms to maximize the population coverage. For each form, the options for financing determine what is feasible in terms of benefits, given the premium schemes. Therefore, the design elements above come into play repeatedly at the point of the public sector selecting from a menu of health insurance types:

- **National health insurance** or government-managed health insurance is usually financed through general taxation and implies comprehensive coverage for all individuals regardless of health status or affiliation. In this case, general taxation implies that no specific earmarked tax is used. Debt relief and other sources of funds such as tolls and the sale of government assets may also be used. Individuals are not usually required to make additional financial contributions beyond taxes. These state-funded health insurance programs can coexist with all other forms of health insurance, including private voluntary health insurance. A prominent example of a national health insurance program is the United Kingdom's National Health Service.
- **Social health insurance** (SHI) is financed via payroll taxes collected from employers and employees. Often this contribution is mandatory for a certain group, such as government

employees. The contribution of the employee and the employer may be balanced, or one may contribute more than the other. Kenya's National Hospital Insurance Fund is one such mechanism, which requires all formal-sector employees to make a mandatory contribution, whereas individuals in the informal sector may participate voluntarily. Another hallmark of SHI is a central management agency that pools the funds and makes payments to providers. The government may step in to make contributions for low-income or marginalized groups to enable them to participate in the scheme.

- **Community-based health insurance** (CBHI) covers a wide spectrum of programs that share at least three attributes: not-for-profit prepayment plans for healthcare, community control, and voluntary membership. The community in question can be defined geographically—for example, a village—or via some other well-defined affiliation. The large variety of CBHI schemes encompass programs that cover high-cost, low-frequency events as well as those that cover low-cost, high-frequency events. CBHI programs are often referred to as health insurance for the informal sector, mutual health organizations (*mutuelles de santé*), and micro-health insurance schemes (Gottret and Schieber, 2006). They are quite common in sub-Saharan Africa, especially in West and East Africa.

In addition to these mechanisms that deploy national government or community resources, private for-profit insurance also exists in many low-income countries. There is a small but growing market for these insurers in many sub-Saharan African countries, including Nigeria. Since these private insurance markets cater to only those who can afford the premium payments, their growth depends on overall growth in income and in the pool of insurers. Currently, they do not offer a viable mechanism to reduce the burden on the public sector for health financing in sub-Saharan Africa.

COLOMBIA

Background

Colombia is a middle-income country with a total population of 46.5 million (2012) who mostly reside in urban areas (75 percent urban). In 2010, Colombia spent nearly 7.6 percent of gross domestic product (GDP) on healthcare (Vargas-Zea et al., 2012). Most of its health indicators are relatively good. For example, in 2008, average life expectancy was 71 for men and 78 for women, the maternal mortality rate was 85 per 100,000, and the infant mortality rate was 16 per 1,000 live births (World Bank, 2012).

Prior to 1993, the spread of health insurance was relatively limited, with only a quarter to a third of the population covered (Escobar et al., 2010). Out-of-pocket costs constituted a significant barrier for care-seeking by the poor. In 1993, Colombia approved a universal health insurance scheme (Law 100) that entitles all citizens, regardless of ability to pay, to a comprehensive health benefits package. Before the reforms of 1993, the national health system had subsidized public hospitals to provide services for most Colombians (supply-side). After the reforms, the system instead subsidized the beneficiaries (demand-side), who could receive services from both public and private facilities, with the intermediation of a variety of insurance organizations (Cabrera, 2010). Therefore, the state was no longer the single source of service provision or healthcare management for the vast majority of individuals.

The 1993 reforms led to the creation of the General System of Social Security in Health (SGSSS), which comprises two insurance regimes:

- **Contributory Regime** (CR): covers workers and their families (spouse and dependents) with monthly incomes above US$170 per month.
- **Subsidized Regime** (SR): covers the poor and indigent, who are unable to fully contribute to the social security system. The poor must apply and are then authorized to become members via a test to calculate an indicator of household economic status based on various variables (also known as proxy-means test index). Certain prioritized populations are covered first, within established coverage goals. These include pregnant or breastfeeding women, children under five years, and the disabled.

In addition to this health insurance system, the government provides free primary public healthcare and covers emergencies and disasters. There is also a special fund for the health needs of victims of traffic accidents, which complements coverage under the CR and SR. Employees of certain government organizations—educational institutions, the military and police, and the petroleum sector—also enjoy special healthcare schemes.

As of late 2011, more than 95 percent of the Colombian population was covered under the SGSSS (Vargas-Zea et al., 2012). It is important to note that both the CR and SR are components of a comprehensive social protection system in Colombia that is intended to cover all life stages across such issues as disease, nutrition, retention in school, ability to work, extreme poverty, and aging (Cabrera, 2010). The CR scheme is connected with the component of social protection that covers occupational accidents and diseases (via pensions for permanent, partial, or total disability, and for payments in the case of death).

The system is managed by the Ministry of Health and Social Protection, with the National Health Regulation Commission providing regulatory oversight, and the National Health Authority (SuperSalud) providing monitoring and quality control.

Healthcare Financing

The financing for the universal health insurance scheme follows an overall principle of enabling access to health services of a uniform quality for all Colombians for a fair contribution. Formal-sector employees and those independent workers earning more than a threshold monthly income must enroll in the CR and contribute 11 percent of their income, plus another 1.5 percent for the SR, as described below, for a total of 12.5 percent of monthly income. For formal-sector members, the contribution is 8.5 percent from the employer and 4 percent from the employee: a 2:1 ratio. Self-employed or informal-sector workers can also join and must pay all of their contributions themselves, based on their reported income at the time of joining.

Funds for the CR are collected by the member's insurer of choice, which then pools the funds across individuals for transfer to the national Solidarity and Guarantee Fund (FOSYGA). The FOSYGA has several financial accounts or sub-funds; for example, one covers traffic accidents and another covers the CR scheme. In return for the transfers from the insurers, the FOSYGA provides a capitation payment unit (*unidad de pago por capitación,* or UPC) to the insurers. In 2012, the UPC for CR stood at US$304 per year. UPC amounts are adjusted for three variables determining risk of disease at the individual level: age, gender, and geographic location.

For the main part, national and local tax and devolved resources, along with the 1.5 percent payroll tax collected as above, fund the SR. This 1.5 percent contribution, which is in addition to the 11 percent collected for the CR, is considered a "solidarity contribution" from those in the CR to help purchase coverage for those in the SR. These solidarity contributions are also pooled in the FOSYGA.

Given that SR members may change their income or work status and become eligible for the CR, The FOSYGA maintains a database of all memberships across the two schemes, which is cross-checked every month to exclude from the SR anyone who meets the requirements of the CR (Cabrera, 2010).

Benefit Packages

Those with health insurance under CR or SR can choose their insurance provider, which then procures services from both public and private healthcare providers. In the past, members of the CR and SR[3] received distinct packages of health benefits. However, since 2009, successive decisions of the Committee on Health Regulation have unified the benefits for the two regimes, initially for youth and the elderly covered under the SR, and later—based on a government decision made in May 2012—for all other beneficiaries of SR (MSPS, 2012). This has led to greater equality.

Currently, the beneficiaries of CR and SR can access the Mandatory Health Plan (Plan Obligatorio de Salud or POS) which covers all levels of care and is considered generous (Escobar et al., 2010). It covers 5,874 procedures and interventions, as well as 730 drugs. Since the passage of Law 1438 of 2011, the benefits are available nationally based on a national identification card. In the past, the benefits of the SR plan were limited to residence in a particular municipality.

Services provided in public hospitals complement the POS and are financed through direct payments to providers, independent of the services they supply and insurance status (supply-side subsidies). These services relate to the public health intervention package or the Plan Básico de Salud (Basic Healthcare Plan). Law 100 also attempted to change supply-side subsidies into demand-side subsidies where insurers

[3] The historical SR package was termed the Mandatory Subsidized Health Plan (Plan Obligatorio de Salud Subsidiado) and covered most low-complexity care and catastrophic illness. The plan limited coverage for most hospital care and provided no short-term disability coverage.

(and not providers) are subsidized for beneficiaries, and insurers pay providers for actual services rendered to clients. This change in emphasis to demand-side subsidies was designed to eventually standardize coverage (provide the same benefits) in both regimes.

Choice of Insurers

In both schemes, a person is free to choose the insurer Entidad Promotora de Salud (EPS), which is a health-promoting entity. The EPS can be of public, private, or mixed ownership and can be run either for profit or not for profit. In 2009, the CR had 21 insurance EPS entities; 82 percent of enrollees were affiliated with private EPS, while public EPS handled the remaining 18 percent. The SR had 43 EPS insurance entities. Forty-four percent of enrollees were affiliated with private EPS and 42 percent with public community-based or local health plans.

Competition and Contracting

The Colombian government determines the prices and benefits of both CR and SR plans, so competition is based solely on quality. Insurers contract for health services with a network of public or private service providers or providers linked to insurers. In the SR, insurers are obligated to contract with the public provider network for at least 40 percent of premiums to protect the financial sustainability of public hospitals. In the beginning, public hospitals had to be transformed into social enterprises that could be contracted and run as businesses.

Premiums and Risk Adjustment

The government sets premiums by adjusting for health risks by age, sex, and location. These premiums are paid to insurers for each beneficiary: currently US$244 per person per year in the CR and US$137 in the SR.

Table 1. Characteristics of the Contributory Regime and Subsidized Regime in Colombia's Universal Health Coverage Scheme, 2007

Characteristic	Contributory Regime	Subsidized Regime
Population coverage target	Individuals and families with the ability to pay; those employed earning at least one threshold salary to be eligible for the CR; self-employed workers earning at least two threshold salaries	Eligible individuals as determined by a means test (Sistema de Identificacio de Beneficiarios, or SISBEN)
Number of enrollees, 2012	24 million	22.5 million
Percentage of the total population covered, 2012	48 percent	48.3 percent

Table 2. Characteristics of the Mandatory Health Plan (POS)

Contents of the benefit package	Mandatory Health Plan (POS)
Family coverage	Yes
Public health education and outreach	Full range of public health education and outreach services
Preventive care, individuals and family	Full range of preventive services
Outpatient services (consultations, treatment, diagnostic tests, rehabilitation)	All
Dental care Inpatient services	Basic care All
Medications	All 730 medications in national listing
Catastrophic care	Treatment with radiotherapy and chemotherapy for cancer, dialysis and organ transplant for renal failure; heart, cerebrovascular, neurological, and congenital surgeries; treatment of major trauma; intensive care unit; hip and knee replacement; major burns; treatment for HIV/AIDS
Transportation	For referrals, catastrophic care
Excluded conditions	Cosmetic surgery; fertility treatment; sleep disorder treatments; organ transplants (except renal, heart, corneal, and bone marrow); long-term psychotherapy and psychoanalysis; treatment for end-stage renal disease. However, certain excluded procedures can be obtained based on approval from the expert panel of the beneficiary's EPS (Law 1438 of 2011).
Maternity and sickness leave	Covered

Source: MSPS, 2013

Performance of the Insurance System

Successes

The Colombian health system experienced significant improvements after Law 100 reforms:

- Before 1993, 24 percent of the population had coverage, but by the end of 2011, more than 95 percent had coverage (near-universal coverage).
- The increase has been most dramatic among the lower socioeconomic groupings, rising from 6 percent before the reform to more than 70 percent by 2007.

- The Colombian government's original target was to achieve universal coverage by 2010 while increasing the payroll tax from 11.5 percent to 12.5 percent. As of 2012, Colombia is reported to have reached near-universal coverage.

Colombia was one of the first and still among the few Latin American countries to establish a functional equalization fund (the FOSYGA) to transform mandatory payroll contributions into risk-adjusted capitation payments to insurers, including a cross-subsidy from the well-to-do to the poor. The complexity of the FOSYGA suggests strong information systems and a well-functioning financial system (Escobar et al., 2010). The transparency and flexibility (in its ability to incorporate public health priorities) of the proxy-means test to identify those eligible for the SR is an example of how to better target government subsidies to those most in need.

The Colombian experience with the expansion of health insurance coverage was not without challenges, and since 1993 many course corrections have occurred to respond to these challenges. The overall governance structure for the social security and health system remains sound, and funding for public health has increased and is increasingly protected (earmarked).

Reviews by Giedion and Uribe (2009) and Escobar (2005) have provided answers to three key questions on the impact of the SR and CR programs:

1. **Has the insurance improved access to and use of health services by both the poor and the non-poor?**

   Evidence suggests that access to and use of health services have improved, particularly among the most disadvantaged. Although a coverage gap between rural and urban areas still exists, the reviewers observed significant increases in use of maternal and child health services in both rural and urban areas. The reforms of 1993 have improved equity in the system. Insurance coverage increased from 9 percent in 1992 to 49 percent in 2003 among the poorest group (lowest-income quintile), and from 60 percent to 82 percent in the same period among the highest-income quintile.

2. **Has the insurance reduced direct costs to consumers so that they may avoid catastrophic spending?**

   In the CR, the incidence of catastrophic spending (spending on catastrophic medical expenses)[4] dropped by 61 percent for both the self-employed and the employed (Giedion and Uribe, 2009).

   Lack of insurance was associated with significantly higher out-of-pocket costs. The uninsured poor spent 35 percent of their income on hospitalization in 2003. In comparison, the lowest-income quintile in each of CR and SR spent considerably less (Escobar, 2005). While 14 percent of the uninsured were pushed below the poverty line as a result of a catastrophic illness requiring hospitalization, this occurred to only 4 percent of those covered by the SR.

   As of 2010, the percentage of the uninsured in the total population had fallen below 10 percent. Therefore, given the facts above, the health insurance expansion in Colombia has significantly improved financial protection for citizens overall.

3. **Has insurance positively affected health outcomes?**

   Health insurance is simply a financing reform that does not directly affect health outcomes. Therefore, any attempt to link insurance and health outcomes is difficult, given the complexity of

[4] "Catastrophic spending" is defined as having to spend 20 percent or more of non-subsistence income on healthcare.

the relationship and other explanatory covariates. However, greater use of healthcare, which is directly related to health outcomes, can be correlated with health insurance in plausible ways.

Based on a survey in 2003, in the lowest-income quintile, those insured were half as likely to report "lack of money" as a reason for not seeking care (Escobar, 2005). In the highest-income quintile, only 6 percent of those insured reported "lack of money" as a barrier to seeking care, compared to 35 percent in the lowest-income quintile. The corresponding percentages among those uninsured were 30 percent and 73 percent. Therefore, while the insurance reforms have benefited higher-income groups more, the gap in terms of the impact of financial barriers on healthcare use has shrunk between income groups as health insurance has expanded.

In the CR program, insurance increased the use of both curative healthcare and preventive services among beneficiaries. The likelihood of CR participants using formal care when ill increased by 57 percent among the employed and 26 percent among the self-employed (Giedion and Uribe, 2009). Self-medication fell by 28 percent among the employed and 15 percent among the self-employed. Visits to dentists for preventive reasons increased by 34 percent among the employed and 46 percent among the self-employed.

Challenges

Like many other countries that have implemented healthcare financing reforms, Colombia has experienced several challenges:

- The system has still not achieved absolute UHC in terms of depth of financial protection from the risk of ill health, especially from complications requiring tertiary care, and problems remain in reaching remote and indigenous populations.
- The reforms of 1993 contributed significantly to increased equity in the health system. Historically, there were differences in the benefits for CR versus SR. Also, the benefits under SR were not portable, since those covered under SR needed to re-register after changing their municipality. Law 1438 of 2011 addressed these issues. In effect, since 2009 there has been increasing unification of health benefits, with attendant fiscal pressures on the government. The government estimated its outlay for the SGSSS at US$68 million per month in 2012 or US$812 million annually (MSPS, 2012).
- Several provisions in the SGSSS attempt to improve efficiency, such as encouraging competition between providers to secure contracts for covering beneficiaries, as well as the requirement that not more than 8 percent of revenues from the capitation payments be used by an insurer for administration. Still, the cost of the SR has been increasing, accounting for 1 percent of GDP in 2003. The continued sustainability of the SGSSS depends on government and local tax revenues and on employment levels in the formal sector. If these sources weaken, the overall financial sustainability of the FOSYGA may be threatened.
- Transforming public hospitals has been difficult; the hospitals are supposed to operate under a set of conditions known as "state social enterprises," yet they are burdened with high labor costs and low managerial capacity (Escobar et al., 2010), which makes it harder for them to compete with private providers. A modernization project for public hospitals was necessary to improve their capacity to participate in the SGSSS, which has shown good results. This program is continuing.

Continuing Health Reforms in Colombia

Law 1438, enacted in 2011 and to come fully into effect in 2013, includes a range of reforms, including the following:

- As of 2012, all members of the SR are entitled to the equivalent Mandatory Health Plan-POS, with procedures and interventions covered similar to the CR.
- Children and adolescents receive preferential attention in the benefit plans. Benefit plans for all insurance schemes are to be updated every two years.
- When those covered under the SR move into formal employment, their employers pay the contributions appropriate for the CR into the employee's former EPS.
- Coverage of procedures and medicines outside the Mandatory Health Plan-POS is allowed, with the approval of experts at the beneficiary's EPS, with the possibility of appeal to the National Health Authority in case of refusal.
- A national health observatory is to be created to monitor health indicators at disaggregated levels within the country. The law also requires a national plan for quality improvement focused on results.
- Healthcare providers have greater autonomy to recommend procedures as dictated by the health status of the beneficiary.

Lessons Applicable to Nigeria

- Colombia passed Law 100 first to provide the legal basis for implementing a national social security system. There has been subsequent legislation that has added to the rules and protections inherent in the original reform. Establishing a legal basis for health financing reforms would facilitate implementation in a federal system such as Nigeria's.
- Colombia's fiscal capabilities allowed for a gradual implementation of coverage among the poorest socioeconomic groups. A prioritization policy enacted alongside a means-testing policy would allow better targeting of government spending in this regard, along with some rationing driven by resource constraints. This has worked well in Colombia and can work in Nigeria, which has similar fiscal capabilities. The key lesson here is to plan for gradual implementation according to available resources.
- The experience with the FOSYGA in Colombia, an effective national equalization fund of mandatory contributions and government subsidy, should be instructive for Nigeria, where the social health insurance program currently operates with no pooling of funds across the various contributory populations. The recommendation of the Ministerial Expert Committee in Nigeria (MEC, 2003) to establish a National Health Insurance Fund is still pending.
- Colombia's expanded SR scheme is possible through financial contributions from the federal government, local authorities at the district and municipal level, and solidarity contributions from CR members. Nigeria has large numbers of individuals with higher income who could also make such solidarity contributions, and it has sources of tax revenue at local government authority levels. Therefore, there could be additional sources of funding beyond the federal government and its devolved resources to contribute to the financing of expanded health insurance coverage, especially for the poor. Nigeria will have to think creatively and negotiate with decentralized levels of governance on financing possibilities in order to fully expand the NHIS to cover more citizens while also maintaining a level of benefits and subsidy adequate to support public health that results in actual financial protection.

- Payroll-based funding needs a strong employment base, preferably with mechanisms to also receive contributions from the self-employed. The levels of revenue from payroll taxes or contributions depend on the size of the formal workforce, which means revenue is limited by the existing pool of workers who can be taxed. Self-employed people are often not as easy to tax, especially if they are not registered taxpayers. It is important to devise other mechanisms of getting contributions, such as flat monthly rates or installments proposed for Nigeria's RCSHIP.
- When designing a contracting model, one must be careful not to disadvantage public providers by saddling them with additional rules or obligations. In addition, public providers may not be competitive for service contracts. In Colombia, a modernization program was necessary to bring public hospitals up to par with private providers in a competitive marketplace for service contracts under the SGSSS. In general, neither private nor public facilities should enjoy unfair advantages. In Nigeria, it is the public providers that may enjoy unfair advantages because the state pays salary costs at most public facilities but does not do so at private facilities.
- Although taxing the self-employed is not easy in low- and middle-income countries, these groups would benefit from insurance coverage. The proposed RCSHIP in Nigeria is likely to address this problem by establishing a per capita funding allocation combined with local financial contributions.
- It is a challenge to balance the provision of comprehensive and subsidized benefits with the financial sustainability of related financing systems. True universal coverage—expanded coverage, deep financial protection, and breadth of conditions covered—may require a higher percentage of spending as a proportion of the GDP, so it is possible that countries such as Nigeria will need to seek a compromise between comprehensiveness and sustainability, as Colombia was forced to do.
- Monitoring and evaluation (M&E) systems are crucial to measuring performance and ensuring the efficient use of resources. Population-level health surveys and health utilization surveys are necessary on a periodic basis. These must be placed on the bedrock of strong health and financial information systems that can track membership, contributions, and utilization. Colombia invested in a database of all members, which is updated monthly by insurers and is used to reconcile all changes in status of beneficiaries across CR and SR. Nigeria is investing in a similar system for its NHIS, which must be strengthened as coverage expands.

INDIA

Background

India is a lower-middle income country by World Bank definition. It has a federal structure, with a population of approximately 1.2 billion. Out of 160 countries, India is 119th on the Human Development Index and 123rd on the Gender Equity Index. India has made major progress in reducing infant mortality over the last decade; the 2011 figure is 47 per 1,000 live births. Life expectancy at birth is 64 years for males and 67 for females (World Bank, 2012). There is substantial disparity in health within India, based on socioeconomic, demographic, and geographic factors. For instance, per-person health expenditures by the state government in the state of Himachal Pradesh from 2011 to2012 were more than 15 times higher than in Bihar State (GOI, 2011; RBI, 2012). Furthermore, a disproportionate amount of public and private resources have been directed toward urban-based and curative health services, which reinforces an urban bias and rural disadvantage in access to healthcare services.

India has long had a healthcare system, where the central government finances certain public health programs using tax funding, the state (provincial) governments fund and implement local health service delivery, and various health insurance schemes cater mostly to the needs of formal-sector workers and civil servants. This has been changing in recent years. The National Rural Health Mission (NRHM), soon to be the National Health Mission with new initiatives for the urban poor, is a major effort to address the gap in provision of affordable and dependable primary healthcare. Another change of note is the growth of private health insurance in the last decade in large cities.

Public sector hospitals provide treatment with low or no user fees. Ostensibly, most essential drugs are also offered free of charge in these hospitals, but in practice, lack of availability has led to patients procuring drugs and commodities out of pocket from private pharmacies. Primary healthcare is provided at municipal and district hospitals and at rural primary health centers. These are supported by a large number of extension or community-level health workers. Historically, the public health sector lacked sufficient resources (staff, finances, equipment), and government hospitals had poor standards of quality, so that most people preferred to visit private medical practitioners at higher out-of-pocket cost. For outpatient services, 78 percent of people in rural and 81 percent in urban areas preferred private providers in 2004 (NSSO, 2006).

Together, the government's demand- and supply-side health financing policies did not yield significant health service coverage measured in quantity or quality. However, in recent years, several different government-funded health insurance programs have taken off, aimed at subsidizing the demand side of healthcare for the poor; they are described in this chapter. These can offer lessons to Nigeria. A robust debate has also begun in India about how best to achieve universal health coverage, which considers the role of health insurance in this process, and this is also relevant to Nigerian policymakers.

Healthcare Financing

Public sector spending on health in India equals about 1 per cent of GDP. In 2008–09, total public health expenditure across federal, state, and local governments was about 587 billion rupees, or nearly US$13 billion at historical exchange rates (La Forgia and Nagpal, 2012).

The High-Level Expert Group on Universal Health Coverage for India (HLEG), commissioned by the Indian Planning Commission, recommended increasing public sector spending on health to at least 2.5 percent of GDP by the end of the 12th Five Year Plan, 2012–17 (HLEG, 2011). In addition, several major public health programs have been launched, especially by the central government. These include the NRHM, launched in 2005, which involves significant transfers of funds from the center to states, and is

intended to fill gaps in facility infrastructure, human resources, and equipment, as long as service providers guarantee certain levels of performance. Several government-funded health insurance programs have also been launched since 2007. A major change in health financing in recent years has been the rapid growth of a private health insurance industry that accompanies the rapid increase in the number of private providers of hospital and diagnostic health services.

Government healthcare funding has been historically divided between service delivery (70%), pharmaceuticals (20%), and medical technologies and other components (10%). More recent estimates suggest that 8 percent of all public health expenditure is on health insurance (La Forgia and Nagpal, 2012). In terms of sources of financing, households accounted for 72 percent of all health expenditure in India, and the central and state governments financed 20 percent as per the National Health Accounts for 2004–05. Employers financed 5.7 percent, and external donors contributed the remainder (2.3 percent).

It was estimated that in 2004, a person from the lowest socioeconomic class spent 2,530 rupees (US$11.80 at the time) for hospitalization in a public facility, and 5,431 rupees (US$120.70) in a private facility—10 and 25 times, respectively, the monthly income of such a household (Narayana, 2010). In the National Sample Survey of 2004, in urban areas, only 4 percent of hospitalizations received reimbursement from any source, including insurance. The same figure for rural areas was a meager 0.7 percent (Narayana, 2010). These statistics suggest the poor status in the past of financial protection against catastrophic expenses for healthcare in India.

Despite the attempts of states to create several funding innovations targeted at the supply side (funding provision) or the demand side (subsidizing or funding insurance), the healthcare system (1) lacked accountability, (2) was disconnected from public health goals, (3) was inadequately equipped to address the population's healthcare expectations, and (4) was unable to provide financial risk protection to the very poor. It is likely that a future shift to universal health coverage will require greater public sector funding, a policy shift that should ensure that this funding is better targeted and spread across both demand- and supply-side programs.

Structure of Health Insurance

In 2010, government-funded health insurance covered about 19 percent of the total population (240 million), and this proportion is growing (La Forgia and Nagpal, 2012). While the exact numbers are not known, approximately another 6 percent are also covered through private and other health insurance programs.

Health insurance schemes in India can be broken down into the following groups, in order of size (Table 3 describes the schemes other than the government-funded schemes, which are the main focus of the rest of the chapter):

- Mandatory health insurance for formal-sector workers or government-run plans for civil servants, such as the Employees' State Insurance Scheme (ESIS) and the Central Government Health Scheme (CGHS)
- The voluntary, enrollment-based government-funded plans targeted at the poor, such as the RSBY
- Voluntary health insurance or private for-profit plans
- Certain employer-based plans in the private sector
- Insurance offered by nongovernmental organizations (NGOs) or community-based health insurance

Most private insurance in India is purchased as supplementary coverage, especially for financial protection against the risk of catastrophic health expenses related to hospitalization and inpatient care. Given that health insurance reaches at best a quarter of the population and is procured for or offers limited benefits from the onset, the overall financial protection available to the population is limited.

Table 3. Nongovernmental Health Insurance Schemes

Health Insurance Scheme	Risk Pool	Operational Details
Voluntary health insurance plans or private-for-profit plans	Insurance buyers who pay a premium to an insurance company that pools people with similar risks and insures them for health expenses	Premiums are based on the risk status of the consumer (or of the group of employees) and the level of benefits provided, rather than as a proportion of the consumer's income.
Employer-based plans in the private sector	Employees of certain private sector firms	Certain employers in the private sector offer employer-based insurance schemes through their own employer-managed facilities by way of lump-sum payments; reimbursement of employees' health expenditure for outpatient care and hospitalization; fixed medical allowance, monthly or annually (regardless of actual expenses); or coverage of employees under the group health insurance policy.
Insurance offered by NGOs (community-based health insurance)	Members of a community or other association who contribute to the community-based health insurance (CBHI), often low-income people; these schemes do not have significant scale	Community-based funds refer to schemes in which members prepay a set amount each year for specified services. Premiums are usually flat rate (not income related) and therefore not progressive. These funds are designed to improve access to services, not to make a profit. Often there is a problem with adverse selection (producing a large number of high-risk members) because the scheme is voluntary and premiums are flat; exemptions may be adopted as a means of assisting the poor, but these may have adverse effects on financial sustainability. In India such schemes are generally run by nonprofit hospitals or NGOs. The benefits offered are mainly for preventive care, although ambulatory and inpatient care is also covered.

Community-based Health Insurance (CBHI): CBHI differs from one state to another, but generally there are two major types in India. In the first type, an NGO acts as an intermediary between a formal insurance provider and the insured community, such as the Self Employed Women's Association (SEWA)[5] in Ahmedabad and the Action for Community Organization, Rehabilitation and Development (ACCORD)[6] in the Nilgiris region. In the second type, the NGO itself provides insurance to the target community. In the latter case, the NGO may itself be the health service provider or may have an

[5] SEWA is a trade union registered in 1972.
[6] ACCORD covers about 13,000 *adivasis* (tribals) under a group policy purchased from New India Assurance.

arrangement with the health service provider. Unless a scheme has a contract with a licensed commercial insurer or is offered by an exempted insurer created by law, it is not considered "insurance," as per Indian law (La Forgia and Nagpal, 2012). Therefore, some NGO-run schemes that collect and pool individual contributions and purchase services are not legally considered insurance in India, even if by a theoretical definition they act as such.

Government-funded Health Insurance Schemes

At least 16 government-funded or sponsored health insurance schemes exist in India, and a few more are in the planning stages. These include a variety of scheme formats and target populations. The schemes can be grouped as follows (also see Table 4):

- **Central government pan-India schemes (four):** the ESIS (formal-sector employees), the CGHS (central government employees and pensioners), and the RSBY (National Health Insurance Plan) targeted at the poor. The Universal Health Insurance Scheme (UHIS) of 2003 was a first attempt to cover hospitalization for the informal sector, offered through existing public sector insurance companies.
- **State government schemes (nine):** schemes in the states of Andhra Pradesh, Tamil Nadu, Himachal Pradesh, Delhi, and Kerala, and two schemes in the state of Karnataka. Punjab (since 2012) and Assam states also have limited schemes covering specific groups.
- **Central government departmental schemes (three):** the departments of textiles, defense, and railways have their own health programs that are not strictly health insurance. For the latter two departments, services are primarily provided through departmental facilities, and no contributions are necessary.

Table 4. Prominent Government-funded Health Insurance Schemes

Scheme Name (Year)	Risk Pool	Number of Beneficiaries	Benefits (Unit of enrollment)
Employees' State Insurance Scheme (1952)	Employees earning less than 15,000 rupees per month of private formal-sector firms across India in "notified areas"	65.4 million	Comprehensive (family)
Central Government Health Scheme (1954)	Employees and pensioners of central government institutions and certain others across India	3 million	Comprehensive (family); the scheme may soon evolve to a voluntary model using private insurance and government subsidy
Universal Health Insurance Scheme (2003)	All families and individuals below 70 years, but redesigned to focus on below-the-poverty-line (BPL) families	3.7–4 million (estimated)	Inpatient care (including maternity) with a secondary focus; life and work insurance
Yeshaswini Co-operative Farmers Healthcare Scheme (2003)	Members of rural cooperative societies in the state of Karnataka only	3 million	Inpatient care with a secondary focus; 1,200 notified surgeries (individual)

Scheme Name (Year)	Risk Pool	Number of Beneficiaries	Benefits (Unit of enrollment)
Rajiv Aarogyasri Community Health Insurance Scheme (2007)	BPL individuals or annual income below 75,000 rupees ($1,364) in the state of Andhra Pradesh only	20.4 million families, 70 million beneficiaries	Inpatient care with a tertiary focus; 938 identified procedures and follow-up packages (family)
Rashtriya Swasthya Bima Yojana, or RSBY (2008)	BPL families and other targeted groups across India	33.6 million families (as of the end of 2012)	Inpatient care with lower-cost secondary focus; maternity care also covered (family)
Chief Minister's Comprehensive Health Insurance Scheme (2009)	BPL or annual income below 72,000 rupees ($1,309), and members of certain welfare boards in the state of Tamil Nadu only	13.4 families, 36 million beneficiaries	Inpatient care with a tertiary focus; 400+ hospitalization procedures covered (family)
Vajpayee Arogyashri Scheme (2009)	BPL in notified area of Gulbarga division of the state of Karnataka only	1.5 million families, 7.5 million beneficiaries	Inpatient care with a tertiary focus; 402 packages and 50 follow-up items covered (family)
RSBY Plus (2010)	RSBY enrollees in the state of Himachal Pradesh only	0.24 million families, 0.8 million beneficiaries	Inpatient tertiary focus; supplementary coverage above RSBY; 326 defined procedures (family)
Comprehensive Health Insurance Scheme (2010)	BPL families under the state definition not in RSBY, and other families in Kerala State	1 million families (estimated)	Inpatient secondary focus; 700 procedures covered
Apka Swasthya Bima Yojana (2011–12)	RSBY enrollees in the state of Delhi only	0.65 million families (estimated)	Inpatient tertiary focus; supplementary coverage above RSBY (family)

Sources: ESIS, 2012; La Forgia and Nagpal, 2012; CHIAK, 2013

As shown in Table 4, two of the schemes (ESIS, CGHS) offer comprehensive coverage across ambulatory, secondary, and tertiary care. These schemes also differ from the others in that they are not explicitly targeted at the poor. The schemes launched since 2007 do explicitly focus on the poor, defined either as those below the poverty line (poverty is defined based on a threshold set by the Indian government's Planning Commission) or those subject to specific eligibility criteria in certain states. The target population may also represent a specific disadvantaged group, such as farmers. The post-2007 schemes also focus on financial protection against catastrophic expenses related to hospitalization. This may reflect the understanding that the poor may access free outpatient care from public health facilities for free or with nominal charge.

The central government-funded RSBY is the touchstone of these schemes, and several state-level schemes are even designed to be "top-up" schemes covering higher-end inpatient care specifically for the RSBY beneficiary populations in Himachal Pradesh and Delhi states. The details of this scheme are the focus of the next section and provide lessons relevant for Nigeria.

Rashtriya Swasthya Bima Yojana (RSBY), 2008

Before 2007, demand-side financing mechanisms for health that could cater to the financial protection needs of the Indian poor were limited. The ESIS and CGHS covered middle-class, salaried workers and had limited applicability for the poor, especially those in rural areas. The extant programs of certain state governments—other than in Andhra Pradesh—were limited due to poor policy design, lack of clear accountability or sustained implementation, weak M&E, and poor awareness among potential beneficiaries (Swarup and Jain, 2010). As a result, the central government decided to launch a health insurance scheme that would provide protection to the poor from the financial burden of hospitalization as well as access to high-quality inpatient healthcare; levels of poverty for eligibility would be defined based on established criteria. This scheme would complement the ongoing supply-side efforts to strengthen primary healthcare under the NRHM and other programs.

From its start in 2008, RSBY was designed with three principles in mind (Swarup and Jain, 2010):

- **Cashless:** the scheme would not require cash payments from the beneficiaries. Since the beneficiaries were the very poor, they could not be expected to pay cash premiums in advance in order to be reimbursed later.
- **Paperless:** the use of smart-card technology to identify families as beneficiaries to avoid the need for paper forms or procedures. Since most of the beneficiaries were functionally illiterate or semi-literate, this provision would improve equity and also avoid any diversion of benefits.
- **Portable:** the benefits of the scheme would be available anywhere in the country. Many beneficiaries were migrants who moved regularly in the year for work.

Identification of the poor: RSBY is intended to cover families below the poverty line (BPL). Based on revised Planning Commission guidelines, the poverty line is defined separately for rural and urban areas, and then is differentiated across states to reflect differences in costs of consumption. Previously, a nutritional norm (calorie-based) approach was used, which has since been shelved. As an average of various state-level thresholds, the pan-Indian poverty thresholds in terms of monthly per capita income in 2009–10 were 673 rupees (US$14.6 at 2009–10 rates) for rural areas and 857 rupees (US$18.6) for urban areas. Approximately 30 percent of the population in India was considered BPL as of 2009–10.

When the plan began, it was meant to cover an estimated 300 million BPL families by 2012. The Planning Commission used household consumer expenditure data to identify the states' populations of people living below the poverty line. If RSBY were initiated in every district of India, and after applying the eligibility at the individual (head count) rather than family level, about 363 million Indians would have been eligible for RSBY in 2010.

Plan benefits: Each RSBY card enrolls a family of five: a primary beneficiary and spouse, plus three dependents as per the BPL list. For a registration fee of 30 rupees (US$0.55 at 2013 rates), the plan's coverage and benefits include an annual inpatient coverage up to 30,000 rupees (US$545), transportation covered up to 1,000 rupees (US$18) at 100 rupees (US$1.8) per hospitalization, pre-existing conditions covered from day one, and no age limit on the enrollment of beneficiaries. The benefits are made available on a "floater" basis (that is, the maximum benefits can be used by an individual or collectively by the members of the family in a year).

Financing: Both central and state governments finance the plan, subject to certain caps. The central government has a commitment to finance 75 percent of the premium charged by insurers up to a maximum of 750 rupees per family (US$14), and the state government pays the remaining 25 percent and/or the excess above 750 rupees. Beneficiaries pay a 30-rupee registration fee (US$0.57), used at the state level for administration costs. The central government has restricted its payments to only those BPL

families that are eligible based on the Planning Commission's estimates; some states have parallel or enhanced BPL lists. Initially, the 750-rupee limit was not breached due to competitive bidding.

State nodal agencies, which are registered independent society or trust organizations, act as the main supervisory and implementing agency at the state level, and contract with the insurance companies based on established guidelines and on the correct BPL lists. Besides funding, the central government's role is to provide the overall regulatory framework and technical support. The Ministry of Labour and Employment is the central coordinating and policymaking agency for RSBY.

The plan also has the following innovative features:

- **Smart card:** once registered, members get a biometric-enabled card to ensure that only registered members benefit from the plan. The smart cards are delivered at the point of enrollment, and the costs (about US$3 per card) are borne by the insurer and included in its premium.
- **Empowerment of beneficiaries:** beneficiaries can consult both public and private providers.
- **Leakage-free:** the system is well protected from misuse by providers and users of services; a management information system monitors use, and government field officers authenticate smart cards before use.
- **Appropriate business incentives:**
    - Insurers receive a premium for each household registered.
    - Hospitals are paid per beneficiary treated, and provider competition encourages quality improvement.
    - Insurers monitor hospitals to prevent unnecessary procedures or fraud through excessive claims.

The plan supports private sector participation by

- Implementing the scheme via public and private insurance companies selected through a transparent and competitive process
- Providing government lists of BPL households to insurers for enrollment at the village level based on a time-bound plan
- Facilitating quick enrollment by having the insurer issue the smart card on the spot at the point of registration
- Having insurers use NGOs and local organizations for public information awareness campaigns
- Expecting insurers to establish a toll-free number for beneficiary assistance and village kiosks to manage the scheme at that level

Evaluation of RSBY

Enrollment: Currently, 468 of India's 640 districts have been selected for RSBY. As of December 2012, RSBY had issued nearly 33.6 million smart cards, each covering a BPL family, out of the 66 million BPL families identified in 27 of India's 30 states.[7] This amounts to a 51 percent conversion ratio based on the BPL list. However, this ratio was highly variable across states of India. Studies have suggested that once they became aware of RSBY, 70 percent of those eligible choose to enroll (La Forgia and Nagpal, 2012). Several reviews of RSBY suggest that gaps in enrollment relate to problems in the quality of local BPL

[7] There is no RSBY coverage in Andhra Pradesh State, which operates its own scheme. There are currently no enrolled families in Goa and Tamil Nadu (www.rsby.gov.in, accessed 12/31/2012).

lists—which are out of RSBY's control—as well as distance from an enrollment station in low-density areas (Sun, 2011).

Utilization and financial protection: Beyond enrollment performance, what has been the impact of the plan? Survey results in one state suggest that out-of-pocket payments for hospitalization of the non-RSBY-enrolled poor were on average six times more than comparable RSBY beneficiaries (Swarup and Jain, 2010). Based on a study conducted in 2010, there were large differences in hospitalization rates (hospitalizations per 1,000 persons in a year) achieved under RSBY across states. Comparing these hospitalization rates to the average rates recorded from national sample surveys, RSBY mostly showed lower rates of hospitalization. At a district level, these lower rates were linked to the number of empaneled (accredited) hospitals in the area, especially private hospitals (Narayana, 2010). The strong correlation with empanelment of private hospitals suggests that clients prefer private providers to the public health system. This further suggests that a weak public hospital system, especially in rural and remote areas without a viable private network of facilities, still hampers the effectiveness of RSBY in improving health outcomes via increasing healthcare use. However, there is evidence that RSBY has spurred the construction of new private facilities to meet the new demand.

Sustainability: By March 2011, RSBY had paid out claims for 7 billion rupees (US$155.5 million at 2011 rates; La Forgia and Nagpal, 2012). The claims ratio (the proportion of premiums collected by the insurer paid out as claims) varied significantly across states, crossing 100 percent in four states. One interpretation of these adverse ratios is that in those four states, insurers were losing money, indicating poor sustainability of the scheme. This may be because insurers submitted bids that had underestimated the hospitalization potential of the beneficiary population. With time and subsequent (annual) quote tendering, the insurers are likely to increase the premiums, as has been seen in many states since 2011.

If the central government maintains its payment of 75 percent of the premium up to a maximum of 750 rupees (US$14), increasing premiums will place a larger burden on state governments to finance the remainder.

Cost containment: According to La Forgia and Nagpal (2012), RSBY uses standard package rates for most procedures as a cost-containment tool to discourage providers from adding services to increase their billing. Whether this has worked is still unknown, but RSBY includes strong monitoring and oversight as well as other mechanisms to control leakage (smart cards for beneficiary identification). Incentives may also be misaligned if insurers expect an adverse claims ratio to allow them to raise premium bids in the next annual round. This suggests that insurers have short-term perspectives versus a preferred long-term relationship of cost control with RSBY.

Quality: Quality of service across empaneled public and private hospitals is higher than at non-RSBY facilities due to competition in securing RSBY business, and due to the threat of dis-empanelment after review. Surveys of beneficiaries give some evidence of this at the service level (Mukherji et al., 2012). The satisfaction level among the beneficiaries of the scheme has been good.

One of the side benefits of the scheme has been that the development of the BPL data improved targeting and outreach by other social protection schemes.

Conclusion: There have been initial problems in bill settlement, enrollment, and use, which are more serious in certain states. These issues are declining with increasing maturity of the scheme. The governance arrangements for RSBY are not fully developed, and managerial functions are mostly outsourced. RSBY and other similar schemes will need to invest in stronger governance structures. However, the scheme is a working example of collaboration between the central and state governments to develop a mechanism to finance and manage a large-scale health insurance program. Political ownership

for RSBY and the related state-level health insurance schemes has been high. The fact of state governments adding "top-up" health insurance schemes for tertiary care to go along with RSBY is a sign of deepening in health insurance coverage, with a larger proportion of procedures covered.

The scheme has become a viable public-private partnership model, since the private sector has experienced the main growth in empanelment of facilities and subsequent use of services. This also raises challenges for monitoring quality and controlling costs. Another corollary to this is that the lack of competitiveness and preparedness of public facilities has been exposed.

The growth of government-funded health insurance schemes in India, of which RSBY is now the largest, suggest that arrangements to "govern, allocate, and manage" the use of public sector funding for health are leading to greater coverage and protection for the poor. The scalable demand-side model introduced under RSBY has several strengths. Together with state-level schemes, the growth in RSBY may lead to government-funded health insurance covering more than 630 million beneficiaries (50 percent of the population) by 2015 (La Forgia and Nagpal, 2012).

Health Insurance in the Achievement of UHC

There has been vigorous debate in India about the best path to UHC. A major article and call to action in the journal *The Lancet*, written by a panel of experts and advocates (the *Lancet* India Group for Universal Healthcare, or *Lancet* Group), recommended an Integrated National Health System (INHS) to cover the population with an "entitlement" package of healthcare to be delivered through both public and private facilities (Reddy et al., 2011). The HLEG report, with similar prescriptions, has called this package the National Health Package or NHP (HLEG, 2011). All Indians would be able to participate in the system with cashless transactions authorized with IT-enabled smart cards.

The *Lancet* Group proposal requires an increase of public sector spending on health from about 1 percent of GDP to 6 percent by 2020, which would require 15 percent of government tax revenues. The HLEG recommendation proposes a lower increase to 3 percent of GDP by 2022. The *Lancet* article anticipates that by 2020, the current high out-of-pocket expenditure on health would be reduced to about 20 percent of total health expenditure, whereas the HLEG anticipates a reduction to 33 percent by 2022. In addition, the *Lancet* Group recognizes that health system improvements would be necessary and also makes recommendations for human resources for health, health information systems, drugs and health technology, governance for the reformed system, and overall consensus building.

Box 1: RSBY: Lessons Learned

- The successful launch and continuation of a massive health insurance scheme targeted to the poor is only possible through the political will of all levels of government and their fiscal commitment. The scheme draws from a working partnership and delineation of roles across six primary stakeholders: the central government, state governments, state nodal agencies, insurers, providers, and NGOs.
- Creation of a clear-cut targeting mechanism based on established (if flawed) lists and appropriate incentives for insurers and third-party administrators, along with the use of technology, have helped lower the cost of enrollment among the poor and hence led to rapid scale-up in the number of targeted beneficiaries. The ability to clearly define who the poor are, even with a system less sophisticated than in Colombia, helps to improve equity.
- Any health insurance scheme that aims to target the very poor may learn from the foundational premises of RSBY and recent government-funded health insurance schemes in India: Make the system cashless, paperless, and portable. Contributions by beneficiaries are nominal because the plan is highly subsidized by the government.
- Standardization of documents and processes along with the proper use of technology helps in situations of low administrative and managerial capacity; examples include contracts between the nodal agencies and insurers, data collection templates, and the standardized package of inpatient treatment benefits under RSBY.
- The focus on secondary care (i.e., lower-complication inpatient procedures) within a defined package of benefits for RSBY members has meant lower cost per family covered.
- Use of IT applications for enrollment and patient management at the provider level has benefited the scheme, beginning with the smart cards similar to those used by NHIS in Nigeria.
- Health insurance is now 24 percent of the central government budget for health, and 41 percent for the state government of Andhra Pradesh, which also has a long-running scheme (La Forgia and Nagpal, 2012). This is evidence of considerable political support and budgetary commitment. However, these percentages have been achieved while premiums paid to insurers have been low, thanks to competition among companies vying for the contracts and cost containment in claims. Because premiums will rise, the funding needed for health insurance for the poor aimed at secondary or tertiary inpatient care may affect the amount available for primary healthcare as well as for other social needs.

In terms of the role of health insurance, the *Lancet* article proposes a merger of all existing government-funded schemes to service the INHS, with the simultaneous existence of a voluntary private health insurance market, tightly regulated. In an article in the same series, Kumar and co-authors (2011) suggest that the merged system will be a workable risk pool, where the poor households joining the system with higher disease risk are offset by a younger middle-class population with rising incomes and better health. Government-funded insurance here would cover low-cost outpatient and medium-cost inpatient healthcare, but also some infrequent and higher-cost hospitalization for serious complications. This system would preserve the element of patient choice by allowing both public and private providers, so that money moves with the patient, and would recreate the competition in provision seen in recent government-funded health insurance schemes in India.

In the view of Kumar and co-authors (2011), the government as single-payer system should be entirely tax-funded, with limited reliance on user fees, a position shared by HLEG. The NHP would be funded with central transfers to states and supplemented with state funds, and would represent an overall increase of spending on health rather than substitution away from other uses. The proposals are not detailed about the fiscal impact of these transfers, or the significance of the need to transfer more to certain states for equity purposes. Overall, this general taxation-funded system would differ from a system that relies on mandatory payroll or social security contributions, hallmarks of social health insurance. This single-payer national health insurance strategy, the proponents argue, would be much easier to manage in a country with a significant informal sector and high levels of poverty, where tax collection is easier than payroll contribution. Separately, the HLEG recognized that the tax-to-GDP ratio would need to increase to finance such a transition to UHC.

Challenges of Implementing UHC in India

In India, there are several government-funded health insurance schemes that offer heavily subsidized coverage for the poor against the risk of expense of secondary and tertiary inpatient care. Limited schemes exist to cover certain formal-sector workers, but most non-poor pay out of pocket without reimbursement or procure voluntary private insurance. These schemes operate over and above a major program to increase the reach and quality of primary and outpatient healthcare, aimed currently at the poor. The overall picture, while showing improvement in access and financial protection, suggests a fragmentation in schemes and benefits. In response to this situation, an integrative national health insurance strategy has been proposed by the *Lancet* Group (2011) and the HLEG on UHC (2011).

Whether this strategy is financially pragmatic remains to be seen, especially as GDP growth has slowed since 2011, and the fiscal pressure on the government has increased with significant demands to finance improved nutrition, guaranteed employment, and education. La Forgia and Nagpal (2012) have proposed a more incremental and mixed approach, which begins with the current state of health finance in India and capitalizes on schemes such as RSBY. Their proposal targets the current gap in financial protection for the poor by including outpatient (ambulatory) care in an RSBY-like, government-funded health insurance scheme targeted at the BPL population. These benefits are couched within a standard package that may not differ materially from that proposed by the HLEG or the *Lancet* Group. This part of the strategy would mainly be financed from central government coffers.

Their strategy also reinforces the centrally funded outpatient and secondary care coverage by including "top-up" or supplementary health insurance for the poor, funded by state governments, and similar to current schemes in Himachal Pradesh and Delhi states that target tertiary care above RSBY (see Table 4).

The significant difference in the La Forgia and Nagpal (2012) proposal from the *Lancet* Group or HLEG's national health insurance strategy concerns the universality of the scheme. While Kumar and co-

authors (2011) envisage financial protection for all, including the non-poor, La Forgia and Nagpal (2012) debate whether there is fiscal space to cover the entire middle class. They see a need for consolidation of existing social health insurance schemes for the formal sector that use mandatory contributions (ESIS and CGHS). But this consolidation cannot extend coverage to the non-poor in the informal sector, the self-employed, and so on.

Some state government health insurance schemes in India already cover the "vulnerable non-BPL poor," that is, the lower-middle class, against a narrow band of risk related to complicated hospitalizations (tertiary care) (La Forgia and Nagpal, 2012). For this population group, La Forgia and Nagpal propose that RSBY-like coverage of outpatient, secondary, and maternity care be made available. Funding would come from state government sources, reduced by the 40 percent copayment from the beneficiary required at the point of use. These non-BPL groups would also be eligible for the state government-funded tertiary "top-up" care.

Which vision is actualized will depend on the state of central and state finances in India. La Forgia and Nagpal (2012) estimate that their strategy would require state governments to increase annual health spending by 20 to 25 percent, which implies that hard budgetary choices will need to be made. The total cost to the public sector of their strategy in 2015 would be about US$7 to 8.6 billion at 2012 exchange rates. The cost of a national health insurance strategy may be even higher.

The future will also depend on the political economy of health, especially whether the "right to health" deriving from the National Health Bill of 2009 can be interpreted to mean a mandate for the state to provide for access to and financial protection related to healthcare for all citizens, not just the poor.

Lessons Applicable to Nigeria

India's GDP per capita in 2011 at current exchange rates was US$1,489 versus Nigeria's US$1,502. The federal structure of India is similar to Nigeria's, although there are marked differences in the way fiscal federalism is applied in Nigeria. Both countries started the current century with significant problems in the delivery of healthcare and equity in health outcomes. Currently, there are significant differences in approach. While the National Health Bill in India has legal weight in mandating that each citizen have equitable access to healthcare, the National Health Policy (2006) in Nigeria is a strategic and policy document. India has a mixed system of mandatory social health insurance for some formal-sector workers and a much larger government-funded voluntary insurance model targeting secondary care for the poor. Policy discussions indicate a future move toward a national health insurance strategy. In contrast, outside of a limited program offering community-based insurance, Nigeria's NHIS has grown slowly, mostly via a voluntary social health insurance framework.

In terms of the existing NHIS structure in Nigeria, three different programs exist with separate targeted populations, membership rules, and coverage patterns. The social health insurance part of NHIS, intended for formal-sector participants, can be compared with the ESIS and CGHS in India, in that they are all comprehensive in intent, covering outpatient and inpatient care. The social health insurance schemes in India suffer from several deficiencies, such as dependence on facilities that the schemes operate themselves, and a sustainability problem for the CGHS, but have evolved to simplify procedures by using package rates and other strategies (La Forgia and Nagpal, 2012). The NHIS formal-sector program has a higher percentage contribution than ESIS or CGHS and uses public and private providers, but its processes suffer from over-complexity and unclear incentives for providers. Various provider payment mechanisms exist, including fee-for-service, although there is a desire to spread the use of a capitation mechanism beyond outpatient services. Overall, uptake of secondary care by NHIS beneficiaries is

reported to be low because the health maintenance organizations (HMOs) that act as gatekeepers for such services are reluctant to authorize them (JLN, 2012).

The NHIS's role in Nigeria is somewhat diluted. It manages subsidy programs for certain population groups, paying 100 percent of their premiums, and negotiates with HMOs for service provision, while it delivers oversight and regulation for the system. Therefore, NHIS functions may require some streamlining, as recommended in the Ministerial Expert Committee Report in Nigeria (MEC, 2003). Some of the recommendations in this regard made by the Ministerial Expert Committee were adopted for creating appropriate institutions for the different tasks in a large system of social health insurance, such as the National Health Insurance Council to govern NHIS (MEC, 2003; JLN, 2012).

State governments in Nigeria have still not played a significant role in expanding health insurance (Asoka, 2012). The division of roles between the central government ministries, state governments, local nodal agencies, and the actual insurers, as seen in the institution and expansion of RSBY, may be instructive for Nigeria.

India's current attempt to rapidly scale up financial protection in healthcare and to map a path toward UHC should inform other developing nations in similar position, such as Nigeria. If Nigeria wants to cover more of its population, then it needs to bolster the NHIS with some mandatory contribution provisions and reconsider the CBHI portion, or select a different health insurance and UHC strategy. Whether a system funded entirely from general taxation, as is being debated in India, will work in Nigeria depends on the ability to broaden and deepen the tax base. An informed analysis of the options, as is occurring in India, may be necessary. The evolution of financial protection in healthcare for the poor in Nigeria may learn from the experience of the RSBY and similar schemes in India, especially in terms of targeting, full subsidy of the premium, rapid scale-up with a defined secondary care benefit package, and cost containment while using the latest technologies.

THAILAND

Background

Thailand is an upper-middle income country by World Bank definition, with a population of approximately 69 million people. Thailand's GDP per capita in 2011 at current exchange rates was US$4,972. In 2011, the country's life expectancy at birth was 74 years, and more than 94 percent of adults were literate. The country's infant mortality rate in 2011 was low at 11 per 1,000 live births, compared to 15, 47, and 78 in Colombia, India, and Nigeria, respectively (World Bank, 2012).

Thailand's health system has improved significantly over the past 20 years. Much of the improvement stems from the introduction of the Universal Coverage Scheme (UCS) in 2002. At the time of these reforms, Thailand was one of only a handful of middle-income countries to attempt universal coverage (Vasavid et al., 2004; Krit et al., 2009). Health indicators confirm the significant positive impacts of this policy. The infant mortality rate of 11 per 1,000 live births has declined dramatically from 1990, when that rate was 26 per 1,000 live births. The under-five mortality rate was 12 per 1,000 live births in 2011, and the maternal mortality ratio was 48 per 100,000 live births in 2010 (all data: World Bank, 2012).

The Thailand government remains by far the biggest funder of Thailand's healthcare expenditure, at 75 percent of the total in 2010. The Ministry of Public Health is the core agency that implements the UCS, which started on a pilot scale in six provinces in 2001, later expanded to an additional 15 provinces, and finally was extended to all provinces in 2002. As a result, in 2003, 74.7 percent of Thai citizens nationwide were covered by the scheme, leaving only 5 percent of the population without any health insurance coverage (the rest were already covered by other health insurance schemes). At present, UCS covers almost the entire part of the population not covered by other schemes or private insurance.

Road to Universal Coverage

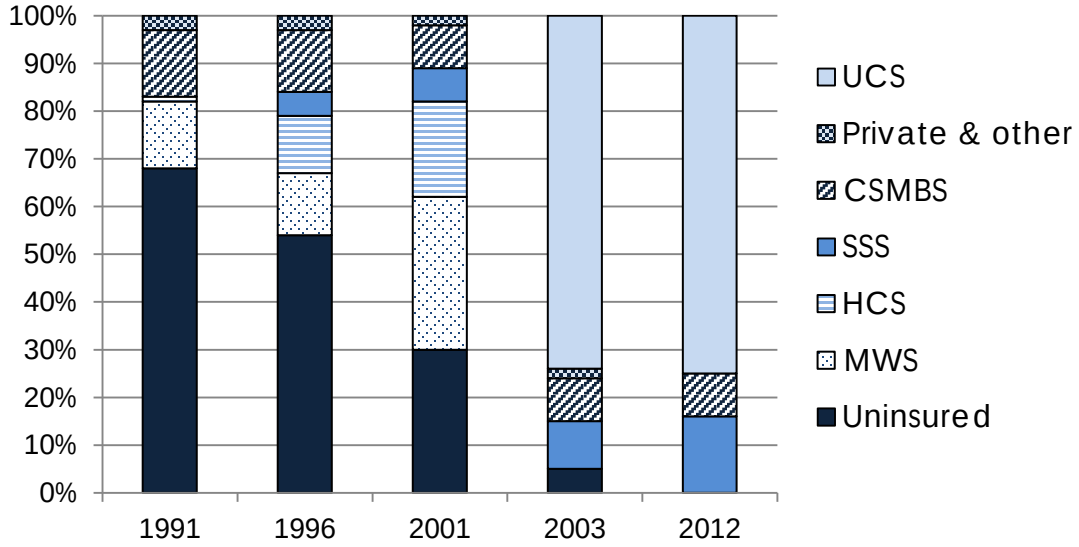
From the 1960s, Thailand experimented with various schemes while trying to achieve universal coverage and health equity among the Thai population. Some of the major programs included an initiative in the 1970s to provide "one hospital for every district and one health center for each sub-district" (Sakunphanit and Suwanrada, 2010). This impressive investment in the supply of primary healthcare laid a solid foundation for innovations on the demand side. Introduced in the 1960s, the Civil Servant Medical Benefit Scheme (CSMBS) provides health insurance coverage for current and retired government employees and their dependents. It is comprehensive, covering both outpatient and inpatient care, and is funded by the government from general taxation revenue, with some copayment required. An analogous scheme—the Social Security Scheme (SSS)—was started in the 1990s for private sector employees, using payroll contributions from both employees and employers and a government subsidy. It also covers outpatient and inpatient care, which can be obtained from a network of facilities across public and private sectors. These two schemes continue to the present day, covering 9 and 16 percent of the population, respectively.

Like other countries, Thailand had also considered the problem of extending financial protection against ill health to the informal sector and the poor. The Medical Welfare Scheme (MWS), originally known as the Low Income Scheme, began in 1975, funded through general tax revenue and incrementally expanded to cover the poor, the elderly, children, and other vulnerable groups. The Health Card Scheme (HCS) began in the 1980s as a community financing fund and later was expanded nationwide as a voluntary insurance scheme to cover the non-poor who were ineligible for the MWS.

However, neither MWS nor HCS were able to significantly increase coverage to the entire uninsured population (Figure 2). The government engaged in study tours and research to understand the processes

and resources required to reach universal coverage. The Health Insurance and Standard Medical Service Bill of 1995–96 proposed a compulsory health insurance plan, which was not taken forward (Sakunphanit and Suwanrada, 2010). However, the agenda for universal healthcare coverage continued to gather force, with significant advocacy from civil society and broad political support. The principle was a feature of the eighth National Health Plan (1997–2001). In 2001, the government finally initiated a universal, nationwide healthcare coverage scheme to improve access to healthcare for all Thai citizens. It received legal standing via the National Health Security Act, enacted in November 2002.

Figure 2. Evolution of Universal Healthcare Coverage in Thailand



CSMBS: Civil Servants Medical Benefit Scheme; SSS: Social Security Scheme; MWS: Medical Welfare Scheme (initially Low Income Scheme); HCS: Health Card Scheme; UCS: Universal Coverage Scheme. Sources: HISRO, 2012; Sakunphanit, 2012

Universal Coverage Scheme

The Universal Coverage Scheme (UCS) consolidated the earlier health insurance schemes targeted at the poor (MWS and HCS), and also expanded to cover all the remaining uninsured. In 2011, the UCS plan covered 50 million Thai citizens (75 percent of the total population). Some Thai citizens are covered through the CSMBS or the SSS and continue to enjoy their benefits under those schemes. Thailand has met its full implementation target of covering 95 percent of the population. The three schemes are compared in Table 4.

The UCS incorporated two main reform initiatives: reforming healthcare financing mechanisms for the uninsured poor and for the informal sector through budget allocation and payment systems, and strengthening service promotion through primary healthcare services using village community volunteers (Vasavid et al., 2004; Krit et al., 2009). The simultaneity of a major demand-side initiative and a supply-side expansion underpin Thailand's success in improving overall health outcomes. These reforms eliminated financial barriers at the point of delivery. General tax revenues paid for these initiatives, with funding allocated annually based on population.

The UCS includes a comprehensive benefit package with outpatient, inpatient, and preventive care (health education and immunization). Since 2006, UCS has covered drugs for HIV/AIDS treatment; since 2007, it has covered increasingly important ambulatory procedures such as hemodialysis and peritoneal dialysis.

Expensive inpatient procedures are included, such as renal transplantation. Rehabilitation is also covered. Exclusions are similar to those for the benefit package in Colombia (e.g., cosmetic surgery, infertility). One key element of the UC program is capitation-based reimbursement for outpatient care, as well as a system with budget caps for inpatient care. Most providers are such government facilities as health centers, community hospitals, and secondary hospitals. Since the abolition of the 30-baht co-payment (US$0.92) at health facilities, the income for these public facilities is mainly from capitation payments.

As a result of the UCS and the CSMBS, the Thai government now provides healthcare services for most of the population (close to 85 percent) nearly free of charge,[8] financed from taxes, similar to a national health insurance strategy. Over time, the UCS has embraced preventive care as a large part of the model of integrated, continuum-of-care design, where most patients must begin with a primary healthcare visit and are referred if necessary. As discussed, such a model would not be possible without the concomitant investment made in strengthening the primary healthcare system over time.

The success of UCS, discussed below, has been built upon strong investments at the community level, which have accompanied the investment into the primary health infrastructure. The UCS uses village health volunteers (VHVs) who are trained to translate health policies into practice. VHVs are used as entry points to build up community participation and gradually encourage villages to be self-reliant in health. Currently, there are more than 800,000 VHVs all over the country—at least one in every village.

Scheme operation: People joining the scheme receive a card that allows them to access services in their health districts and, if necessary, get referrals for specialist treatment elsewhere. Providers must organize themselves as a Contracting Unit for Primary care (CUP), and fulfill some criteria in terms of staffing to be recognized as a CUP. By policy, each CUP, especially those led by large hospitals, must have primary care units that act as gatekeepers. Each citizen covered under the UCS is registered with the nearest health center, which belongs to a CUP. Such a beneficiary can access care from another health center or a hospital belonging to that CUP. Going beyond the CUP of one's primary health center can lead to copayments. Due to the presence of health centers in virtually all districts, and multiple facilities in urban areas, it's unusual for beneficiaries to go outside of their assigned CUP network. A national registry records the personal identification number of each beneficiary and is updated twice a month. The registry also records the membership in CSMBS and SSS.

Payment mechanism: A complex payment system is in place, which cannot be fully described in this case study. The CUPs receive funds on an age-adjusted capitation basis for covering outpatient care. Adjustments are made for remote areas and based on the size of the catchment area served by the CUP. For inpatient care, the CUP receives case-based payments that have been aligned with "diagnosis-related groups" (DRGs), which classify different hospital procedures. In addition, specific services requiring high-cost care or management of chronic diseases are managed with selective contracting with the CUPs, such as diabetic screening, cardiac surgery, and HIV and AIDS treatment.

Efficiency and cost containment: The UC scheme incorporates several features that promote efficient healthcare delivery. First, the scheme has a fixed annual budget, arrived at by multiplying the capitation payment with the number of beneficiaries. The capitation payment is capped after negotiation with the CUPs on the cost of offering the benefit package to a beneficiary in the forthcoming year, inclusive of operating expenses and staff salaries. To avoid cost overruns, the total budget for inpatient services is capped as well at a preset amount at the regional level. In addition, the strict gatekeeping function of the primary healthcare unit of the CUP and a managed referral system mean that there are limited opportunities in theory to over-treat patients. According to one evaluation, the purchasing policies set in

[8] The CSMBS requires copayments for inpatient care when the beneficiary accesses the service at a private facility.

place by the National Health Security Office (NHSO) for the UCS have led to "higher efficiency, largely on cost containment" in the hospital sector (Sriratanaban, 2012).

However, studies also indicate an increasing challenge in setting the appropriate capitation rate, which is re-negotiated every year between providers and the NHSO, the institution responsible for managing the UCS and purchasing services. There were indications that the fixed payment system may encourage some providers to undertreat patients, thus reducing the availability of services paid for by the scheme (Sakunphanit, 2008).

Table 4. Types of Public Health Insurance Plans in Thailand

Description	Civil Service Medical Benefit Scheme (CSMBS)	Social Security Scheme (SSS)	Universal Coverage Scheme (UCS)
Beneficiary population	Government employees as well as pensioners and their dependents (parents, spouses, and up to three children under 20 years old)	Private sector employees, excluding dependents	The portion of the population not covered by SSS or CSMBS
Legal framework and governance	1982: Decree of Civil Service Medical Benefit Scheme	1990: Social Security Act; managed by Social Security Organization and falls under the supervision of the Ministry of Labor	2002: National Health Security Act; the National Health Security Office designs benefit packages and payment arrangements
Sources of funding	General tax; non-contributor	Payroll tax; tripartite contribution of 1.5 percent of salary from employee, employer, and government	General tax; non-contributory
Approximate number of beneficiaries (2012)	6 million people or 9 percent of the population; beneficiaries live mainly in urban areas	10.7 million people or 16 percent of the population; beneficiaries live mainly in urban areas	50 .3 million people or 75 percent of the population; beneficiaries primarily live in rural areas and rely on district health services
Benefit packages	Comprehensive package, considered slightly better than SSS or UCS; excludes special nurses	Comprehensive package; covers inpatient/outpatient care for non-work-related illnesses, injuries, maternity, disability, and old age; excludes special nurses and private beds	Comprehensive package similar to SSS; covers inpatient/outpatient care at the registered primary care and referral secondary facilities; excludes special nurses, private beds, and certain services
Accessibility	Free choice of public providers without registration	Contracted public or private hospitals and the network of referral facilities; requires registration of member in advance	Access to contracted CUP hospital and its network of referral system (mainly public); requires registration of member in advance

Description	Civil Service Medical Benefit Scheme (CSMBS)	Social Security Scheme (SSS)	Universal Coverage Scheme (UCS)
Income group	Middle or high income	Middle or high income	Low income
Purchasing mechanism	Reimbursement model: fee for service with direct disbursement to providers for outpatient care; use of DRGs for inpatients	Contract model: capitation payment for outpatient and inpatient services, with additional payment schedules for accident, emergency, and high-cost care	Contract model: capitation payments cover outpatient care, and a global budget with case-based payments using DRGs covers inpatient care
Expenditure per capita (2010)	US$367	US$71 (government: US$24)	US$79

Source: HISRO, 2012; Wagstaff and Manachotphong, 2012

Evaluation of the UCS

Impact on financial protection: The implementation of the UCS has reduced or eliminated financial barriers to accessing health services and has thus provided many benefits for the poorest sections of the population. Surveys have suggested that the proportion of households facing impoverishment caused by catastrophic medical expenses has from 2000 to 2006 been substantially reduced by 77.5 percent in the poorest quintile of the population (Limwattananon et al., 2011). Multiple studies that have evaluated the Thai experience since the reforms of 2002 have concluded that the strategy has worked to increase health equity; that is, the impact has benefited the poor, and levels of financial protection related to ill health have increased across the population (Limwattananon et al., 2011; HISRO, 2012).

Impact on health utilization: The utilization of outpatient care increased by 31 percent from 2003 to 2010. The investments made on the supply side are also to be credited for this achievement. A comprehensive evaluation of the outpatient and inpatient utilization record suggests that the growth in visits and admissions has been pro-poor, particularly in rural areas (HISRO, 2012). A population-level survey conducted in 2010 shows that unmet need for outpatient and inpatient care is very low across Thailand, given the presence of the UCS, CSMBS, and SSS programs. The levels of unmet need are better than those in most high-income countries (HISRO, 2012).

Thailand had the highest average annual rates of reduction in child mortality in a sample of 30 low- and middle-income countries between 1990 and 2006 (Rohde et al., 2008). Between 2003 and 2008, the proportion of cases that were well controlled rose from 8.6 to 21 percent for hypertension and 12.2 to 31 percent for diabetes (Sakunphanit and Suwanrada, 2010). Wagstaff and Manachotphong (2012) use statistical techniques to suggest that UCS had four times as large an effect on the self-reported likelihood of individuals being too ill to work as did the village fund program, a microcredit intervention in Thailand from the same period.

A recent assessment did not find any evidence to suggest that the government's expenditure on UCS had come at the expense of other social-sector spending, such as education or social welfare. The spillover effects of UCS include the boost given to the Thai health information system and the improvements to hospital functioning. Thai hospitals are now attracting medical tourists from other countries. Overall, medical production in the Thai economy has also grown as a result of the UCS (HISRO, 2012).

Challenges: Despite the benefits of the UCS, its financial sustainability depends on overall government finances and the continued growth of the economy. In fiscal year 2008, the UCS cost nearly 1 percent of GDP or US$2.6 billion at 2009 exchange rates; it also accounted for 32.5 percent of all public sector spending on health (Sakunphanit and Suwanrada, 2010; Manprasert and Suwanrada, 2012). Using 2002 as an index, by 2008, spending on UCS had more than tripled (Manprasert and Suwanrada, 2012). Projections indicate that total health expenditure as a percentage of GDP will grow to 4.5 percent by 2020 (HISRO, 2012).

There is an inherent inflationary trend in UCS capitation payments and budgets for inpatient care as the population ages (and hence uses healthcare more frequently and for more complex procedures) and as the burden of non-communicable diseases becomes more acute. Over and above these, costs also rise due to an increase in the complexity of healthcare demanded and the rising price of such inputs as drugs. These trends affect all government-funded or subsidized programs, including the CSMBS and SSS. The Ministry of Finance in Thailand has conducted a feasibility study on changing the benefits under CSMBS.[9]

Overall, it is not surprising that government spending on health had climbed from US$2.7 billion in 2002 to US$7.4 billion in 2008 which, adjusted for inflation, represents a 76 percent real increase (HISRO, 2012). During this period, Thailand's economy grew steadily so that total health expenditure remained within a band of 3 to 4 percent of GDP, which is considered to be affordable for the government and society in general.

The three schemes have significant differences and different expenditure per capita. There is still a need to harmonize the schemes and manage equity. The government has pledged to consider greater integration of the government funds that finance each of the three schemes.[10] Other challenges highlighted in the recent evaluation of the decade of UCS suggest that Thailand will need to address human resources for health challenges, specifically to reduce an urban-rural disparity in the availability of qualified doctors and nurses. Currently, UCS is implemented with a somewhat centralized structure, with decisions on rates and processes made by the NHSO. Researchers in Thailand suggest that a decentralized decision-making structure would increase autonomy at local levels (HISRO, 2012).

Lessons Applicable to Nigeria

Valuable lessons and experiences from Thailand can be drawn for Nigeria and other countries seeking to expand demand-side initiatives such as health insurance for increased financial protection and to achieve UHC.

- **Strong government commitment and management of the reform:** Thailand had several decades of experience with health insurance—financed in a mixed manner, with both mandatory contributions and general taxation—before it attempted a move toward universal health coverage in 2002. The past decade has seen strong political commitment to the principle of universal coverage, even during significant political disruptions and changes of government. Since 2005, the share of health expenditure as a percentage of total government spending has been maintained between 13 and 14 percent, regardless of drops in the growth of GDP. Access to healthcare and financial protection from its costs were seen as an essential element of an overall poverty reduction strategy. A legal framework was present, which enshrined a right to health. Most important, different actors in the system, from civil society to government, were willing to work together to achieve the vision.

[9] Source: *Bangkok Post*, "Finance Ministry rejigs health scheme," August 15, 2012.
[10] Source: *Bangkok Post*, "Integrating three state systems 'a challenge'," March 22, 2012.

- **Intelligent design for the UCS:** A recent evaluation of the decade of Thai experience with the UCS has summarized key lessons for other countries (HISRO, 2012). One of these is that the Thai strategy got three elements right that are necessary to achieve universal health coverage: (1) improving fundamental access to healthcare services prior to a demand-side intervention, (2) implementing cost containment thoroughly, and (3) using strong purchasing mechanisms. The Thai government invested heavily throughout the 1980s and 1990s to expand district hospitals and health centers in rural areas before it attempted to achieve 100 percent coverage. In addition, newly graduated health professionals, such as medical doctors, dentists, and pharmacists, were required to serve in rural hospitals for a certain period. This compulsory service helped significantly in providing for the health professionals who could meet the increasing use that was seen under UCS and the two other schemes.

- **Development of the healthcare system from the bottom up:** The success of the UCS and the improvement of health outcomes are based on a strong commitment to primary healthcare as the entry point for every Thai citizen seeking health services. Before reaching a health center or community hospital, individuals have access to a community-based model that has been vastly strengthened over time. Sub-district administrative authorities all over the country now allocate a portion of their budget to support VHVs and local health center activities. Moreover, under the UCS, a portion of health budgets earmarked for health promotion and disease prevention is transferred to each sub-district local administrative authority.

- **Adaptation of the health service administrative structure:** Other design-related factors were important in the success of universal coverage in Thailand, including the following:
  - Use of stringent provider reimbursement mechanisms, reviewed in this study, as appropriate to the scheme, that allow consumers to choose an optimal primary healthcare provider under UCS.
  - Development of strong institutions, such as the NHSO (which is able to negotiate with the government's Budget Office for its financial outlays), coordinate with the Ministry of Public Health on policy, and contract with the providers. In addition, Thailand has institutions for the regulation and accreditation of the providers, such as the Healthcare Accreditation Institute.
  - Establishment of the National Heath Commission Office as an autonomous agency under the Prime Minister in 2007, with responsibility to achieve broader participation in health policy formation through support of national and local health assemblies and to promote better coordination among stakeholders.
  - A continuous process of health system research and M&E of the health financing model, allowing for course corrections and tweaking of the design.

OVERALL CONCLUSIONS

The path that different countries take toward achieving UHC, and the role of health insurance in this path, depends a lot on the individual context of the health systems. According to a recent declaration by the World Health Organization, the path to UHC is more than just extending a minimum package of services to a maximum number of people (WHO, 2013). It involves making available the basic health inputs that individuals require (essential medicines, health worker time, infrastructure, and information), covering as much of the cost of those inputs as possible, and covering this cost for as many as people as possible. Health insurance is a good mechanism for pooling resources in advance for covering the cost, and potentially a financially sustainable way of covering a large number of people, especially when the costs also involve less frequent and more expensive health services, such as those requiring hospitalization.

How health insurance expansion features in a UHC strategy depends on the resources available to the government via general taxation, the growth and maturity of private voluntary health insurance markets, and, most important, the state of the health system across primary, secondary, and tertiary healthcare. These case studies suggest that pragmatic choices made by lower-middle and middle-income governments—a group that may include Nigeria—have involved hybrid health financing models. These models can be partly a national health insurance scheme financed from general taxation (non-contributory), and partly an SHI scheme financed from mandatory contributions for those who can pay. The downside of mixed or hybrid models is the increase in administrative costs overall, since each scheme must maintain its own systems of information management and oversight.

Strong cost-containment practices are important before health insurance coverage expands substantially. Supply-side investments into the basic inputs, especially for primary healthcare, are necessary before attempting UHC and health insurance expansion. Choices for Nigeria, which currently has low health insurance coverage, will necessarily involve innovation in choosing models and practices.

The experience of **Colombia** suggests that a middle-income country with a strong tax base and government commitment to a pluralistic, solidarity-based health system can achieve UHC via expanding health insurance to nearly all citizens. Colombia's success in combining government contributions from general tax revenue with the mandatory contributions from the formal sector helped it create a national pooled fund that allows risk-pooling and cross-subsidization as it reduces fragmentation. Colombia has also moved to true equity in terms of the health benefits offered across income groups, though the program comes at significant cost to the government exchequer. None of this would be possible without the commitment of the government to a strong foundation in primary healthcare through a minimum benefits package provided to all without charge, and to a strong national identification system that allows better administration and regulation of the system. Colombia's system results in a mix of national health insurance and SHI. Nigeria can examine the solidarity-based system in Colombia and the strength of government commitment there to the principle of UHC.

The debate in **India** about the best course toward UHC indicates the complexities when governments face difficult fiscal choices in the social sector, increased expectations of benefits in the general population, and a poor historical healthcare base from which to make investments. India may move to a national health insurance model that some have advocated, where the government uses both public and private providers to allow all citizens—not just the poor—access to a comprehensive benefit package. Such a strategy would come at significant cost, and its potential will be weighed against the government's overall fiscal base and the state of the economy. The public sector has already invested significant funds into the improvement and expansion of the primary healthcare system under the NRHM. It has also invested in improved access to and financial protection in the use of secondary healthcare services via a variety of central and state government insurance schemes. This expansion in the public sector's role is widely

considered to be fiscally neutral to other social sector programs, even in health—that is, more resources have become available overall.

However, India may encounter sustainability challenges as the government expands toward UHC. Currently only 19 percent of Indians have subsidized health insurance of some form, and the resource needs are already large. Therefore, pragmatic proposals for India involve a mixed strategy: expand health insurance further for the poor using the existing schemes (that is, approximating a national health insurance model funded from general taxation), and consolidate other insurance schemes that use mandatory contributions for formal-sector employees. Consolidation of the latter schemes yields the benefits of larger risk pools, cross-subsidization, and reduction in fragmentation. At the same time, the government must continue its investments into the primary healthcare system and reduce the costs and disincentives that prohibit citizens from entering the system via a primary healthcare unit rather than hospitals.

India's choices, given its comparable income status and similar healthcare infrastructure at the beginning of the decade, may have important lessons for Nigeria. Even as these choices are made, Nigeria can learn from the processes and operational strategies used to expand government-funded health insurance to millions in India. The evolution of financial protection in healthcare for the poor in Nigeria may benefit from the experience of the RSBY and similar schemes in India, especially in terms of targeting, full subsidy of the premium, rapid scale-up with a defined secondary care benefit package, and cost containment while using the latest technologies.

Nigeria must continue its current programs to strengthen primary healthcare and forge meaningful resource investment partnerships between states and the central government, as India has tried to implement in its similar federal system. State governments in Nigeria have still not played a significant role in expanding health insurance (Asoka, 2012). The division of roles between the central government ministries, state governments, local nodal agencies, and the actual insurers, as seen in the institution and expansion of RSBY, may be instructive for Nigeria.

Thailand's experience is salutary, as it demonstrates that moving to UHC for a middle-income country can involve a significant length of time and require political ownership of a process fraught with competing interest groups, programs, and strategies. Thailand's investments into UHC began at the base of the healthcare pyramid—the primary health facility—and in community health. Its current mix of health-financing strategies reflects a pragmatic middle-of-the-road option that has evolved over time. It combines a national health insurance model for the majority of the population, along with consolidated, high-quality, mandatory contributory schemes for the formal sector.

In terms of the existing NHIS structure in **Nigeria**, three different programs exist with separate targeted populations, membership rules, and coverage patterns. The social health insurance part of NHIS, intended for formal-sector participants, is comprehensive, covering outpatient and inpatient care. The NHIS formal-sector program has a high percentage of income contribution, and reviews suggest its processes suffer from over-complexity and mixed incentives. If Nigeria proceeds on a path to making NHIS contributions compulsory for formal-sector employees, it must improve on the benefits package and provide for cost containment. This will avoid problems in sustainability and acceptance later. There are opportunities for improvements in provider payment mechanisms, and Nigeria can observe the processes in many other countries to implement appropriate changes. There have also been recommendations to improve the role and functioning of the NHIS as its operations grow, such as the measures already taken in response to the Expert Committee Report of 2003 (MEC, 2003).

Even allowing for its gradual implementation schedule, starting from 12 states, the NHIS's RCSHIP (community-based health insurance) initiative has not grown significantly. This may reflect a lack of

awareness, or complexities in the norms of membership (the scheme requires a community to self-organize for participation), or a lack of satisfaction in the benefits and financial protection offered. An urgent evaluation of the RCSHIP's progress is required.

There are state-level CBHI schemes—such as in Lagos State[11]—that demonstrate that there is demand for a prepaid, risk-pooling mechanism that can cover the costs of basic primary healthcare and reduce out-of-pocket expense. However, Nigeria cannot consider covering large numbers of citizens, especially the very poor, with a basic primary healthcare package using a patchwork of such schemes. It is also not clear how the very poor can participate in these schemes and access healthcare. Therefore, these schemes, despite the attention placed on them, do not obviate the need for investing in strengthening primary healthcare, eliminating user fees, and otherwise reducing out-of-pocket costs for the poorest citizens. The National Health Bill (2008 draft) being considered in the National Assembly proposes free healthcare for children under age five, the elderly, and pregnant women. It is important to understand the depth of services and financial protection this will entail in practice.

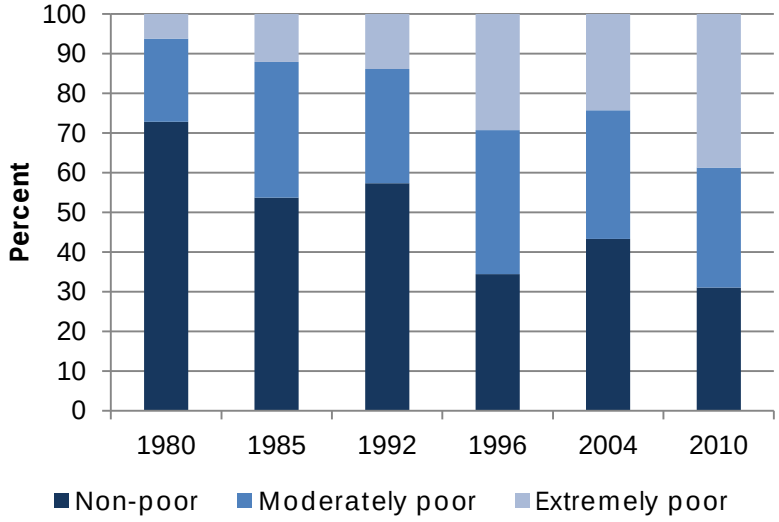
Implementing a CBHI strategy under NHIS that can cover a more comprehensive benefit package with primary healthcare and basic secondary healthcare (short-term admissions and some procedures of higher cost such as for diabetes) will require serious advocacy work to get financial participation from states, local governments, and beneficiary communities. As observed in Colombia, India, and especially in Thailand, such stakeholders are crucial in the successful implementation of community-based health insurance. In Thailand, significant investments were made in engaging communities to understand the purpose of the UCS, including the establishment of local-level community or political structures to oversee its operations in their areas.

Most successful community-based schemes have received government subsidies, and this means that the proposed Office of the Special Assistant on Millennium Development Goals within the Office of the President in Nigeria is necessary. However, NHIS planners need to develop a revenue model to ensure the RCSHIP's financial sustainability. Globally, the usual model for financing such subsidies is a national health insurance scheme, in which governments make fiscal commitments to fund overall healthcare from general revenues and not from temporary funding sources, such as Millennium Development Goal funds. Countries such as Thailand and India have also introduced innovative hybrid health financing strategies.

In this context, the use of an earmarked tax to create a "health fund" to finance the premium contributions for certain high-priority demographic groups, as proposed under the Bill HB 276 currently under consideration in the National Assembly, may not have sufficient fiscal weight to truly broaden the covered population, especially the large number of Nigerians who are considered indigent by the definitions adopted in the bill (income below 30,000 naira per year, or US$192). From Figure 3, we can observe that currently about 40 percent of Nigerians are "extremely poor" by a different measure, in this case having less than a threshold per capita household expenditure per year, as defined by the National Bureau of Statistics (2010). This threshold was one-third of 66,802 naira per year (US$428 at current exchange rates), or 22,044 naira (US$141). By this relative poverty measure, 63 million Nigerians are extremely poor.

[11] The Ikosi-Isheri Mutual Health Plan was piloted in 2008 in Lagos State. For a monthly premium of 800 naira (US$5.30), members in the community can access basic outpatient care at a designated primary healthcare center, serviced by a private provider. Active members who pay their dues number nearly 5,000 out of 20,000 or more ever registered.

Figure 3. Relative Poverty in Nigeria, 1980–2010



Source: Harmonized Nigeria Living Standard Survey (National Bureau of Statistics, 2010)

Given the very large size of the "extremely poor" population by Nigeria's official measures, the earmarked taxes will need to provide significant revenue to fund financial protection for this demographic segment, which will find it difficult to contribute to community-based or other health insurance programs. Therefore, special fiscal and actuarial studies should be undertaken to understand how well the proposed "health fund" will work in practice, and whether it has the chance to significantly increase financial protection for health in the country.

In Ghana, the performance of the National Health Insurance Levy suggests that an earmarked tax can generate significant resources, but these resources need to be used and targeted effectively. In Ghana, a 2.5 percent levy is imposed on all sales of goods and services. In 2008 the levy generated nearly US$160 million in revenue, primarily intended to make membership in the country's National Health Insurance Scheme (NHIS) cost free for certain exempt groups such as the elderly, children, and the very poor (Atim, 2011). The degree of coverage achieved by the NHIS is unclear, with figures claimed to be as high as 62 percent in 2009 (NHIA, 2009) and as low as 18 percent (Apoya and Marriott, 2011). Despite the substantial earmarked resources, the Ghana NHIS has not made sufficient progress in covering the very poor, and inequities in coverage persist. Of adult women in the lowest-income quintile, 17 percent were NHIS cardholders, while among women from the highest-income quintile, this figure was 29 percent (GSS et al., 2008). The differences for men are even starker. Nigerian stakeholders should review the Ghanaian experience in this context, along with the case studies in this report, before developing operational plans for the use of health fund monies.

More fundamentally, Nigeria needs to review its strategy for the achievement of UHC. At present, the growth in NHIS membership beyond the formal sector has stalled. If Nigeria wants to cover more of its population, then it needs to bolster the NHIS with some mandatory contribution provisions to capture more of the numbers in formal-sector employment and reconsider the CBHI portion, or select a different overall health insurance and UHC strategy. Whether a system funded entirely from general taxation, as is being debated in India, will work in Nigeria depends on the ability to broaden and deepen the tax base. Many Nigerians have opined that this ability is limited at present. Nigeria should consider the experience of other countries, such as those studied in this report, to emulate their path to a graduated transition to universal health coverage.

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