**A comparative Analysis of Health Insurance Schemes in Five sub-Saharan African Countries**

**Background**

Financial protection against catastrophic health expenditure is certainly an important pillar in the agenda for universal health coverage (UHC) which is at the core of the sustainable development goals (SDGs). The idea of health insurance is anchored on people pooling financial resources to provide for their health needs. In fact, health insurance is intended to reduce the financial burden of purchasing health care by pooling funds and sharing the risk of unexpected health events. Risk sharing mechanisms are particularly important in sub-Saharan Africa (SSA) where inadequate resources are allocated to health care and out-of-pocket (OOP) constitute the largest share of health financing. This leaves most people who need health care but without the financial power unattended to. Others are faced with catastrophic health expenditures which ends up leaving the health system fragmented and unequitable, obviously an undesirable health statistic. The World Health Organization (WHO) points out that health insurance is a promising tool for achieving UHC (Devadasan et al., 2007; Hsiao and Shaw, 2007; McIntyre, 2006). This position by the WHO however needs to be given serious attention in SSA where out-of-pocket expenditure seems to dominate the health financing strategies of most SSA countries. Joao et al., (2010) for instance, observed that the insufficient dedication of resources to the health care needs, including, medicines in sub-Saharan Africa invariably meant that the health care needs are financed largely by out-of-pocket payments.

There are different types of health insurance schemes practiced in different countries with varied design parameters which may have different impacts on the populations and other measures of performance such as their efficiency and sustainability. Types of schemes in Africa include: national or social health insurance (SHI) which is based on individuals’ mandatory subscription; voluntary private health insurance (PHI) which has been viewed widely in the literature as a mechanism that largely serves the affluent in society while leaving behind the poor and marginalized; and community based health insurance (CBHI) which is popular in Africa and whose impact on various health system goals has often been mixed at best. As Spaan et al., (2012) points out, different types of insurance schemes have different impact on the population they serve and policymakers should critical consider this in setting up an insurance mechanism.

National or social health insurance is increasingly the dominant trend in scheme design in the drive of countries towards UHC. And even within that trend, there are different designs and practices with regard to how they adhere to international best practices in UHC design, especially as advocated by the World Health Organization and within the context of the Sustainable Development Goals.

There is now a body of experience in Africa on health insurance organization whose performance against certain important efficiency and sustainability criteria could be assessed against international best practices in those areas. There is indeed a gap in comparative analysis of the different health insurance mechanisms in different African countries, specifically on best practices and emerging challenges. A comparative analysis of health insurance systems is important and will provide learning about the different policies to improve performance across countries. This proposed paper helps to close this knowledge gap by providing a comparative analysis of health insurance systems in five (5) African countries.

AfHEA in collaboration with the National Health Insurance Authority (NHIA) and its Korean Development Partner, the Korea Foundation for International Health Care (KOFIH) propose an organised session that will discuss a comparative analysis of the different health insurance mechanism in five (5) sub-Saharan Africa countries namely; Ethiopia, Kenya, Ghana, Tanzania and Uganda. Each country will have a team that will compile the key performance indicators for this comparative analysis. The comparative analysis focuses on; the structures of health insurance schemes in these countries; years in operation; population actively covered; the skills and competencies available; average provider reimbursement time; fraud control measures; payment mechanisms; participation by stakeholders’ groups and reserve ratios.

**Objective**

The objective of this paper is to provide a comparative analysis of health insurance mechanisms across selected SSA countries to shed light on best practices, emerging challenges, potential options for mitigating these challenges; and offer learning opportunities for improving health insurance in these countries.

**Key performance indicators for comparative analysis**

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| **Key comparative indicators** | **Countries** |
| Ethiopia | Kenya | Ghana | Tanzania | Uganda |
| Presence of Key Technical Staff/Skills, specifically (state numbers and level of expertise): Claims administrationClinicians (supporting claims work) Actuary(ies)Monitoring and evaluationOthers eg health economists, costing, etc |  |  |  |  |  |
| Average provider claims reimbursement time in months |  |  |  |  |  |
| Fraud control measures, state measures used |  |  |  |  |  |
| Do you have a statutory mandatory medical loss ratio or long-term solvency ratio – state the ratio of administrative/overhead charges to operational (health care) expenses |  |  |  |  |  |
| Do you have a statutory administrative reserve ratio – state how many months’ average expenses or percent of average monthly expenses |  |  |  |  |  |
| What payment mechanisms are used at different levels of care |  |  |  |  |  |
| Is there a health technology assessment or priority setting process in place – describe, including how the insurance organization sets and reviews prices for its health care services  |  |  |  |  |  |
| What forms of membership empowerment exist |  |  |  |  |  |
| Organizational structure (i.e. level of decentralization) |  |  |  |  |  |
| What fora exist for dialogue /negotiation with providers /other stakeholder groups  |  |  |  |  |  |

**Methods and Data**

A multifaceted approach that includes review of official documents, documented literature, key informants, expert opinion and interviews of key officials would be adopted. Thus, a combination of both primary and secondary data would be explored to carry out this analysis. A team of research experts in the insurance sector space from the selected countries will assist the insurance agency where necessary, to generate this information for analysis and presentation.

The responses will be analyzed against best practice in these areas from a mixture of the WHO advice, the SDG targets or from best performing UHC countries and literature on UHC design.

The session will begin with an overall best practice presentation of the criteria used, to be followed by country presentations per the format provided above. The information collected and presented would be useful to inform future decision making and for reforms to make insurance schemes more efficient and sustainable.

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Presenters: Reps of insurance schemes for Ethiopia, Ghana, Kenya, Tanzania and Uganda.

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