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# A HEALTH INSURANCE FEASIBILITY STUDY IN AFGHANISTAN

*Learning from Other Countries, a Legal Assessment, and a Stakeholder Analysis*

This publication was prepared by the Health Policy Project.

USAID FROM THE AMERICAN PEOPLE

HEALTH POLICY PROJECT

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# CONTENTS

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# EXECUTIVE SUMMARY

## Background

Significant improvements have been made in the health sector in Afghanistan over the past decade, largely due to implementation of the Basic Package of Health Services and the Essential Package of Hospital Services, which define the type and setting of healthcare services available free to all Afghans, regardless of their ability to pay. The 2010 Afghanistan Mortality Survey showed that since 2000, maternal mortality estimates declined from 1,600 deaths per 100,000 live births to 327 and under-age five mortality declined from 257 deaths per 1,000 births to 97. Despite these gains, challenges to health care delivery remain. Afghanistan's health financing system is characterized by high out-of-pocket expenditures, high donor dependence, and low levels of government contribution to total health expenditure.

Then, too, over the past decade, Afghanistan—similar to many post-conflict countries—has depended heavily on external aid both to provide and finance health services and to reconstruct the health system. The country has limited capacity for generating domestic revenues, because the population is poor, the economy is largely informal, and collection of revenues for health through a broad tax base is difficult. As donor aid decreases and the country moves toward more sustainable governance systems, alternative financing mechanisms are needed to increase the resilience of the existing health system and the health gains the system has achieved.

To address these issues, the Ministry of Public Health developed the Health Financing Policy 2012–2020 and an associated five-year strategy. This policy sets several priorities: increased generation of domestic resources for health through taxation and prepayment mechanisms, reduced donor dependence, and introduction of risk pooling mechanisms to provide greater financial protection for households. It calls for exploration of potential health insurance schemes—social health insurance, community-based health insurance, and private health insurance—to pool resources for service delivery and reduce out-of-pocket expenditures and reliance on donor funding.

The USAID-funded Health Policy Project has been supporting the Afghanistan health ministry's Health Economics and Financing Directorate in its mandates to strengthen overall health financing in Afghanistan and to implement the health financing policy successfully. In line with the priorities outlined in the national policy and the need to address government financing shortfalls, HPP worked closely with the directorate to explore the possibility of introducing nonprivate insurance schemes in Afghanistan. In order to do so, HPP designed and implemented the first phase of a health insurance feasibility study. This phase consisted of a review of relevant literature covering the Afghan health system; case studies of health insurance schemes in Kyrgyz Republic and Thailand and of microinsurance in India; an assessment of the legal and regulatory environment for introducing health insurance schemes in Afghanistan; and an analysis of the views of Afghan stakeholders on health insurance and related issues. If the study's second phase goes forward as envisioned, it will investigate willingness to pay, financing options, targeting of beneficiaries, identifying and costing of a benefits package, actuary work, provider engagement, and local capacity building.

## Findings

According to our historical analysis of health coverage and health financing in Afghanistan, although no large-scale insurance schemes have been implemented, the country does have some experience with health insurance: a community-based health insurance pilot program carried out between 2005 and 2006 and a limited social health insurance program for civil servants implemented during the 1970s. The Afghan health system has improved substantially in the past decade, but it remains weak—undercut by

low-quality care, limited access by the rural poor, shortages of human resources and medical supplies, and inadequate financial resources.

Three case studies suggest routes to a more comprehensive and sustainable health financing system. Kyrgyzstan provides a model of healthcare reform that relies heavily on taxation and employers' and employees' contributions. Microinsurance in India offers a model to protect households in the informal sector—a large share of the Afghanistan population—from burdensome healthcare expenses. Thailand's universal health coverage shows how health insurance schemes can evolve over time. Key lessons here are that political commitment is paramount for successful health financing reform; health financing reform is a lengthy process and requires the close collaboration of multiple stakeholders, including donors, government agencies, and communities; no single health insurance scheme can solve all health system issues, so Afghanistan needs to consider designing multiple health insurance schemes to finance its health system; and efforts to address health system obstacles, such as low quality, limited accessibility of care, and insufficient human resources, need to be considered when planning health financing reform.

Our assessment of Afghanistan's constitution and laws confirms a clear right to healthcare but ambiguity in the interpretation of their references to "free care": what services are free, and does this mean free care at the point of services or free care solely funded by the government?

This ambiguity can be clarified by new legislation, which should establish the following:

- A central health insurance entity whose level of independence is clearly defined
- Earmarked tax or/and other resources for social health insurance
- Authority to pool financial resources from various sources
- Authority to purchase services from eligible healthcare providers
- Authority to regulate healthcare providers with respect to social health insurance

The establishment of social health insurance in Afghanistan will require significant and high-level government buy-in and support. The passing of legislation and establishment of a central managing entity will require the sustained focus and strong support of high-level members of the Afghan government.

To assess the interest of stakeholders in introducing health insurance in Afghanistan and shed light on the steps the country can take to build a more sustainable health financing system, we conducted a stakeholder analysis of health insurance in Afghanistan. This analysis consisted of 16 key informant interviews with 21 officials from ministries, Parliament, and donors and with staff from two insurance companies. It also involved five focus group discussions with 30 community savings group implementers, implementers of the country's package of free basic health services, public hospital managers, staff from the health ministry's financing directorate, private hospitals, and insurance companies. The interviews focused on stakeholders' understanding of the need for protection from financial risks and perceptions of both barriers and factors that could facilitate the introduction of health insurance.

Most stakeholders were aware of the challenges of the Afghan health financing system; they acknowledged that health insurance could be an instrument to address or mitigate these challenges and that introducing health insurance could reshape the health system into a more sustainable form. However, stakeholders differed in their beliefs about how and when a health insurance scheme could be initiated. In addition to the country's well-known security concerns, they saw lack of clear legal guidance, low quality of healthcare, low awareness of health insurance among the population, and limited technical capacity and willingness to pay as the major barriers to establishing a successful nationwide health insurance scheme, despite increasing demand for health insurance from some organizations in the formal sector and improved labor capacity in the country.

## Conclusions

Reforming the country's health financing system is imperative for Afghanistan to continue to improve the health status of its population as it transitions into a period of decreasing international aid. Health insurance is one mechanism that can potentially improve the financial sustainability of the healthcare system while protecting the population from catastrophic health expenditures.

Legal, quality, and capacity barriers will prevent Afghanistan from establishing a health insurance scheme in the short term (one to two years). The next four years will be critical in reshaping Afghanistan's healthcare system, because they provide a limited period of donor-funded free health services in clinics and hospitals during which the government could develop alternative mechanisms to generate domestic resources for health. Afghanistan will need to progressively address the major concerns that impede the establishment of health insurance and take an incremental approach to building a health insurance system. Once legal barriers have been addressed, pilot insurance schemes can be introduced with support from donors and tested in places where there exists reasonable quality of care, starting with those working in the formal sector and their families while continuing to provide free care for the poor. If the pilot program performs well and the effort to address the barriers takes effect, the pilot schemes could be scaled up gradually from the formal sector to the informal sector, from populations in cities to those in rural areas, and from a more limited benefits package for hospital care to a more comprehensive one.

# ABBREVIATIONS

| | |
|---|---|
| ADP | Additional Drug Package (Kyrgyz Republic) |
| AISA | Afghanistan Investment Support Agency |
| ATRA | Afghanistan Telecommunications Regulatory Authority |
| BHC | basic health center |
| BPHS | Basic Package of Health Services |
| CBHC | community-based healthcare |
| CBHI | community-based health insurance (Afghanistan, India) |
| CHC | comprehensive health center |
| CHF | Community Health Fund (Afghanistan) |
| CSMBS | Civil Servant Medical Benefit Scheme (Thailand) |
| CUP | contracting unit for primary care (Thailand) |
| DH | district hospital |
| DRG | diagnosis-related group |
| EC | European Commission |
| EPHS | Essential Package of Hospital Services |
| FAP | Feldsher-obstetrical ambulatory point |
| FGD | focus group discussion |
| FGP | family group practice |
| FMC | family medicine center |
| GCMU | Grants Contract Management Unit |
| GDP | gross domestic product |
| GPC | general practice center |
| HEFD | Health Economic and Financing Directorate |
| HPP | Health Policy Project |
| KII | key informant interview |
| MHIF | Mandatory Health Insurance Fund (Kyrgyz Republic) |
| MIA | Micro Insurance Academy |
| MOF | Ministry of Finance |
| MOJ | Ministry of Justice |
| MOH | Ministry of Health |
| MOLSA | Ministry of Labor and Social Affairs |
| MOPH | Ministry of Public Health |
| MWS | Medical Welfare Scheme (Thailand) |
| NGO | nongovernmental organization |
| NHA | National Health Accounts |
| NHF | National Health Fund |

| | |
|---|---|
| NHSO | National Health Security Office (Thailand) |
| OOP | out of pocket |
| PCU | primary care provider unit (Thailand) |
| PETS | public expenditure tracking survey |
| PFEM | Public Finance Expenditure Management Law |
| PPPY | per person per year |
| RBF | results-based financing |
| RSBY | Rashtriya Swashthya Bima Yojana (India) |
| SGBP | State Guaranteed Benefit Package (Kyrgyz Republic) |
| SHI | social health insurance |
| SSS | Social Security Scheme (Thailand) |
| SWOT | Strengths, weaknesses, opportunities, threats |
| THE | total health expenditure |
| UCS | Universal Coverage Scheme (Thailand) |
| UHC | universal health coverage |
| UPHS | Universal Package of Health Services |
| USAID | United States Agency for International Development |
| VHCS | Voluntary Health Card Scheme (Thailand) |
| WHO | World Health Organization |

# CHAPTER I: OVERVIEW OF AFGHANISTAN'S HEALTH SYSTEM AND THREE PERTINENT CASE STUDIES

This chapter has five parts:

- An overview of the health system in Afghanistan
- A description of reforms in the Kyrgyz Republic's health system, which is funded primarily by the government
- A discussion of the concept of microinsurance and its application in India, primarily for rural and poor populations
- An outline of the evolution of universal health coverage (UHC) in Thailand
- A summary of lessons learned from the three case studies and their application to Afghanistan's progress toward UHC

## Part 1. An Historical Analysis of Afghanistan's Health System

Since the fall of the Taliban in 2002, Afghanistan has made important advances in its health outcomes. From 2001 to 2010, life expectancy increased by 20 years, from age 42 to age 62; infant mortality decreased from 70 deaths per 1,000 live births to 65; and under-five mortality dropped from 96 deaths per 1,000 live births to 84. The maternal mortality rate also improved during the same period [1]. These changes were made possible in part by the implementation of free benefits packages: the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS), which define the type and setting of healthcare services available free to all Afghans, regardless of their ability to pay. The BPHS has increased access to primary care services for the poor, especially for key maternal and child health services [2, 3]; the EPHS has improved the use of hospital care and standardized hospital care delivery.


Despite these major accomplishments, challenges remain. For instance, full immunization coverage of children has not increased in the past half-decade, notwithstanding investments in the country's Expanded Program on Immunization [4, 5]. Studies have shown improved quality of care in counseling and in managing childhood illnesses, but performance in health facilities overall is suboptimal [6]. Referral services across different health facility levels are fragmented and threaten the quality-of-care continuum, particularly for children [7].

In the midst of these pressures, Afghans lack a functioning system of insurance to protect themselves from catastrophic medical expenses and to gain access to services not covered under the BPHS and EPHS. UHC has been promoted by the Ministry of Public Health (MOPH) as a means of addressing these issues [8].

### *The Afghan population*

Of Afghanistan's 32.7 million people, 75 percent live in rural areas, most of which are mountainous, remote, and difficult to reach, especially in winter. As of 2008, 44.6 percent of the population was below the age of 15. The mean household size was 7.8 [1]. Afghans' healthcare, transportation, and educational systems have been destroyed repeatedly since 1979. Successive wars have increased the number of orphans and people with disabilities.

Afghanistan's formal economy has consistently ranked among the poorest in the world. Average annual income is estimated at US$470 per person [9]. Wealth disparity, though a problem, is not as severe as in some developing countries. The Gini[1] coefficient of Afghanistan is low, at 27.8, indicating a relatively equal distribution of wealth across the population [9]. Despite this low Gini coefficient, a notable wealth disparity exists between urban and rural areas. Sixty-eight percent of the top wealth quintile lives in urban areas, but only 8 percent lives in rural areas [1]. Afghanistan's economy is largely agricultural, and a sizable amount of the economy consists of black market or informal transactions. As a result, official estimates of annual income based on formal transactions underestimate the true size of the economy.

Geopolitically, Afghanistan consists of 34 provinces, each with a governor appointed by the country's president. The government is unitary, which means that the central government is the chief administrator of all policies. Provinces manage only those functions that the central government wishes to delegate. Regarding health and healthcare, the Constitution of Afghanistan can be interpreted as guaranteeing all Afghans free health services and access to health facilities. The MOPH has narrowed these rights, however, by stating that it is responsible for providing "free preventive and curative services for highly endemic diseases, natural treatment, and first-aid services to citizens of the country … and secondary curative services … in the financial purview of the government" [10].

### *A brief history of the Afghan healthcare system*

Afghanistan conducted a short-lived experiment with health insurance from 1955 to 1978. Civil servants contributed 2 percent of their salaries to a health insurance scheme and had access to a wide range of health provider networks for preventive, curative, and pharmaceutical services. The scheme was managed by the Department of Health Insurance, which was established in 1955 under the Ministry of Finance (MOF) and transferred to the MOPH in 1963. Through the 1960s, healthcare in Afghanistan was generally limited to urban areas, such as Kabul; rural areas had little access to healthcare, especially hospital services.

This health insurance scheme was cut short by the Saur Revolution, in 1978, which was followed by more than 30 years of conflict until the fall of the Taliban, in 2002. Over the two decades after 1978, most medical professionals fled Afghanistan. Because of various healthcare supply constraints, a quarter of the population did not have access to healthcare, and some healthcare facilities were responsible for attending to as many as 300,000 Afghans.

The successive conflicts effectively destroyed the Afghan health system. What remained of the healthcare sector in the 1980s and 1990s, especially in rural areas, were uncoordinated, externally funded nongovernmental organizations (NGOs). Before the current Afghan government took office, several previous governments had failed to work with these NGOs, partly because various political factions controlled different parts of the Afghan countryside, hindering national outreach. Despite these problems, the quality of care at NGO primary care facilities was well-regarded [11, 12].

[1] The Gini index measures equality among individuals or households in a nation. It is calculated by determining the distribution of income or consumption expenditure. Zero represents perfect equality, and 100 represents perfect inequality.

Before and throughout the early years of conflict, community-based healthcare (CBHC) became common throughout Afghanistan. The Afghan MOPH defines CBHC as consisting of three key factors: (1) "Partnership between the community and the health facility staff," (2) "Appropriate and good quality care by community-based providers," and (3) "Promotion of healthy practices and lifestyles" [13]. CBHC emerged within the context of NGO health providers, due to the continuing conflicts, the lack of healthcare services, and the geographic distance from facility-based services of much of the Afghan population. Today, Afghanistan's healthcare system is still based on CBHC. Community health workers are many patients' first points of contact with the healthcare system. They promote public health issues and serve as a connection between healthcare providers and the community [13].

In 2003, the MOPH oversaw the development of the BPHS to "address the highest priority health problems with services and interventions that would be available to all Afghans" [13]. The BPHS forms the bedrock of the Afghan healthcare system. It constitutes a set of standard benefits intended to be available at all primary care facilities in Afghanistan, as well as some secondary-care district hospitals. The BPHS has seven key elements: (1) maternal and newborn care, (2) child health and immunization, (3) public nutrition, (4) communicable disease treatment and control, (5) mental health, (6) disability and rehabilitation services, and (7) a regular supply of essential drugs. As of 2010, the BPHS has been implemented in facilities that, as of 2008, were reaching 71 percent of the population [1] at a cost of $4.96 per capita. (Afghans lacking BPHS services largely reside in the most remote rural areas [13].) Because this set of benefits is uniform, the BPHS also serves as a tool with which the MOPH can evaluate the performance of healthcare providers, particularly that of the implementing NGOs.

The EPHS, a secondary care-based complement of the BPHS, was developed in 2005. The EPHS establishes a standard services package for each hospital level, provides staffing guidelines for hospitals, and promotes a referral system to integrate BPHS facilities with hospitals. It mandates that all hospitals providing EPHS have four clinical functions: medicine, surgery, pediatrics, and obstetrics and gynecology. The goal of the MOPH is to cover the entire Afghan population with BPHS and EPHS [14].

### *Types of health facilities*

The BPHS and EPHS clearly delineate the functions of each type of healthcare facility in Afghanistan. These functions are summarized in Table 1. The MOPH prefers that a 1:1 ratio be achieved between male and female health providers throughout all levels of the BPHS. Depending on geographic accessibility, the structure of healthcare facilities differs by region. We will briefly discuss each of the functions of the various healthcare facilities.

Health posts are the front line of the Afghan CBHC system. They are staffed only by community-based health workers, and many have the same address as a worker's home. These workers are able to treat common minor illnesses and injuries, and also are responsible for public awareness of public health issues. They are intended to connect the communities they serve to the healthcare system.

Basic health centers (BHCs) and comprehensive health centers (CHCs) are the clinics of Afghanistan. Both offer primary outpatient care, immunizations, and maternal and newborn care. BHCs also supervise health posts. BHCs are staffed, at a minimum, by a nurse, community midwife, and two vaccinators. CHCs offer more complex services than BHCs, such as beds for limited inpatient care and a laboratory.

Health subcenters and mobile health teams are critical to the Afghan health system, because they serve remote rural areas, where 75 percent of the population lives. Health subcenters are intended to offer most of the services that BHCs do, when possible. They serve smaller, more sparsely populated areas than BHCs do but are required to be located no more than two hours from any resident in their intended catchment areas. They are staffed by a nurse, a community midwife, and a cleaner. Mobile health teams

provide BPHS services to remote areas by vehicle when establishing a clinic is not feasible; they are also intended to provide the services of a BHC.

District hospitals (DHs) are where the BPHS and the EPHS meet. They cover all services in the BPHS. Together with provincial and regional hospitals, they also encompass the facilities providing the EPHS. DHs are staffed by numerous physicians and medical professionals of junior rank. Provincial hospitals provide more complex services than DHs, as well as some specialist care. They may fill the role of DHs regarding primary care where DHs do not exist. Regional hospitals are similar to provincial hospitals, though they provide more specialized care, engage in research, and train medical professionals. Specialty and national hospitals serve patients with highly specialized, more complicated needs. In so doing, they act as a referral source for EPHS hospitals. Many of their functions are unique. For this reason, they are not governed by the generalized, nonspecialist structure of the EPHS [13].

**Table 1: BPHS and EPHS Facilities**

| Facility | Patients Covered | BPHS/EPHS | Levels of Care | Service Area |
|---|---|---|---|---|
| Health post | 1,000–1,500 | BPHS | Primary | Community |
| Basic health center | 15,000–30,000 | BPHS | Primary | Villages |
| Health subcenter | 3,000–7,000 | BPHS | Primary | Villages |
| Mobile health team | Varies | BPHS | Primary | Province |
| Comprehensive health center | 30,000–60,000 | BPHS | Primary/secondary | Villages |
| District hospital | 100,000–300,000 | Both | Primary/secondary | District |
| Provincial hospital | Province | EPHS | Primary/secondary | Province |
| Regional hospital | Region | EPHS | Tertiary | Region |
| Specialty hospital | Nation | Neither | Secondary/tertiary | Nation |
| National hospital | Nation | Neither | Secondary/tertiary | Nation |

Source: Ministry of Public Health of Afghanistan, 2005 and 2010 [13, 14].

### *Financing sources and agents*

Despite the rapid expansion and implementation of the BPHS and EPHS, 73.3 percent of health financing in Afghanistan comes from individual households in the form of out-of-pocket (OOP) payments. This amounts to $41 per capita, according to the MOPH's 2011–2012 National Health Accounts (NHA) report—a 39.7 percent increase since the 2008–2009 report [10]. The central government covers 5.6 percent of total health expenditures (THE), and international donors cover an additional 20.8 percent. The remaining 0.3 percent of health funds comes from international organizations paying for the medical expenditures of households. The MOPH acts as a financing agent for 10.8 percent of health expenditures, while international donors directly control 14.8 percent of health expenditures. THE per capita was $56, according to the 2011–2012 Afghanistan NHA [10].

Health funds in Afghanistan are spent almost equally on hospitals, outpatient facilities, and medical goods, each consuming about a quarter of health expenditures. An additional 5 percent is spent on public health. The remaining 20 percent consists of administrative and other expenses. The percentages of OOP funds differ substantially, with 35.3 percent of OOP funds spent on medical goods, 29.5 percent on outpatient care, and 22.1 percent on hospitals. Twenty-six percent of OOP funds are spent on healthcare abroad; this constitutes 19 percent of Afghanistan's THE. Spending so much on healthcare abroad is quite rare for any nation, either developed or developing. As for the types of care purchased, curative care consumes 36.6 percent of THE; ancillary services and medical goods each consume about a quarter of THE [10]. Afghanistan's THE amounts to 8 percent of the country's gross domestic product (GDP), which is higher than the roughly 6 percent of GDP spent by the average low-income country [9].

### *Challenges in financing and delivery of healthcare*

Despite the recent successes of the Afghan healthcare system, two huge challenges are apparent: reliance on foreign donors and high OOP expenses [15]. Although foreign aid as a percentage of THE has decreased from 8 percent in 2002 to 4.6 percent in 2011, it has quintupled in value from $11 million to $56 million over the same period. Whether or not this level of funding will continue in the future is uncertain [8].

Of even greater concern is the 73.3 percent of THE in OOP expenditures. This large percentage holds despite the fact that BPHS and EPHS facilities implemented a user fee ban in 2008 [15]. Given that one-third of the population lives below the poverty line, this large proportion of OOP expenses implies that catastrophic medical expenditures are a very real problem. Although BPHS coverage has expanded rapidly in recent years (only 71 percent of the population was covered in 2008 [1]), providing coverage to remote rural areas remains a logistical as well as a security challenge [16].

High OOP spending is attributable largely to two factors: (1) a lack of drugs in public healthcare facilities [16] and (2) the demand for the higher-quality care that private facilities offer [17]. The MOPH identifies limited supply and over-prescribing of medicines as possible causes of the drug shortage, which in turn forces patients to turn to the private sector [10]. Demand for healthcare at private facilities is attributable to the shortcomings of the BPHS system: "long waiting times, absence of laboratory services, shortages of drugs, and even disrespect for patients" [17].

As the largest component of OOP expenditures, pharmaceuticals represent the main OOP cost barrier to Afghans' use of EPHS hospitals. Almost 80 percent of OOP expenditures in public hospitals are for pharmaceuticals. Shortages are so problematic that admitted patients have had to leave the hospital, buy the drugs they need, and return for care [10]. This may be influencing Afghans' preference for private-sector medical facilities over EPHS hospitals. As such, an increase in drug availability in BPHS and EPHS facilities has the potential to significantly reduce OOP expenditures while increasing the quality of care.

Representing 8.7 percent of average annual income, OOP expenditures in Afghanistan also pose a severe equity problem for the Afghan healthcare system [10]. Afghans who lack funds to pay for healthcare do not have access to the pharmaceuticals and high-quality private care used by wealthier segments of the population. In effect, a tiered system of access exists. Wealthier Afghans have access to private healthcare facilities in Afghanistan and sometimes abroad, as well as to the EPHS and BPHS systems. Those with less ability to pay can access only the BPHS and EPHS systems. The poorest, remotest segments of the population have no access to formal healthcare.

To address these issues, the MOPH has a stated goal of "rapid movement toward universal health coverage through raising sufficient funds and improving efficiency and equity." By achieving this goal, the MOPH hopes to expand access to healthcare, improve the quality and use of health services, reduce financial risk, and improve the predictability of funding streams [8]. The MOPH's Revenue Generation Strategy 2009–2013 and its revised follow-on strategy for 2014–2020 outline three ways to increase domestic revenues for health: a tobacco excise tax, user fees at secondary and tertiary health facilities, and risk-pooling mechanisms—that is, health insurance [18].

### *The Afghan experience with health insurance to date*

For the services covered and implemented by the BPHS and EPHS, Afghanistan—with some caveats—uses a Beveridge system. In such a system, the government uses tax money to operate healthcare facilities and employ providers. In Afghanistan's case, though, the BPHS and EPHS are funded mostly by donors. In 31 provinces out of 34, international partners—the World Bank, the U.S. Agency for International Development (USAID), and the European Union—contract with NGOs to deliver the BPHS and EPHS

directly. The MOPH is responsible for implementing the BPHS for the remaining three (largely urban) provinces [8]. In 2008, the BPHS covered 71 percent of the population [1]. Due to drug shortages, waiting lines, and in some cases, poor quality of care, Afghans can lack access to the services covered by the BPHS even in areas where this package is being implemented [13].

Between June 2005 and October 2006, the Health Financing Pilot project—a joint venture of the Johns Hopkins Bloomberg School of Public Health, a number of NGOs, and the MOPH—ran an experiment with community-based health insurance (CBHI) in Afghanistan. CBHI is characterized by local health workers in low-income countries marketing an insurance plan to reduce the financial riskiness of changes in health [15]. Such a scheme has the potential to reduce OOP spending and improve cost recovery, which makes it an attractive prospect for Afghanistan [19]. Although not explicitly acknowledged by Rao et al. [15], CBHI is under the umbrella of "microinsurance": "low-cost health insurance based on community, cooperative, or mutual self-help arrangements" used to provide low-income countries access to healthcare. It has been implemented in several less-developed countries, such as India [20].

The CBHI scheme made available in Afghanistan for the experiment is known as the Community Health Fund (CHF). The CHF operated only out of rural health centers in four provinces: Parwan, Saripul, Wardak, and Nimroz. Local health workers publicized a health insurance scheme available to Afghans at a premium, based on household size and economic status. The scheme offered relatively poor households a CHF plan for free. Enrollees also paid a small co-pay[2] per visit—US$1—and received drugs free of charge.

The scheme charged nonenrollees larger user fees and drug costs. Those who could not pay were not denied treatment. After one year, the pilot did not reduce OOP expenditures, but use rates for enrollees increased significantly during the program. CHF enrollment[3] varied from 1 percent to 38 percent across the provinces. Security in the more remote provinces proved to be an impediment to implementing the program. Although the program was successful in gaining the approval of enrollees, nonenrollees experienced higher user fees. The program achieved modest cost recovery. Despite some positive results, the pilot did not significantly reduce OOP costs or provide the MOPH with a clear path forward to financial independence from donors [15].

The decreased demand of nonenrollees observed in the CHF pilot concerned the MOPH so much that it led to a ban on user fees in 2008 [21]. Although this had the potential to reduce OOP expenditures, the increased revenue from user fees also provided healthcare facilities with a means of purchasing needed medical goods, such as drugs [15]. User fees have been eliminated, but only for MOPH-financed healthcare facilities. Private facilities were not impacted by the ban. Additionally, drug shortages sometimes forced patients to bear the cost of drugs associated with their treatments in clinics, and even hospitals [16]. Future health insurance schemes that involve the private sector will still have to acknowledge the need for high user fees for patients.

Limited private health insurance schemes exist in Afghanistan. The major clients of such insurance are embassies, international and domestic NGOs, and wealthy individuals; also, insurance companies generally contract with private health providers to deliver services to enrollees. As the economy grows, the demand for private health insurance is increasing. However, the population covered by such insurance remains small.

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[2] The terms *co-pays* and *user fees* are used, sometimes interchangeably, throughout the literature. These are both charged to patients at the point of service, though co-pays usually only account for a portion of the total cost of a visit. User fees, on the other hand, typically account for the entire cost.

[3] This statistic is based only on those who had to pay to be a part of the CHF plan, not those able to enroll at no cost.

Aside from the previously mentioned civil service health insurance in the 1970s and the CHF pilot, Afghanistan has had no experience with health insurance. Although the BPHS and EPHS act as payers for some health services, such services are simply regarded as free, since Afghans do not interact with an insurer as a precondition. Although several commercial insurance companies, such as the Insurance Corporation of Afghanistan, have begun operating in Afghanistan in the past few years, few of them have offered health insurance to Afghans [8].

### *Ability to pay*

To our knowledge, no studies have been performed that sought to determine Afghans' ability to pay or willingness to pay for health insurance. The CHF experiment set its baseline annual premium at US$6, with an adjustment for family size. Of those surveyed, 100 percent in Parwan and 91 percent in Saripul stated that the insurance policy was worth its cost, even with US$1 co-pays per visit. Given that per capita OOP healthcare expenditures are already $41, the $6 would seem to be an attractive price for health insurance; however, the insurance provided in the CHF experiment was limited mostly to BPHS services. Drug shortages were reduced but remained a problem [15].

The $41 annual OOP expenditure per capita statistic could serve as an upper-bound baseline price for a comprehensive insurance package with no user fees and access to private-sector healthcare. This figure is likely to be high for rural Afghans, given the geographic distribution of the country's wealth quintiles: 68 percent of the top wealth quintile of Afghanistan resides in urban areas [1]. As Afghanistan's low Gini coefficient of 27.8 indicates [9], Afghans' ability to pay for healthcare expenditures in different wealth quintiles does not differ by large degrees of magnitude. Premium waivers for the poorest quintiles may be a solution if enrollment in wealthier quintiles is sufficiently high.

### *Summary*

Although the Afghan health system has improved substantially in the past decade, it remains weak. The health system continues to encounter major issues of (1) low quality of care, (2) limited accessibility by the rural poor, (3) shortages of human resources and medical supplies, and (4) inadequate financial resources. Specific to financing the health system, high dependency on donor funding and high OOP spending among the Afghan populations are major threats to the sustainability of the health system. As donor funding is expected to drop in the near future, the share of OOP spending, which is high already, will be even higher unless further actions are taken. In view of this challenge, the MOPH is considering alternative ways to finance healthcare and provide financial protection for vulnerable populations as well as exploring the feasibility of health insurance in the country. This literature review presents case studies of three countries—the Kyrgyz Republic, India, and Thailand—to provide insights into implementing health insurance in low- and middle-income countries.

## Part 2. Bismarck, Beveridge, and the Evolution of Universal Health Financing in a Low-Income Country: The Case of the Kyrgyz Republic

### *History*

In August 1991, following the disintegration of the Soviet Union, a small mountainous region, home to approximately 4.4 million people, voted for independence and elected democratic leadership. By 1993, the Kyrgyz Republic had adopted both a new government and constitution [22]. Whereas many of the Soviet governmental structures were cast aside (in those first two years, the Kyrgyz Republic shifted toward a market economy, promoted a free press, and allowed political associations), some of the systems initially developed by the Soviet government were retained and reformulated to better benefit the population.

### *Soviet framework*


Prior to its emergence in the post-Soviet era, the Kyrgyz health system followed a model based on central planning and management that was financed primarily by state budgetary resources. The Soviet healthcare system provided substantial infrastructure for care in the region. With high standards for accessibility and the baseline demand that healthcare be free at the point of service, Moscow had succeeded in establishing a network of facilities throughout the region [23]. The system was, however, largely inefficient, due to a reliance on hospital care rather than primary care, a curative rather than preventative approach to service delivery, and an extensive network of providers. Severe cuts in government expenditure at the time of independence and the low priority placed on health system reform meant that by 1995, 92.6 percent of all health spending in the nation was covered through OOP payments [9]. With more than half of the population living in poverty (nearly 20% in extreme poverty) at that time, the new government sought a more equitable solution for distributing health resources [24].

### *Manas national healthcare reforms*

In 1996, the Kyrgyz government embarked on a 10-year systematic reform of the health financing system—the Manas National Program on Health Care Reforms—with the objective of developing a single system of healthcare and financing for the entire population [22]. The new government of the Kyrgyz Republic, motivated by the intrinsic values written into its new constitution, set out to improve the health of the population. With assistance from the World Health Organization (WHO), World Bank, and USAID, the country introduced comprehensive change to the delivery system, strengthening primary care capabilities while restructuring the hospital and inpatient care sector. Fiscal constraints and resource concerns made it necessary to reduce the number of facilities available, especially given the proliferation of service availability during the Soviet era [25]. Fundamentally, however, these changes were driven by system reforms that pooled funds for the payment of health services. Run at a regional level defined by seven distinct *oblast* level governments, Manas quickly initiated systemic reforms [26].

### *Manas Taalimi*

By 2006, the shortcomings of the system were evident, and the country undertook a second series of reforms: the Manas Taalimi [27]. Under this program, a central fund took complete responsibility for financing the healthcare system in the country. From Bishkek (the capital city of the republic), the Ministry of Health (MOH) undertook more widespread reforms of the delivery sector, as well as nationalizing a mandatory health insurance fund (MHIF) to provide financing for the care of the entire population. In addition to some foreign aid, the MHIF is funded through general tax revenues and an MHIF-specific payroll tax [22]. The blend of Beveridge (government provision of healthcare) and Bismarck (employment-based health insurance) approaches has met with substantial success: health expenditure per capita rose from $21 (2013 USD) in 1997 to $71 in 2013; by 2004, 95 percent of Kyrgyz families were enrolled in a family group practice [28].

### *Healthcare financing*

*Revenues and expenditures*

The current health financing structure in the Kyrgyz Republic is based on a mix of public, private, and external funds. The Kyrgyz Republic finances its health system mostly through general state taxation. The passage of Manas introduced a small payroll tax as a secondary source of funds, with donor aid and OOP payments to round out the funding [29]. Private expenditure (OOP payments and premiums for private health insurance) still accounts for the bulk of THE, including 53.8 percent of the burden in 2008. Governmental spending accounts for 32.7 percent, external funding for 9.5 percent, and mandatory health insurance for 4 percent [22]. In 2011, the cost of an annual insurance policy in the Kyrgyz Republic was about 400 soms, or US$10 [30]. Moreover, informal payments often are collected by providers at the point of service [31]. A mandatory health insurance contribution, first introduced in 1997, was implemented to bring additional resources to the health sector. The MHIF was created to administer the revenues from the payroll tax. The payroll tax operates as follows (Table 2):

**Table 2: Contribution to Mandatory Health Insurance Fund from Payroll Tax**

| Population Group | Payroll Tax Rate and Source |
|---|---|
| **Employed groups** | |
| Employees in formal private sector | 2% payroll contribution by employer (upper limit excludes earnings above 12,000 soms) |
| Employees of public sector and public enterprises | 2% payroll contribution by employer |
| Self-employed | 2% of total enterprise income |
| Private farmers | 5% of land tax (only after 2001) |
| **Unemployed groups** | |
| Pensioners | 1.5 x minimum wage (from state budget to MHIF) |
| Unemployed | 1.5 x minimum wage (from state budget to MHIP) |
| Children and students | State budget |
| Disabled and others receiving social benefits | State budget |

Source: Jakab, 2007 [32].

In addition to payroll taxes, health providers in the Kyrgyz Republic charge users co-payments, regulated by the State Guaranteed Benefit Package (SGBP). Co-payments are flat payments made upon admission to a hospital. Before the introduction of the Manas Taalimi and SGBP, regional and even local variation in co-payments could create significant barriers to care. In 2001, pilot SGBP programs allowed two of the seven *oblast* regions to charge co-payments; by 2004, all *oblast* regions conformed to the same standards [32]. SGBP-regulated co-payments cover both personnel and input costs, with the vast majority (80%) being used for the purchase of medicines, supplies, food, and other inputs. Co-payments still vary among populations, but are regulated based on insurance, exemption, referral status, and case type.

Co-payment exemptions are available for populations with high expected use of the healthcare system. Vulnerable groups, including the elderly, disabled, and veterans, are exempt from fees. Additionally, to reduce the incidence of disease in the overall population, those with communicable diseases that sustain high external costs (such as HIV and AIDS, tuberculosis, syphilis, and polio) also qualify for the exemption [33]. In 2003, 8.8 percent of the population qualified for co-payment exemption or reduction; by 2008, 50 percent of the population qualified. That same year, 44.4 percent of health system users in hospitals made reduced or no co-payments [22]. Finally, although enrollment in the MHIF is mandated

statutorily, in 2013, only about 80 percent of the population actually was enrolled. To reduce the free-rider problem[4] within the system, the uninsured are required to pay a higher co-payment [30]. The 2008 Review Report of the Manas Taalimi Health Sector Strategy noted that patient financial burden has decreased: for the poorest quintile of patients, OOP health expenditures dropped 30 percent, from 7.1 percent of the annual household budget in 2004 to 4.9 percent in 2006. For the second poorest quintile, the reduction was 24 percent, from 5.5 percent to 4.2 percent [33].

Under Manas, the health financing reforms undertaken were based on a purchaser-provider split. While the MOH retained responsibility for purchasing some individual health services (especially costly or infectious disease-related purchasing) and public health services, the MHIF assumed purchasing responsibility for most individual health services. In 2006, MHIF funds began pooling at a national rather than *oblast* level, signaling a shift toward a single-payer system, reminiscent of a national health insurance model [26].

As the Kyrgyz health system has evolved, the MHIF has separated itself from the MOH. Even while under the purview of the MOH, the MHIF established itself as a "quasi-governmental authority" [22]. By 2009, the MHIF separated from the MOH entirely, reporting directly to the Kyrgyz government. By the end of the Manas health reforms, the MHIF acted as the single payer of the public health system and was responsible for purchasing health services covered by the SGBP. The national single-payer system made it more feasible for the MHIF to distribute funds equitably, determining and defining the standard benefits package as well as a new Additional Drug Package (ADP) [22]. Thus, while the MOH coordinates and controls local state administrations, the MHIF draws general tax revenues and payroll tax funds into one pool to purchase health services under the SGBP and ADP; moreover, it is charged with the development of health information systems and quality management [22].

The Kyrgyz Republic's total health spending has increased substantially in recent years, yet private payments still represent a significant portion of spending (Table 3). Nonetheless, their share of the total expenditure is falling. While private payments represented 55.6 percent of THE in 2006, just four years later, in 2010, this share had fallen more than 20 percent, to 43.3 percent. A survey of Kyrgyz households found that between 2004 and 2007, the share of patients in primary care group practices who reported making payments fell from 17 percent to 13 percent. Over that same period, the percentage of patients who reported making payments in polyclinics dropped by nearly half, from 45 percent to 23 percent, and no patients reported making payments for maternity care in 2007 [34].

**Table 3: Total Health Expenditures in Kyrgyzstan, 2000–2010 (Millions of Soms, in Nominal Terms)**

| | 2000 | | 2006 | | 2007 | | 2008 | | 2009 | | 2010 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | num | % | num | % | num | % | num | % | num | % | num | % |
| **Budget (general taxation)** | 1,248 | 43% | 2,421 | 34% | 2,967 | 33% | 3,873 | 38% | 4,809 | 39% | 4,945 | 38% |
| **MHI contribution** | 105 | 4% | 467 | 7% | 704 | 8% | 477 | 5% | 683 | 5% | 813 | 6% |
| **Private** | 1,521 | 53% | 3,922 | 56% | 4,398 | 48% | 4,823 | 47% | 5,357 | 43% | 5,672 | 43% |
| **External joint financing** | N/A | N/A | 253 | 4% | 530 | 6% | 409 | 4% | 943 | 8% | 824 | 6% |
| **External parallel financing** | N/A | N/A | N/A | N/A | 520 | 6% | 709 | 7% | 683 | 5% | 852 | 6% |
| **Total** | 2,875 | 100% | 7,062 | 100% | 9,119 | 100% | 10,291 | 100% | 12,475 | 100% | 13,105 | 100% |

Sources: Giuffrida et al., 2013 [30] and Temirov et al., 2011 [35]; MHIF data based on NHA report 2012, unpublished.

[4] In economic terms, "free riders" are those who benefit from goods, services, or resources without contributing payment toward the costs. The free-rider problem is a topic of interest for many public benefits for which tax revenues pay, such as military and defense forces and public education systems.

### *Flow of funds*

In 2003, the Kyrgyz Republic passed a law that transformed its budgetary funding system from a four-level bureaucracy to a two-level system (national and local), phased in over time and completed by 2006. Adoption of this standard means that almost no health funding comes from local budgets; instead, the MOH and MOF transfer health funds from the regional or local level to the republic level. The MHIF, meanwhile, collects revenues from insurance premiums and in turn implements the SGBP and ADP with these funds. From the outset of Manas, primary care services have been paid on a capitation[5] basis, whereas hospital services are paid per case, according to their clinical cost groups, which are similar to diagnosis-related groups (DRGs).[6]

### *Infrastructure*

#### *Providers*

During the Soviet era, Moscow encouraged a proliferation of hospitals and clinics to meet minimum standards for the availability of health workers to ensure equitable access to care. One of the first major legislative changes to the Kyrgyz system involved significantly reducing the hospital sector while simultaneously stimulating primary care services and family medicine [26]. Since then, the number of health workers has dropped dramatically: between 2000 and 2007 alone, the number of physicians dropped by an estimated 1,404, even as the population increased. Nurses and midwifery personnel per 1,000 fell from 6.4 in 2004 to 5.7 in 2007 (an absolute decrease of 7,653 between 2000 and 2007) [36]. These levels are significantly below those of neighboring regions, such as Central Asian Republics and Kazakhstan and the Commonwealth of Independent States. Moreover, rural shortages due to regional variations limit access to care outside of urban centers [22].

The reasons for provider shortages are multifold. Migration within the country to urban centers and emigration to other countries are problems. Moreover, health worker salaries have remained low compared to salaries in other industries, thus deterring entry into the sector by graduates of higher education [22]. A primary focus of the reforms under Manas was to develop a healthcare infrastructure sensitive to the needs of the population, given the resources available. While OOP and informal payments to providers remain an issue, primary care has become more accessible throughout the region [22, 37].

### *Facilities*

The Kyrgyz healthcare system is oriented around three levels of primary care facilities: primary healthcare within Feldsher-Obstetrical Ambulatory Points (FAPs),[7] family group practices (FGPs), and family medicine centers (FMCs). FAPs provide primary care services in remote areas of the country. Staffing may be as limited as a single paramedic (or *feldsher*) or may include nurse and midwife services [30]. With 95 percent of the population enrolled in FGPs, it is at these points that most of the population receives basic services, such as immunizations and prenatal and postnatal care. FMCs act similarly to ambulatory surgical centers, providing specialized procedures, diagnostics, and limited minor surgeries under the supervision of 10 to 20 physicians. In general, each of the 40 *rayons*, or districts, of the country has one FMC with responsibility for all FGPs and FAPs in its vicinity [22].

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[5] Capitation payments constitute an arrangement in which a physician or group of physicians receives a set amount of money for each enrolled person assigned to them per period of time for whatever health services that person receives.

[6] DRGs are used to classify hospital cases into a set of groups based on a patient's severity of illness and condition; they often are used to create a set payment for each group, regardless of the actual cost of care.

[7] *Feldsher* was the name given to healthcare professionals operating in rural areas of the Soviet Union. Feldshers are classified as paramedical practitioners, typically lacking professional qualifications as physicians, but with training in pre- and advanced clinical sciences.

Secondary treatment facilities are regional and territorial hospitals capable of treating more complex cases. In addition to 27 general practice centers (GPCs) that provide both secondary and primary care services, 41 territorial hospitals (including three children's hospitals) serve the country. GPCs formed under the second iteration of health reforms, as Manas Taalimi further consolidated and centralized both services and financing. Under the reform, primary healthcare and territorial hospitals in rural areas with populations under 25,000 merged to form the GPCs [38]. Forty-three percent of all hospital buildings closed between 2000 and 2003, amounting to a 35 percent reduction in floor space [22].

Tertiary care facilities in the Kyrgyz Republic are all federally run facilities supported as national hospitals and research institutes. These specialized centers concentrate in narrow disease spaces, providing both inpatient and outpatient services for patients of the facility. Tertiary care specialties include cardiology, tuberculosis, trauma, orthopedics, oncology, obstetrics, pediatrics, rehabilitation, infectious disease, and mental illness [30].

Emergency services tend to be a weakness of the Kyrgyz system, generally because of shortages or lack of access: in 2009, 103 ambulance stations and departments served 665,245 calls. In an effort to improve the system and enhance the role of primary care, FMCs became responsible for ambulance units in 2004. Under Manas Taalimi, emergency service provider locations were reviewed to ensure equitable access across the population; additionally, funding helped update stations and equipment. Regional variation in the demand for emergency services has decreased since the implementation of Manas Taalimi. However, urban centers such as the capital city are better served: in Bishkek, private ambulance services are available 24 hours a day [22].

Outpatient and primary care services in the Kyrgyz healthcare system are funded through capitation-based payments to providers. Capitation rates are adjusted geographically, allowing cross-subsidization that facilitates sustainable services across the rural and mountainous areas of the country [33]. Implementation of capitation-based payments for primary care began with Manas; simultaneously, hospitals also maintained case-based payments. These payments, however, are in addition to the global budgets supplied to the hospital. DRGs tend to be broad in characterization and classification [39].

### *Benefits packages*

*State-guaranteed benefits package*

The SGBP is a comprehensive declaration of the rights of Kyrgyz citizens regarding health services, decreeing and regulating the basic package of health benefits funded and available to the population [33]. Specifically, the SGBP guarantees the following:

- Primary care free of charge, although some laboratory and diagnostic tests may require co-payment
- Inpatient and specialized outpatient care, with co-payment upon admission (targeted exemptions exist)
- Outpatient drug benefits for cost-effective medicines that reduce hospitalization (e.g., medicines for anemia, ulcers, pneumonia, and hypertension) [40]
- Palliative care services
- Mental healthcare, including emergencies, consultations, diagnostics, treatment, prevention, and rehabilitation
- Limited dental care, especially for children and pregnant women [30]

To receive these benefits, patients must first enroll in an FGP; the ability to choose and switch between FGPs is limited.

*Additional drug package*

In 2000, the ADP was introduced to further encourage appropriate use of primary care services [22]. Under the ADP, the MHIF contracts with pharmacies for provision of a set of listed drugs. In 2003, the outpatient drug benefit covered the entire country; by 2008, pharmaceutical expenditure represented 33 percent of THE. A list of 37 generic drugs was initially covered under the benefit, with patients responsible for payment of half of the referenced price at the point of purchase. By 2008, the ADP covered 74 generic and roughly 350 branded medicines [30]. The industry has developed rapidly, with a 47.8 percent increase in the number of retail pharmacies between 2003 and 2009 [22]. Today, 2,383 licensed pharmacies across the nation dispense drugs from the list determined by the federal government, which has expanded substantially [36]. Among the categories of drugs covered are anesthetics, psychotropics, anticonvulsants and antiepileptics, non-opioid analgesics, narcotic analgesics, antiemetics, antihistamines, antacids, cardiac glycosides, antiarrhythmics, antihypertensives, and hormonal contraceptives.[8]

### *Health reform outcomes*

*Controlling costs*

The restructuring of the Kyrgyz health system likely has had a significant effect on reducing costs. Under Manas, a 47 percent reduction in physical hospital space was undertaken between 2000 and 2005; more recently, the introduction of energy-saving technologies has driven down facility costs [22]. The reduction in health facility expenditures allowed an increase in direct patient expenditures—from 20 percent of all health expenditures in 2005 to 30 percent in 2009. Other efficiencies were realized through improvements in resource allocation, strategic purchasing, and explicit budget allocation decisions, with an increase from 29 percent of primary care being considered cost-effective in 2005 to 38 percent by 2009. Over this same period, the average length of stay for hospital admissions decreased by about 28 percent annually [30]. Admissions themselves increased, however, likely due to low payment rates for those primary care physicians, who thus would not wish to incur the risk or cost of treating some patients [41].

### *Financial protection and accessibility*

A primary stated objective of the 2006 reforms was the reduction of poverty in the Kyrgyz Republic, including limiting the financial burden on hospitalized patients, whose OOP costs had risen to all-time highs by 2004. Significant reductions in OOP spending in the poorest quintiles of the population were realized under Manas Taalimi [42]. Moreover, household surveys indicate that financial barriers to care are lessening (Table 4).

**Table 4: Financial and Geographic Barriers to Access in the Kyrgyz Republic**

| | 2000 | 2003 | 2006 | 2009 |
|---|---|---|---|---|
| Respondents who reported that they needed but did not seek healthcare within the past 30 days | 13.5% | 15.1% | 18.2% | N/A |
| Of those, respondents who did not seek care, because it was "too expensive" or "too far away" | 11.2% | 6.3% | 3.1% | 4.4% |

Source: Ibraimova et al., 2011 [22].

[8] See http://www.pharm.kg/ru/live_important/ for a complete list of drugs in the ADP.

### *Quality indicators*

Under Manas, not only did the health system expand, but specific guidelines for seven diseases (asthma, ulcers, anemia, hypertension, acute respiratory infections, diarrheal diseases, and pneumonia) were set out for doctors to follow. Indicators on quality of care, including the percentage of children receiving appropriate immunizations and the percentage of women giving birth who suffer from anemia, did not show any significant changes in population health or quality of care. In other arenas, however, the efficacy of the reforms is demonstrable. Between 2006 and 2009, the percentage of adults who had their blood pressure checked increased from 63 percent to 80 percent. Over that same period, appropriate prescription of first-line medications for hypertension jumped from 64 percent to nearly 80 percent [22].

Primary health indicators also demonstrate the efficacy of health reforms in the country. After dropping significantly in the mid-1990s, the life expectancy for the Kyrgyz people has been steadily increasing, to 69.60 years in 2011 (from 65.79 years in 1995, just before the implementation of Manas) [43]. Moreover, between 2007 and 2012, the infant mortality rate dropped by 34.6 percent, from 30.6 deaths per 1,000 births to 20.6 [44].

### *Challenges*

Despite achievements in the health system of the Kyrgyz Republic produced by Manas and Manas Taalimi, significant shortcomings persist. On the one hand, gains in efficiency during the reforms led to decreases in unofficial payments for medicines, and the number of suppliers was consolidated significantly. On the other hand, though, informal payments to medical personnel rose [45]. At the same time, fewer people entered the medical field, probably because of low base wages and the failure of wage rates to keep paces with inflation. Although low wages are crucial for the development of a sustainable system, they must not undercut the profession so much that they discourage the development of a robust professional community, nor should they encourage medical personnel to levy unsanctioned charges when they see patients.

In conjunction with WHO, the International Health Partnership evaluated the existing health system of the Kyrgyz Republic to prepare for a new iteration in 2012 [43]. One major weakness they identified was the country's failure to create the intended single-payer system in full. Instead, the MOH took responsibility for high technology and maintenance costs, and the MHIF covered the costs of services provided under the SGBP (moreover, Bishkek city continued purchasing services for the insured in that *rayon*). Increasing the number of payers in the system risks diluting the strength of the state's bargaining power. Moreover, other parallel medical systems continue in the Kyrgyz Republic for special populations, such as the army.

Other weaknesses cited were rapid growth in hospital admissions and lack of explicit attention paid to pharmaceutical management or overall quality improvement strategies. Although the MHIF is charged with quality management under Manas Taalimi, international observers have recommended greater focus on and investment in clinical practice and population-level health behavior. Whereas some evidence-based health services (such as immunization rates and appropriate prescription of first-line antihypertensives) have improved, access to early detection of tuberculosis, prenatal care, diabetes, and other health problems is still lacking. An appropriate quality improvement plan, however, must be predicated on knowledge of the system at baseline. The Kyrgyz Republic failed to complete a formal evaluation of the country's disease burden before implementation; thus, although Manas Taalimi does focus on the country's main diseases, a baseline does not exist against which to assess the programs' success or failure.

### *Lessons learned for Afghanistan*

The Kyrgyz health system is interesting to investigate, because the two countries have similar cultures and demographics and also because Afghanistan's economic status is similar to that of the Kyrgyz Republic when Manas started in 1996.

The Kyrgyz Republic undertook health reforms, by funneling a variety of revenue streams to a single-payer system responsible for funding and decision making on a global level. Indeed, initial efforts at local governance of the healthcare system proved unsuccessful, resulting in a second set of reforms aimed specifically at centralization. With funding coming jointly from foreign aid, federal tax revenues, insurance-specific taxes, and co-payments at the point of service, the Kyrgyz Republic has decreased the financial burden of receiving care while increasing health services accessibility throughout the region. Afghanistan, facing a similar funding situation, may be able to replicate the rapid expansion of universal health financing through the Bismarck/Beveridge blended approach. The lessons of the second set of Kyrgyz reforms suggest that even though an immediate transition to a single-payer system is daunting, in the long run, administrative efficiency and standardization make the costs worthwhile.

If a significant change in healthcare system financing is to take place, however, changes in the way providers are paid must also be considered. The Kyrgyz Republic facilitated a simultaneous financing and compensation transition, by building on its existing infrastructure. Continued support of hospitals through global budgets eased the conversion, as payments became case-based. Furthermore, it allowed for less complexity in case groupings, thus easing the administrative and bureaucratic burden of establishing DRGs [46]. If Afghanistan is to implement single-payer healthcare, funding hospitals mostly under global budgets to cover fixed costs could smooth the process; case-based payments could then be phased in over time. Case-based payments also could be used by hospitals as bonuses for physicians to offset lower reimbursement rates that may occur when reforms are implemented.

Deciding which basic services should be covered under the government's insurance plan remains a challenge for the Kyrgyz Republic, as it does for many nations. Differential access based on risk (such as dental services provided to pregnant women and children) helps limit costs, but contradicts the system's core values. Nonetheless, beginning with a smaller and easily defined population may be the easiest way forward in implementing long-term reforms. The Kyrgyz Republic has aimed to improve health, by targeting the highest-burden diseases first. Afghanistan could adopt a similar method. First, though, officials must implement a detailed study of the burden of disease. This will help policymakers not only to define the health system's goals but also to evaluate the system's implementation and results.

The ADP has been a major success for the Kyrgyz Republic. In addition to being a popular program, its stated goal of providing cost-effective drugs to prevent unnecessary contact with other elements of the healthcare system has tended to make the program cost-effective. Afghanistan could implement such a program rapidly, by focusing on the pharmaceutical supply chain's integrity. Creating a list of approved drugs that require little to no monitoring by medical personnel and have a strong history of cost-effectiveness or even cost saving would be the first step.

Like nearly every nation facing ballooning costs of healthcare, the Kyrgyz Republic struggles to provide equitable healthcare across the population, limit the use of unnecessary services, and satisfy the salary requirements of health professionals. A commitment to the end goal of UHC has continued to move the project forward, however [42]. With limited financial resources, the Kyrgyz Republic has successfully created a universal health financing system, enrolling 80 percent of its population in the MHIF and connecting 95 percent of its citizens to a primary-care point of contact. Many of these achievements could be replicated in Afghanistan, as well.

# Part 3. Microinsurance and Its Application in India

### *Background of microinsurance*

During the past two decades, microinsurance has been implemented widely across developing countries, aimed at encouraging community involvement in health risk protection and reducing OOP spending at the point of seeking healthcare [47]. In general, health microinsurance[9] is insurance adapted to the needs and priorities of people whose earnings come from the informal, untaxed business sector who are excluded from other forms of health insurance. The schemes are mostly voluntary, with premiums suited to people with low incomes. Although health microinsurance is independent of the size of the insurer, the scope of the risk covered, and the delivery channel, it is essential that a scheme be designed to benefit the insured. Such a health insurance scheme is characterized at a minimum by the community's central role in its design and possibly also in its operation and governance [48].

Microinsurance usually is considered appropriate for low- or middle-income countries that wish to broaden health insurance coverage but are unable either to require all (or most) citizens to enroll in contributory health insurance or to subsidize the premiums of those who do not or cannot pay. Since the late 1990s, recognition has been growing that microinsurance can be viable at the local level, and that it represents a different paradigm than low-cost "traditional" insurance (based on the underlying explanation of why people demand health insurance, the pricing of premiums, and the business process).

Given microinsurance's unique suitability for populations in the informal sector, such a scheme should be implemented in the following three ways. First, because microinsurance targets people who have never been insured and have almost no confidence that contracts for credence goods can be enforced, it is essential to create awareness and insurance literacy before enrolling anyone, and to do so separately from sales. Absent the creation of awareness about how health insurance works, rural residents might not wish to pay for it. Lack of awareness may in fact explain the very low insurance penetration rates in most low-income countries [49]. Second, health microinsurance schemes must be designed to benefit the insured, not only because that is their raison d'être, but also because their success depends on voluntary enrollment and renewals, which are more likely when members clearly perceive a value proposition. It is self-explanatory why contextualized packages that include coverage of the target population's perceived priorities might be more successful in conveying such a value proposition. Third, rather than train an insurance company's employees in the skills of awareness creation, contextualization, and group empowerment, microinsurance requires that prospective clients be engaged in such capacity development. These three elements are essential for a microinsurance scheme to succeed.

Many countries have adopted microinsurance schemes in the informal business sector since the 1990s: Bangladesh, Burkina Faso, Cambodia, Ghana, India, Mali, Nepal, the Philippines, Rwanda, Senegal, Tanzania, and Zambia. (Appendix Tables 1.A and 1.B provide more details.) There are three main types of microinsurance schemes: CBHI, provider-based health insurance, and government health insurance schemes with community involvement.

CBHI schemes are initiated by conducting awareness-creation activities prior to enrollment and engaging the prospective insured in critical decisions relating to benefit package design, pricing, administration of enrollment, claims, governance, and dispute resolution. The degree of involvement by the membership differs, but the purpose and intention are similar for all: empowering members to act as decisionmakers

[9] Different authors have used various names for the generic "microinsurance": e.g., micro health insurance, mutual health organizations (in French, *mutuelles de santé*), community-based health insurance (CBHI), community-based health funds, and community-owned and operated plans. In this report, we use *microinsurance* for all kinds of systems—rather than CBHI—to refer to a people-centered mutual aid scheme.

and assisting them in that role over and beyond their role as contributors (since many CBHI schemes do not enjoy any subsidy).

Provider-based health insurance can be either nonprofit or for-profit and is characterized by delivering most or all of the covered services within provider facilities. Some such schemes base their prices (or premiums) on actual costs of the services included, but many fix the premium by reference to other considerations (i.e. age and health history). Also, some provider-based schemes are part of a provider network or chain; thus, local facilities may apply prices that corporate head offices determine.

Some government-run schemes in low- and middle-income countries are also called "microinsurance," because they include some form of community participation.

Appendix Table 1.A lists examples of the three types of microinsurance by the countries that have adopted them and the titles of specific schemes. Appendix Table 1.B summarizes these types' key features. It should be noted that, in this taxonomy, CBHI can be described as a variant of the Bismarckian model, and government-run health insurance could be a variant of the Beveridgian model (if the government provides most or all of the funding without collecting a premium).

In the next section, this review focuses on microinsurance schemes in India from the standpoints of the collection of premiums, the design of benefits, and the provision of services, as implemented by the Micro Insurance Academy (MIA), a global nonprofit organization.

### *CBHI in India*

India, a lower middle-income country according to the World Bank [9], has a complex healthcare system. Like most other countries, India uses a mix of financing mechanisms to support its healthcare system, including tax funding, social insurance, voluntary health insurance (i.e., CBHI and private funding for private insurance), and donor funding [50]. However, the target of each financing approach may be different. India's central government finances public health programs through taxation. Government national civil services or employees in the formal sectors enjoy the benefit of mandatory health insurance plans, such as the Employees' State Insurance Scheme and the Central Government Health Scheme. Recently, voluntary government-funded plans for the poor—for example, a program in Andhra Pradesh and CBHI schemes provided by NGOs—are flourishing in addressing the health needs of the poor and of the population whose earnings come from informal business sectors. At the same time, the private for-profit insurance market also is expanding. By the end of 2010, government-funded health insurance schemes covered 19 percent of the population, and private insurance covered about 6 percent of the total population [51]. According to WHO, India is spending 4 percent of its GDP on health, and health spending per capita was estimated at $61 in 2012 [52]. More details on health financing in India can be found in Berman et al. (2010) [50].

Based on the definition of microinsurance provided above, it has three variants, including both government-run schemes with community involvement (i.e., government-funded health insurance for the poor) and community-initiated health insurance plans. In the past few years, MIA has implemented several CBHI schemes in India and Nepal. For those programs, participants usually pay premiums for the year when they enroll. Before the implementation of a CBHI scheme, a willingness-to-pay study is also conducted to help estimate the premium [53]. Most CBHI schemes charge an identical premium for all members, meaning that the premium is rated by community (ignoring differences in age, gender, or medical condition). A few schemes charge a different (lower) premium per person for large families; such a premium (based on a per-person per-year [PPPY] amount) can be decreased even more if large families join together. In many cases, there is a strong emphasis (or even a requirement) that all members of a group join "en bloc" to avoid adverse selection. In a few rare cases, there is a waiting period before new enrollees can receive benefits. Without a substantial government or donor subsidy, the premium is often

set at a low level due to the low capacity to pay of people in the informal sector. For example, in Kalahandi, India, the premium was 100 India Rupees ($1.6) PPPY; in Aishali, India, it was about 192 India Rupees ($3.0) PPPY.

Typically, the benefits packages under CBHI schemes are designed after baseline information is in hand regarding the frequency (incidence) and severity (cost) of health events, as well as indirect expenditure, willingness to pay, and socioeconomic status (to assess ability to pay). Other factors also may be considered when designing a benefits package, such as priority of illnesses and political pressure. Although each community may choose a different initial composition of benefits, experience confirms that within a few years, a considerable convergence occurs toward a similar package across schemes in the same country or region. In Table 5, we provide examples of benefits packages selected in several CBHI schemes that the MIA has implemented in India and Nepal. These packages most often cover the following:

- Hospitalization (lasting more than 24 hours)
- Lab tests and or imaging tests
- Consultations with local medical practitioners (in some cases, these are not licensed but rather are rural medical practitioners, or "nondegree allopathic practitioners," who must be distinguished from traditional and other healers following other systems of medicine [e.g., in India, they are called practitioners of AYUSH: ayurveda, yoga and naturopathy, unani, siddha, and homoeopathy])
- Wage loss during hospitalization
- Transportation when a person is hospitalized

In India, each benefit is reimbursed up to a predefined maximum amount, or cap. When providers charge more than the cap, the amount above the cap is payable by the insured; the effective level of coverage thus depends on how much, on average, insured people must pay on insured services over and above the cap. Given the low premium collected from households, the benefits package also is limited, with a reimbursement cap applied. Again, taking Kalahandi and Vaishali as examples, with premiums of $1.6 and $3.0, respectively, the reimbursement cap for hospitalization in Kalahandi is $56 per year; for lab tests in Vaishali, the cap is $32 per year. On the one hand, the application of such reimbursement caps helps the insurance schemes guard against financial risks. On the other, the limited benefits discourage people from joining the schemes. In South Asia, coverage typically starts from the first rupee, without a deductible or threshold, because it is very difficult to enforce providers' accurate billing and compliance to show the true threshold amount they collect from patients.

As for service provision, health insurance schemes contract with an eligible health service provider network, based on agreed payment mechanisms and rates. The network can consist of both public and private health providers. One concern in using private facilities is that if the private health sector is unregulated and unaccountable, the introduction of health insurance can result in a cost escalation without a guarantee of quality of service [54]. A few programs, with the government's involvement and the inclusion of private providers, have yielded positive results, improving the quality of care and the accessibility of services. In the Andhra Pradesh program in India, any public or private hospital with 50 beds or more is eligible to be empaneled. In 2013, the network of hospitals included 271 private hospitals and 102 government hospitals; about 70 percent of admissions occurred in private hospitals [55].

**Table 5: Incidence Rates and Key Parameters of the Cost per Event Distribution, from Household Surveys and Benefits Packages, First Year of Operation**

| Locations | Benefits | Incidence Rate | Observed Cost per Event | | Benefits Package, First Year of Operation | Premium |
|---|---|---|---|---|---|---|
| | | | Mean | SD | | |
| Kalahandi (Orissa, India) | Hospitalization | 0.5495 | 1,430 | 4,697 | Any hospitalization (>24 hours): up to an individual annual cap of INR 3,500<br>Cost of delivery in hospital: above INR 1,400 (covered by the government)<br>Maternity benefit: flat rate of INR 500 | INR 100 PPPY |
| | Lab Tests | 1.0091 | 134 | 264 | | |
| | Imaging | 0.1389 | 214 | 278 | | |
| | Consultation | 0.8183 | | | | |
| Vaishali (Bihar, India) | Hospitalization | 0.0351 | 9,269 | 11,284 | Lab test: individual annual cap of INR 200<br>Imaging: individual annual cap of INR 300<br>Wage loss from 4th to 9th day: INR 100 per day<br>Consultation, with medicine (limited), from empaneled local medical practitioners: free | INR 197 PPPY for up to a family size of 5; INR 188 PPPY for family with 6 or more |
| | Lab tests | 0.2539 | 676 | 997 | | |
| | Imaging | 0.2030 | 743 | 839 | | |
| | Consultation | 0.7594 | | | | |
| Kanpur (UP, India) | Hospitalization | 0.0280 | 19,518 | 21,981 | Hospitalization: individual annual cap INR 3,000<br>Wage loss: from 4th to 13th day @ INR 75 per day<br>Transportation: INR 100 flat,<br>free consultation, with medicine (limited), from the empaneled local medical practitioners | INR 192 PPPY |
| | Lab tests | 0.2100 | 580 | 748 | | |
| | Imaging | 0.1610 | 930 | 1,260 | | |
| | Consultation | 0.7794 | | | | |

| Locations | Benefits | Incidence Rate | Observed Cost per Event | | Benefits Package, First Year of Operation | Premium |
|---|---|---|---|---|---|---|
| | | | Mean | SD | | |
| Pratapgarh (UP, India) | Hospitalization | 0.0226 | 12,004 | 13,929 | Hospitalization: individual annual cap INR 6,000<br>Cost of caesarean delivery in hospital: above INR 1,400 (covered by the government) up to INR 5,000<br>Wage loss: from 3rd to 6th day @ INR 100 per day<br>Transportation: INR 100 flat per hospitalization | INR 176 PPPY |
| | Lab tests | 0.2206 | 310 | 556 | | |
| | Imaging | 0.1502 | 598 | 769 | | |
| | Consultation | 0.8183 | | | | |
| Dhading (Nepal) | Hospitalization | 0.0402 | 14,330 | 18,962 | Hospitalization (>24 hours): up to an individual annual cap of NPR 4,000<br>Transportation cost: NPR 400 flat per hospitalization<br>Imaging: up to individual cap of NPR 500<br>Lab tests: up to NPR 250 | NPR 336 PPPY |
| | Lab tests | 0.1672 | 482 | 564 | | |
| | Imaging | 0.1511 | 899 | 1,098 | | |
| | Consultation | 1.1176 | | | | |
| Banke (Nepal) | Hospitalization | 0.044 | 12,19 | 20,48 | Hospitalization (>24 hours): up to an individual annual cap of NPR 2,000<br>Transportation: flat cost NPR 100<br>Imaging: up to individual cap of NPR 250<br>Lab tests: up to NPR 200 | NPR 252 PPPY |
| | Lab tests | 0.3152 | 345 | 654 | | |
| | Imaging | 0.2243 | 503 | 564 | | |
| | Consultation | 1.5550 | | | | |

CBHI schemes in India have mixed results. Those initiated by NGOs alone often fail due to small pools, limited benefits, adverse selection, low capacity of management, and lack of trust [55]. Conversely, a few CBHI programs, such as the Andhra Pradesh program and Rashtriya Swashthya Bima Yojana (RSBY), which government runs and subsidizes for the poor, have gained increased popularity. A recent review of CBHI in India concluded:

*… the success of such schemes depends on its design, [the] benefits package it offers, its management, economic and non-economic benefits perceived by enrollees, and solidarity among community members," and that "collaboration of government, NGOs, and donor agencies is very crucial in extending coverage; similarly, overcoming the mistrust that people have [of] such schemes and subsidizing the insurance for the many who cannot pay the premiums are important factors for [the] success of CBHI in India* [56].

Globally, CBHI schemes have been widely advocated since the late 1990s, with generally disappointing results. Odeyemi (2014) recently reviewed CBHI programs in sub-Saharan Africa and came to the same conclusion: effective government leadership and support is one of the key elements of a successful CBHI program [57].

### *Challenges in implementing CBHI*

A few practical issues have arisen in implementing CBHI schemes, as follows:

**Low level of awareness.** When the majority of key stakeholders, the target population, and the implementing partners lack a conceptual understanding of health insurance and CBHI, they have trouble understanding the need for it. In some cases, even when people say they understand the value of being insured, they often are unclear about a scheme's operation or the benefits package itself, resulting in low uptake.

**Value of insurance.** When people (especially poorer or less-educated people) are not clear about the collective nature of welfare gains from insurance, they tend to expect direct cash transfers in the short term, often in direct proportion to premiums paid. For example, if they pay a premium of US$5, they expect a return of more than US$5 during that particular period.

**Volunteerism and insufficient funds.** CBHI schemes are often offered among the poor and those without regular salary voluntarily. The ability to pay for health insurance schemes is low. So are the premiums collected from beneficiaries, which limits the pool of funds. Meanwhile, voluntary participation tends to raise the issue of adverse selection, and leads to a sustainability concern.

**Management capacity.** Often it is difficult to keep the account books of the schemes up to date at all times, with the risk that interim (paper-based) receipts may not be recorded in the management information system. This challenge may be due to the low educational level of office holders, lack of electricity connectivity or other aspects of physical infrastructure, a lack of rigorous supervision of lower-level officials by higher-level personnel, or lack of awareness of the critical importance of regularly updated account books.

**Insufficient and low-quality supply of care.** As the supply of care can change in quality and quantity, there have been cases in which, even if a certain service is included in a benefits package, it is in short supply, of poor quality, or available only at a distant location. Such situations discourage people from joining a CBHI scheme.

**Lack of trust.** A lack of trust may exist among community members or between the CBHI scheme's managers and its members. This can also exist among implementing partners (funders, field implementing NGOs, and government officials, if involved); distrust anywhere can obstruct a scheme's smooth functioning.

**Lack of commitment.** Some CBHI schemes have experienced a lack of continued commitment by NGOs, funders, or other external partners that originally played a crucial role in either the launch or operations. Partners lacking sustained commitment until their planned exit point can spell the end of implementation operations, even if the members wish to continue their affiliation with the CBHI.

### *Experience of community health funds in Afghanistan*

CBHI schemes are a way to raise revenue from communities while providing financial protection through pooling resources. From 2005 to 2006, a CBHI scheme—the CHF—was piloted in BPHS (BHCs and CHCs) catchment areas in five provinces of Afghanistan: Parwan, Saripul, Wardak, Helmand, and Nimroz. The CHF was essentially a prepayment scheme in which households paid an annual premium and a nominal co-payment to access curative health services. Nonmembers paid a consultation fee and drug costs. Importantly, very poor and female-headed households were enrolled in the program free of charge. Preventive and promotive healthcare (i.e., maternal services) were free for all subscribers. Due to security issues, the program was not implemented in Helmand and only partially implemented in Wardak and Nimroz.

When implemented, the CHF was able to attract only from 1 percent to 38 percent of all households in the catchment areas. Cost recovery for facilities was modest (below 16 percent) of a clinic's total operating costs, though the scheme recovered up to 32 percent of a clinic's nonsalary operating costs [15].

All pilot facilities used the generated revenue for the following quality improvements:

- Market purchases to prevent drug and supply shortages
- Outreach services conducted by mobile clinics
- Incentives for health facility staff
- Repairs and maintenance on vehicles and health facilities
- Expenditures on community items, such as transportation costs for referred patients and CHF committee meetings

The CHF's performance offers evidence of the feasibility of implementing a CBHI scheme in Afghanistan. The pilot program resulted in the following findings [15]:

- There was no evidence of financial protection at the community level, though there was indirect evidence that the CHF offered financial protection to members through greater accessibility
- The CHF exemption program did not adequately focus on the poorest individuals in the community, and there were substantial leakages regarding nonpoor households being enrolled free of charge
- CHF members strongly supported the program's continuation and had a disproportionately higher use of services compared to nonmembers
- The main reasons for nonmembers not enrolling were lack of awareness of the program, high premiums, and a low quality of services at the CHF clinics

The pilot CHF was one piece of a three-part study regarding the introduction of user fees, the CHF, and free services, and functioned only for one year due to a ban on user fees as a result of significant decreased use of services among nonenrollees [21]. As Afghanistan considers health financing options for generating revenues and protecting individuals from catastrophic payments, it is crucial that any lessons learned be applied in the next phase. Health sector stakeholders unanimously agree that the primary healthcare services outlined in the BPHS should remain free, as supported by the law. Yet opportunities

exist at the secondary and tertiary levels of the health system to introduce prepayment mechanisms through various insurance schemes, including CBHI. The CHF on its own was inadequate for raising substantial revenue but, based on other country experiences, might be more successful as one part of a combination of financing sources, such as combining community financing, public taxation, equity funds, and social/private health insurance.

Future CBHI schemes should consider the following in designing and implementing a community financing mechanism:

1. The CHF was designed to create funds by catchment area. The catchment areas of a health facility are large and include many villages. Experience from community-based savings groups (microfinance programs) in Afghanistan has shown that individuals and households are able and willing to save and pool funds within the community/village unit. This traditional sense of solidarity and trust should be leveraged at a smaller unit level than that of a catchment area.
2. Exemptions should target the poorest households.
3. Significant communications and education campaigns are needed to sensitize communities to the concept of community financing, promote appropriate use, and prevent disproportionate overuse or misuse of health services.
4. A pilot program needs to be implemented for a longer period for trends and effects to be seen clearly.

### *Lessons learned for Afghanistan*

CBHI has the potential to be an alternative resource for the health system, other than tax, social insurance, and donor funding. In Afghanistan, government spending on health has been low, accounting for 5.6 percent of THE in 2012 [10]. External donors are the main sources of funding for Afghanistan's health system for the delivery of basic health services; in 2013, more than 75 percent of total public spending on health was funded by foreign aid [58]. With an expected drop in donor funding, an alternative strategy to fund the country's health system needs to be developed, and CBHI could be considered one of the options.

A well-designed and implemented CBHI scheme could also provide financial protection to the vulnerable populations in the informal sector. Along with low public spending on healthcare in Afghanistan, OOP spending on healthcare by households has been very high. It is imperative to develop mechanisms to reduce such high spending. The MOPH has recognized that CBHI schemes have a high potential for acceptance by the population and offer one sustainable solution for Afghanistan's present health financing system [8].

In a country with a large population in the informal sector, CBHI should be considered a financing mechanism. Because the capacity to collect taxes generally is weak, social and private health insurance are limited, and donor funding may be insufficient for low-income countries, communities must participate in generating financial resources for health risk protection [59]. The government and donors should be actively engaged in designing and supporting health insurance, because of the low capacity of the population to pay and the low capacity of communities to implement health insurance. This support could be technical support to the community regarding how to operate health insurance and a subsidy for premiums. Rwanda and Ghana have the two most successful CBHI schemes. CBHI in both countries receives strong government and/or donor support. Without a subsidy, the premiums collected from those of the population without regular jobs are likely to be inadequate to sustain a CBHI program in the long run.

Strong government leadership in implementing CBHI also is critical in ensuring the success of CBHI programs. Although many countries have implemented CBHI, the results are far from positive. The reasons for this failure are lack of a clear framework, inadequate financial support, unrealistic enrollment requirements, and failure to engage beneficiaries [57, 59]. Effective government control and support are essential in addressing those bottlenecks, as reflected in the cases of Rwanda and Ghana [60, 61].

With government and donor involvement, one issue that arises is community distrust of government-managed health schemes. Thus, it is crucial to engage communities in the design and implementation of CBHI so they have a strong sense of ownership and the program meets their particular health needs [62]. In addition, the risk pool of CBHI programs is generally small and the demand for healthcare is vast, forcing governments, donors, and communities to limit the choice of services that a CBHI program can cover, in order to be able to address the most pressing health issues and sustain a CBHI program in the future.

Low-income countries often face the issues of low quality of care and inaccessibility of public health services; involvement of the private sector in service delivery could mitigate some of these concerns. For this reason, in designing CBHI programs, it is important to foster the growth of the private sector and include it in service delivery [55], through public-private partnerships.

Very few countries use CBHI alone to finance their health systems. However, CBHI could be a powerful tool to protect rural and poor populations in the informal sector from the financial risks of adverse health. Once communities accept the concept of CBHI, they will have a better understanding of health insurance overall. With the development of CBHI and economic growth, CBHI programs could be integrated with other government-run health insurance programs, thus serving as an intermediate step toward UHC.

# Part 4. Thailand's Universal Health Coverage

### *Background*

According to the World Bank, Thailand is an upper middle-income country with a GDP per capita of 8,463.4 in constant 2005 international dollars in 2012.[10] The total population in 2012 was approximately 66.8 million, with 65.5 percent of the population living in rural areas [58].

Thailand has some of the best health indicators in Southeast Asia: In 2012, the infant mortality rate was 12.2 deaths per 1,000 live births; the average life expectancy was 71 years for men and 77 years for women [50]. Yet Thailand faces both demographic and epidemiologic transitions, with an aging population and an increasing burden of chronic noncommunicable diseases [58, 63].

Since the introduction of UHC in 2001, Thailand has seen dramatic changes in public and private expenditures on health. By 2011, Thailand was spending 4.1 percent of its GDP on healthcare; 14 percent of total government expenditure was on health. As in many other middle-income countries, the government's share of THE has increased considerably, from 56.1 percent in 2000 to 75.5 percent in 2011 [9]. Moreover, the proportion of OOP expenditure relative to total private health expenditure has decreased, from 76.9 percent in 2000 to 55.8 percent in 2011 [9].

[10] In this context, GDP per capita based on purchasing power parity (PPP) refers to GDP converted in international dollars using PPP rates based on the 2005 International Comparison Program (ICP) led by the World Bank. In 2012, 1 PPP$ = 17.6 baht. According to the World Bank, "An international dollar would buy in the cited country a comparable amount of goods and services a U.S. dollar would buy in the United States. This term is often used in conjunction with Purchasing Power Parity (PPP) data." From: World Bank. "What Is an International Dollar?" 2014. Available at: https://webmail.east.cox.net/do/redirect?url=https%253A%252F%252Fdatahelpdesk.worldbank.org%252Fknowledgebase%252Farticles%252F114944-what-is-an-international-dollar.

### *On the path to universal health coverage*

Thailand has been on the path to UHC since the 1970s. Figure 1 illustrates the phases of four different financial protection schemes that the country has introduced in its health system. Two schemes were for formal employees and two were for the informal sector or vulnerable populations. All four were financed from multiple sources, such as general government tax revenue, employers, employees, and beneficiary premiums. Challenges that emerged in the two schemes focused on the informal sector and vulnerable populations and were related to the adequacy of funding, reaching populations in the informal sector, and the quality of care [64].

By 1998, about 80 percent of the Thai population was insured by one of these four schemes. Despite their existence, more than 18 million people (about 30% of the total population) still remained uninsured in 2001, due either to ineligibility or nonparticipation in existing public or private health insurance schemes.

Two pivotal moments paved the way for universal coverage: a universal coverage policy was incorporated in both the 1997 constitution and the eighth National Health Plan (1997–2001). Although attempts were made to establish a universal coverage system, the political will was not strong enough [65]. The Thai-Rak-Thai party campaigned for a universal coverage scheme (UCS): "the 30 baht treat all." After the party's landslide victory in 2001, the MOPH launched a new payment scheme in six pilot provinces[11] to implement the UCS. In 2002, the UCS expanded its coverage nationally, and the government enacted the National Health Security Act, which states that health is considered an entitlement of Thai citizens and equal access to basic health services should be guaranteed.

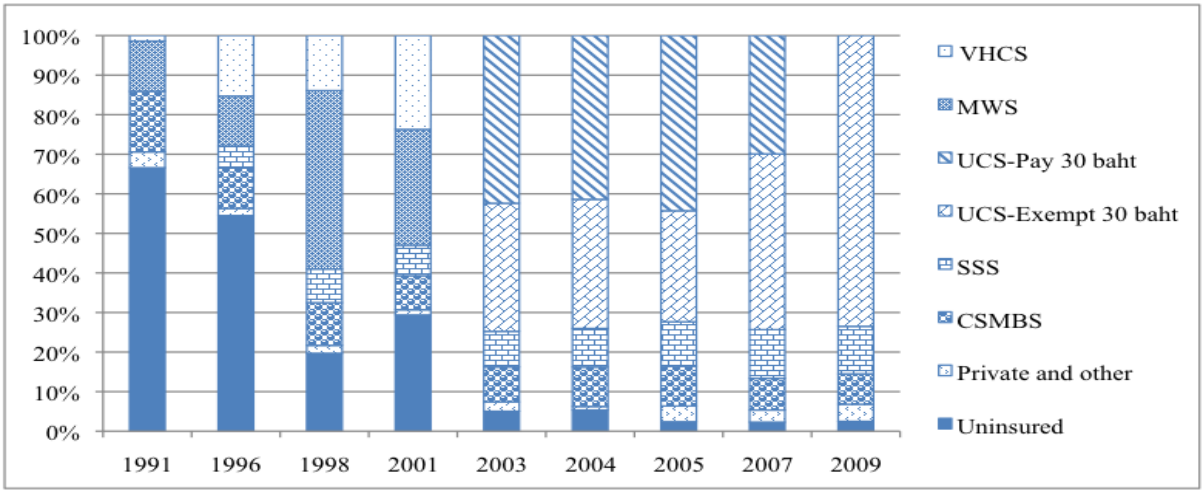
**Figure 1: The Road to UHC in Thailand**


| | | | | |
|---|---|---|---|---|
| **Scheme** | Medical Welfare Scheme (MWS) | Civil Servant Medical Benefit Scheme (CSMBS) | Social Security Scheme (SSS) | Voluntary Health Card Scheme (VHCS) |
| **Population** | Informal sector: Elderly age 60 years or older, children under age 12, the disabled, veterans, and monks | -Fringe benefit for government employees and dependents<br>- Public sector retirees | Formal private sector as a Worker's Compensation Fund, excluded dependents | Near-Poor and the non-poor in the informal sector who were not eligible for any of the other health insurance schemes |
| **Funding** | | General government taxes | Employees, employers, government | Premiums from households, the Ministry of Public Health, and an Asian Development Bank Loan |
| **Management** | Government | Comptroller General Department of the Ministry of Finance | Social Security Office | Government |
| **Benefit package** | Comprehensive package of services without user fees at public health facilities | Beneficiaries free to choose health care services from any public health facilities, and could seek care from private health facilities in the cases of accidents or emergency only | Beneficiates are required to choose their designated health facilities from among those that have a contract with the Social Security Office (SSO) | Beneficiaries register and receive health care services from certain health facilities as their first contacts |
| **Payment Mechanism** | | Fee-for-service payment method, resulting in escalating health expenditures | Capitation | |
| **Source** | (Pannarunothai 2002) | (Sriratanaban 2002) | | |

[11] Patum Thani, Samut Prakan, Nakhon Sawan, Phayao, Yasothorn, and Yala.

During the early phase of the UCS implementation, beneficiaries were required to pay 30 baht (approximately US$0.75)[12] for each outpatient or inpatient visit and for the drugs specified for coverage. Individuals previously covered by the Medical Welfare Scheme (MWS) and other designated groups were exempt from the fee; by 2007, the exemption had been extended to all UCS beneficiaries. However, the elimination of the 30-baht co-payment had no impact on overall healthcare use [65]. In 2010, approximately 75 percent of Thai citizens were covered by UCS, 9 percent were covered by the Civil Servant Medical Benefit Scheme (CSMBS), and 16 percent were covered by the Social Security Scheme (SSS) [66]. The percentages of the Thai population covered by health insurance from 1991 to 2009 are shown in Figure 2. Over this period, the uninsured decreased from almost 70 percent of the population to below 5 percent.

**Figure 2: Percentage of Coverage in Different Health Insurance Schemes, 1991–2009**




VHCS: Voluntary Health Card Scheme. MWS: Medical Welfare Scheme. UCS: Universal Coverage Scheme. SSS: Social Security Scheme. CSMBS: Civil Servant Medical Benefit Scheme.

Sources: Thailand's National Statistics Office (NSO); Wibulpolprasert and Thaiprayoon, 2008 [63].

Currently, three main public health insurance schemes operate in Thailand: CSMBS, SSS, and UCS. Table 6 summarizes the main characteristics of these three schemes. The CSMBS and SSS are associated with an individual's employment status; the UCS exists for the rest of the population not already covered, including those who were under the MWS or Voluntary Health Card Scheme (VHSC) or previously uninsured. In other words, the UCS includes people who are self-employed, unemployed, disabled, children, and the elderly. CSMBS beneficiaries can choose to receive healthcare from any public providers without previous registration, whereas SSS and UCS beneficiaries are required to register with a health facility, with only limited referrals within the network. The sources of funds for the CSMBS and UCS are mainly from general tax revenue, whereas joint contributions by employees, employers, and the government finance the SSS. Finally, payment mechanisms for the SSS and UCS are closed-ended (i.e., through capitation and DRGs, based on a global budget), whereas under the CSMBS, the payment is on a fee-for-service basis for outpatient care and DRGs for inpatient care.[13] This difference results in a large

[12] 1.9 constant 2005 PPP$.

[13] DRG is a system used to classify different hospital inpatient services into one of the DRGs, based on discharge diagnosis, co-morbidities, length of stay, discharge status, and other key parameters. Cases classified in the same group use similar resources and have the same cost weight. This cost weight is applied to pay the hospitals for the cost assigned to each case (HISRO, 2012 [66]).

gap in per capita health expenditure between CSMBS beneficiaries (US$367) and the other two groups (US$71 for SSS and US$79 for UCS).

**Table 6: Characteristics of Thailand's Three Public Health Insurance Schemes After Achieving Universal Coverage in 2002**

| Characteristics | SSS | CSMBS | UCS |
|---|---|---|---|
| **Scheme type** | Compulsory | Fringe benefit | Social welfare |
| **Population coverage** | Formal private sector employees, excluding dependents | Government officials; retired government workers and their dependents (parents, spouse, children) | Thai population not covered by CSMBS and SSS |
| **Percentage of coverage** | 16 | 9 | 75 |
| **Benefits package** | Comprehensive package: outpatient, inpatient, accident and emergency, and high-cost care, with a very minimal exclusion list; prevention and health promotion are excluded | Comprehensive package: slightly higher than SSS and UCS | Comprehensive package: similar to SSS, including prevention and health promotion |
| **Choice of provider** | Registered public and private competing contractors | Free choice of public providers, no registration required | Registered contractor provider, notably the district health system |
| **Financing sources** | Payroll tax financed by tripartite contributions: 1.5% of salary equally by employer, employee, and government | General tax, noncontributory scheme | General tax |
| **Financing body** | Social Security Office (SSO) | Comptroller General Department, Ministry of Finance | National Health Security Office |
| **Purchasing relationship** | Contract model | Reimbursement model | Contract model |
| **Payment mechanism** | Inclusive capitation for outpatient and inpatient services | Fee for service, direct payment to public providers for outpatient services, DRG for inpatient services (July 2007) | Capitation for outpatient services and global budget, plus DRG for inpatients |
| **Per capita expenditure (2010)** | US$ 71 | US$367 | US$79 |

Source: HISRO, 2012 [66].

### *How the Universal Coverage Scheme is implemented*

*Scheme design*

The UCS is a result of reform and combines the MWS and the VHCS. Four main features distinguish the UCS from these other two systems [65, 66].

**"Closed-ended" or fixed-budget provider payment approaches to contain costs.** A capitation payment is used to pay for outpatient and preventive care. For inpatient care, healthcare providers are paid

based on the case-mix system, in which the payments are calculated based on the total relative weight of the DRGs. The closed-ended payment mechanisms, together with the use of primary care providers as gatekeepers, are aimed to promote the efficiency of the system, as primary care providers can control access to expensive care at the secondary or tertiary levels. Moreover, a fixed-budget payment strategy can help control costs, by minimizing the likelihood of "supply-side" moral hazard, as medical providers have no financial incentive to induce unnecessary demand [66].

**A "contracting model," in which the healthcare purchaser and providers are separate entities.** The National Health Security Office (NHSO) was established as an independent organization responsible for managing the UCS. The NHSO is the single purchaser of healthcare services from all contracted providers on behalf of all UCS beneficiaries; due to its monopsony power, the NHSO can control program costs. Since the MOPH manages both the NHSO and the majority of UCS providers, the extent to which the healthcare purchaser and providers are completely separate entities is still not clear [66].

**Equitable healthcare.** In designing the scope of the coverage, the UCS aimed to promote equity in access to healthcare, by providing a comprehensive benefits package comparable to the benefits packages for the SSS and the CSMBS.

**Quality healthcare.** Along with a cost-containment strategy, the UCS also implements the Voluntary Quality Improvement Program, in which a public organization provides voluntary hospital accreditation for both public and private providers.

*Healthcare delivery*

The UCS delivers healthcare to its beneficiaries by using a *primary care-based* system, in which primary care provider units (PCUs) are assigned as gatekeepers for the healthcare of people in their catchment areas [63]. The contracting units for primary care (CUPs) are the main local contracting units that manage PCUs within a catchment area.[14] Most CUPs are based in a district or provincial hospital, whereas PCUs, which offer curative, preventive, and rehabilitative services to UCS beneficiaries, can be either community health centers/private clinics or district hospitals. The majority of UCS providers are MOPH facilities, because all public health facilities are required to serve under the UCS, whereas private health facilities can choose whether or not to participate. To be in the network, healthcare facilities must register with the UCS.

To receive healthcare, UCS beneficiaries must register with one or two health facilities within the CUP in the area where they live; to obtain healthcare, they must use the services furnished by their registered healthcare facilities as the first point of contact. Beneficiaries are not allowed to go directly to secondary or tertiary medical care units without a referral from their PCUs, unless they have had an accident or similar medical emergency. From 2002–2006, a group of UCS beneficiaries was required to make a 30-baht co-payment for each visit. As mentioned before, this co-payment was eliminated in 2007.

*Healthcare financing*

The main financing source for the UCS is general tax revenue, as no specific taxes in Thailand are earmarked for healthcare. Unlike SSS beneficiaries, UCS beneficiaries—most of whom are self-employed, economically inactive, unemployed, or working in the informal sector—do not contribute directly to any healthcare funds. Which tax rates apply to the different groups of workers in the informal sector is unknown; in practice, it is hard to collect taxes from this population. Hence, using general tax revenue to finance the UCS could be seen as a method of ensuring compulsory contributions to health insurance schemes, although those unable to contribute can still benefit from the scheme [67].

[14] More details on the minimum CUP requirements (e.g., minimum numbers of health workers per 10,000 persons) can be found in Wibulpolprasert and Thaiprayoon, 2008 [63].

Each year, the MOPH negotiates the government's healthcare budget allocation, by competing against other ministries. Tax revenues allocated to pay for healthcare are highly dependent on Thailand's political situation. After the healthcare budget is determined, the NHSO is responsible for allocating the funding to the local CUPs, which receive an annual capitation-based budget according to the size of their registered populations. In 2001, the annual capitation budget was set at 1,202.40 baht (about 75.65 constant PPP international $) per person per year. The capitation budget is reviewed annually and negotiated with the government; in 2011, it increased to 2,546.48 baht (about 143.86 constant PPP international $) per person per year [68]. Appendix Table 1.C provides details on the items included in the UCS capitation budgets during 2003–2011.

Once a CUP receives its capitation budget, it generally will allocate the funding in three main portions [69]. The first portion pays for outpatient care in district and provincial hospitals as well as healthcare promotion and prevention in district hospitals and health centers. The second portion finances inpatient treatments in both district and provincial hospitals at the applicable DRG rate. The third portion pays for referrals to higher-level hospitals. For high-cost treatment and emergencies, funding comes directly from the NHSO.

*The basic benefits packages*

The UCS provides a comprehensive benefits package with three components: the curative package, the healthcare promotion and prevention package, and the high-cost care package [63]. The curative package covers outpatient, inpatient, and accident and emergency services; dental care; and diagnostics, special investigations, medicines on the National List of Essential Medicines, and medical supplies. Examples of exceptions are cosmetic surgery, infertility treatment, and provision of a private room. The healthcare promotion and prevention package covers immunization, annual physical checkups, antenatal care and family planning services, and other preventive care. Table 7 illustrates the details of current curative and preventive care benefits.

**Table 7: Current UCS Benefits Package, 2014**

| Curative Benefits | Preventive Care Benefits |
|---|---|
| General examination, curative and rehabilitative services | Having and using personal health record books |
| Medical examination, diagnosis, and treatment and rehabilitation until the treatment ends, including alternative medical care as recognized by the Medical Registration Committee | Examination and prenatal care for pregnant women |
| Childbirth delivery services, totaling no more than 2 deliveries | Services related to childbirth and child development and nutrition, including immunization according to the national immunization program |
| Meals and room charges for inpatients in common rooms | Annual physical checkups for the general public and high-risk groups |
| Dental services: extraction, filling, scaling, plastic-based denture, milk-tooth nerve cavity treatment, and placement of an artificial palate in children with harelip and cleft palate | Antiretroviral medications for the prevention of mother-to-child transmission of HIV |
| Medicine and medical supplies according to the national essential drug list; referrals for further treatment among health facilities | Family planning services |
| High-cost medical services, including artificial organs and prostheses (both inside and outside of the body), as per | Home visits and home healthcare |
| | Provision of knowledge about healthcare for |

| Curative Benefits | Preventive Care Benefits |
|---|---|
| the payment criteria set by the NHSO | patients |
| Care for accidents and emergency illnesses: any accident or emergency case can go for medical care to any health facility participating in the scheme located nearest to the scene | Counseling and support for people's participation in health promotion<br>Oral health promotion and disease prevention |

Source: NHSO, 2014.

The high-cost care package is similar to the package provided by the SSS. Expensive treatments, such as antiretroviral treatment for HIV and renal replacement, initially were not included in the package; they were incorporated in the inclusion list in October 2003 and January 2008, respectively. Table 8 presents a list of expensive healthcare interventions included in the UCS package.

**Table 8: UCS Inclusion and Exclusion List of Expensive Healthcare Interventions, 2001**

| Inclusion List | Exclusion List |
|---|---|
| Chemotherapy for cancers | Antiretroviral treatment for HIV[a] |
| Radiation therapy for cancers | Renal replacement therapy, including kidney transplants for patients with end-stage renal disease[b] |
| Open-heart surgery, including prosthetic cardiac valve replacement | Other organ transplants |
| Percutaneous transluminal coronary angioplasty | Cosmetic surgery |
| Coronary artery bypass grafting (CABG) | Infertility treatment |
| Stent for treatment of atherosclerotic vessels | |
| Prosthetic hip replacement therapy | |
| Prosthetic shoulder replacement therapy | |
| Neurosurgery (e.g., craniotomy) | |
| Antifungal treatments for cryptococcal meningitis | |

Sources: NHSO, 2001, cited in Wibulpolprasert and Thaiprayoon, 2008 [63].

[a] Included since October 2003.

[b] Included since January 2008.

### *Challenges in implementing the Universal Coverage Scheme*

The UCS has succeeded in expanding healthcare coverage to the Thai population, but challenges persist.

**Financial pressure on providers from closed-ended provider payment approaches and negative impacts on quality of care.** During the early years of UCS implementation, the capitation budget led to financial problems, particularly among large hospitals in urban areas [70]. Moreover, the UCS's strict policy on provider payments resulted in limited resources for inpatient care and generated some adverse effects, including decreased access to new drug technology, treatment choice restrictions, and inequity across health schemes [71].

**Inadequate and poorly distributed healthcare workers in public health facilities.** Even before adoption of the UCS, greater financial incentives in the private sector attracted healthcare workers,

particularly physicians, from rural public facilities to urban private facilities [72]. After implementation of the UCS, the expansion of healthcare coverage resulted in a substantial increase in demand, creating greater workloads for healthcare professionals at public health facilities. Consequently, the UCS has worsened the existing tensions between rural and urban workers, as well as between public and private workers [73].

**Inequity across different health insurance schemes.** In 2010, per capita health expenditure for the UCS was US$79, whereas for the CSMBS it was US$367 [66]. This dramatic difference is due to different provider payment mechanisms, which result in variations in practice between the two schemes. For instance, the CSMBS spends more on branded medicines and allows longer hospital stays for most DRGs [66]. In contrast, to contain costs, UCS providers have incentives to choose generic medicines over branded medicines and refrain from providing extra or unnecessary treatments.

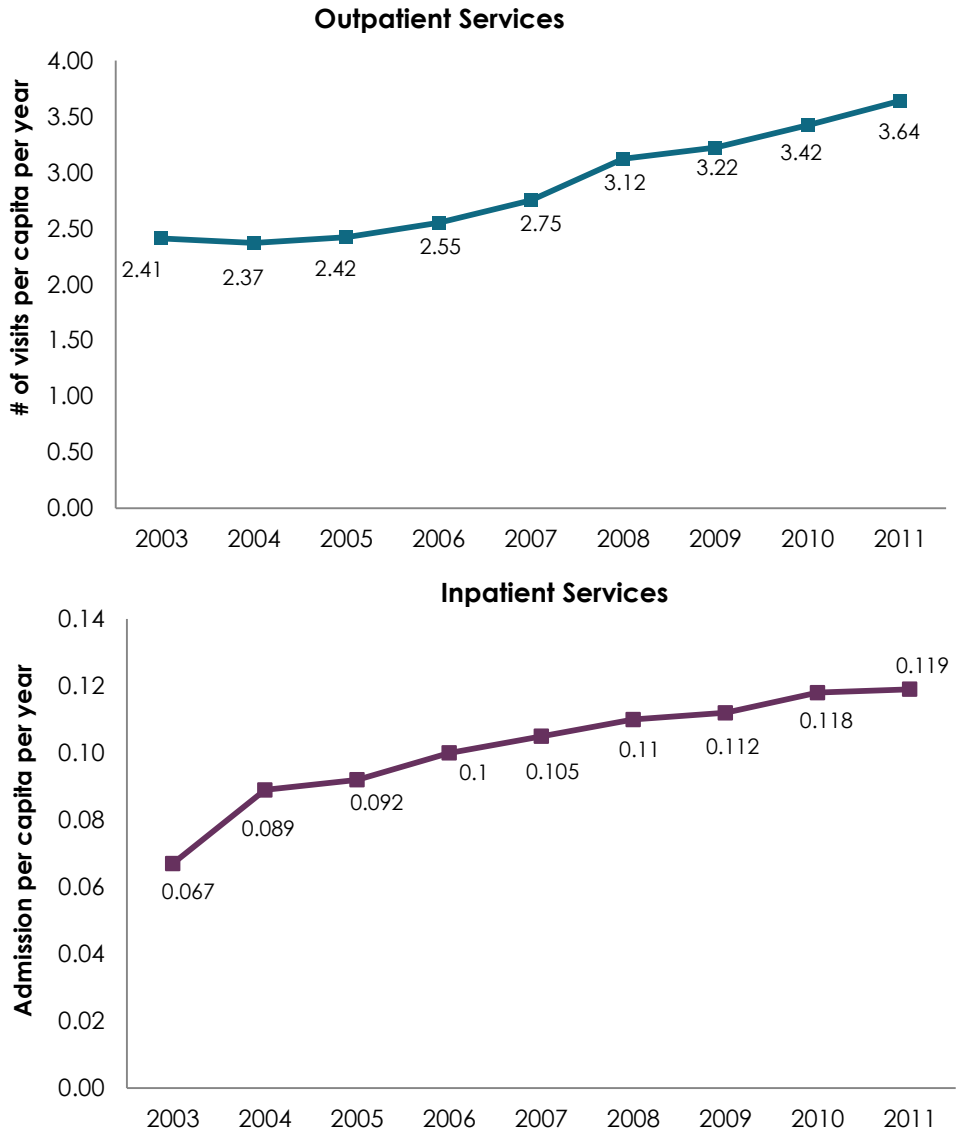
**Challenges in financial sustainability of the UCS due to different government budget allocations.** Each year, the NHSO negotiates the budget with the government in an effort to obtain sufficient resources to provide quality healthcare to beneficiaries. As long as the growth rate of THE as a percentage of GDP is kept within the government's fiscal capacity, using general tax revenues to finance the UCS will still be feasible. However, in the event that THE grows at a faster rate than the country's financing capacity (or the GDP grows at a lower rate than THE), the ability to finance the UCS might be at risk.

### *Evaluation of UCS impacts*

#### *Impact on healthcare use and health outcomes*

Based on household surveys, use of both outpatient and inpatient care has risen since the implementation of UCS. Figure 3 illustrates the use rates of both outpatient and inpatient services during 2003–2009 and projections for 2010–2011. However, it is difficult to determine whether this increase has resulted from the implementation of the UCS or is caused by other factors, such as an increase in the overall income of households and greater availability of public and private healthcare services [66].

**Figure 3: Service Use Rates among UCS Beneficiaries, 2003–2009, and Projections for 2010–2011**




Source: HISRO, 2012 [58].

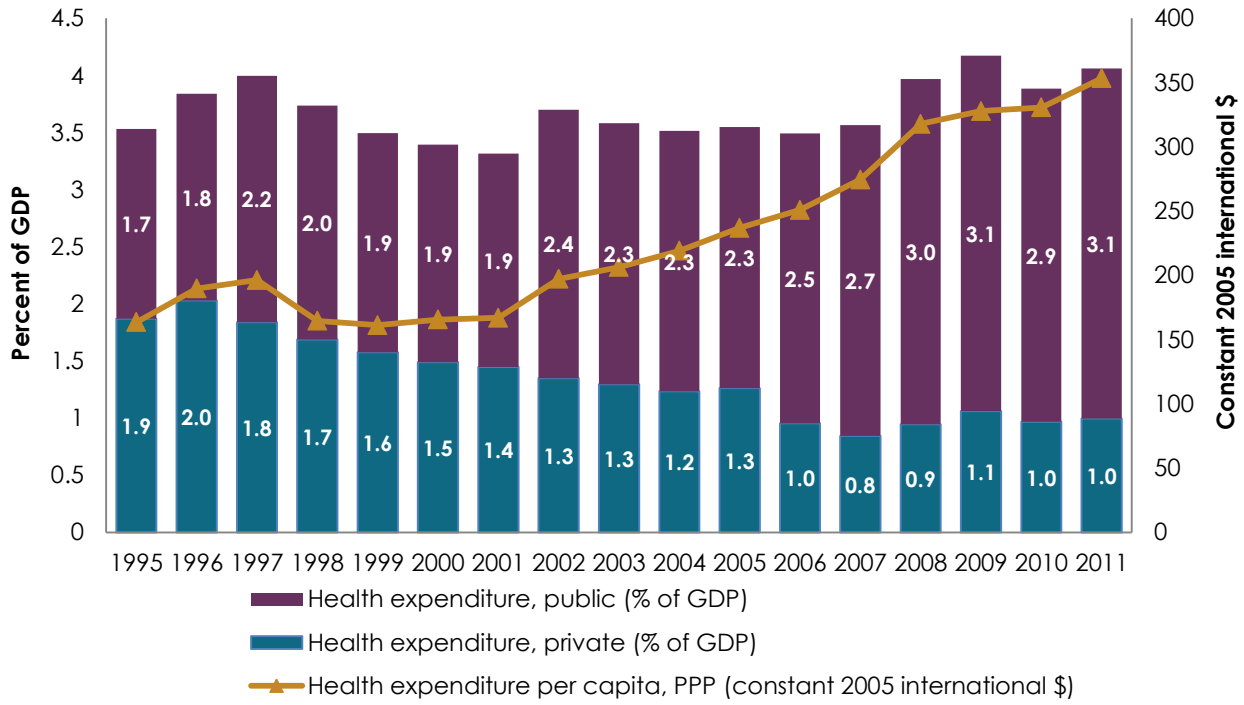
A number of studies have tried to examine the causal impact of the UCS on healthcare use; most found that UCS showed positive impacts. For instance, based on hospital-level data, one study found that the UCS resulted in increased demand for outpatient care, particularly among the elderly and the poor [69]. The impacts were most pronounced during the first year of program implementation, after which they decreased substantially. Data from Thailand's Health and Welfare Surveys showed that the UCS increased the probability of receiving public outpatient care and admission to a public hospital by 5 percent and 18 percent, respectively [74]. Similarly, Ghislandi et al., 2013 [75] found that the UCS increased the likelihood of using preventive care, particularly among women; it also raised hospital admissions and outpatient visits by 2 percent and 13 percent, respectively. Another study reported that the UCS reduced the likelihood of people reporting themselves as too sick to work, and the estimated effects are much larger among the elderly (ages 65 and over) [76].

*Impact on health expenditure and financial protection*

As a result of increases in healthcare use, THE in Thailand has increased. Figure 4 depicts Thailand's public and private health expenditures as percentages of GDP, as well as health expenditure per capita, during 1995–2011. Not surprisingly, health expenditure per capita almost doubled after the UCS in 2001, increasing from 167 constant PPP$ in 2001 to 353 constant PPP$ in 2011. During the same period (2001–2011), public health expenditure as a percentage of GDP rose by approximately 1.1 percent, while private health expenditure as a percentage of GDP declined by only 0.4 percent. Figure 5 illustrates a decline in OOP health expenditure in Thailand during 1995–2011. In particular, OOP health expenditure as a percentage of private health expenditure declined by more than 50 percent. These changes suggest that, whereas individuals on average spent more on healthcare, the burden of healthcare expenditures shifted from households to the government.

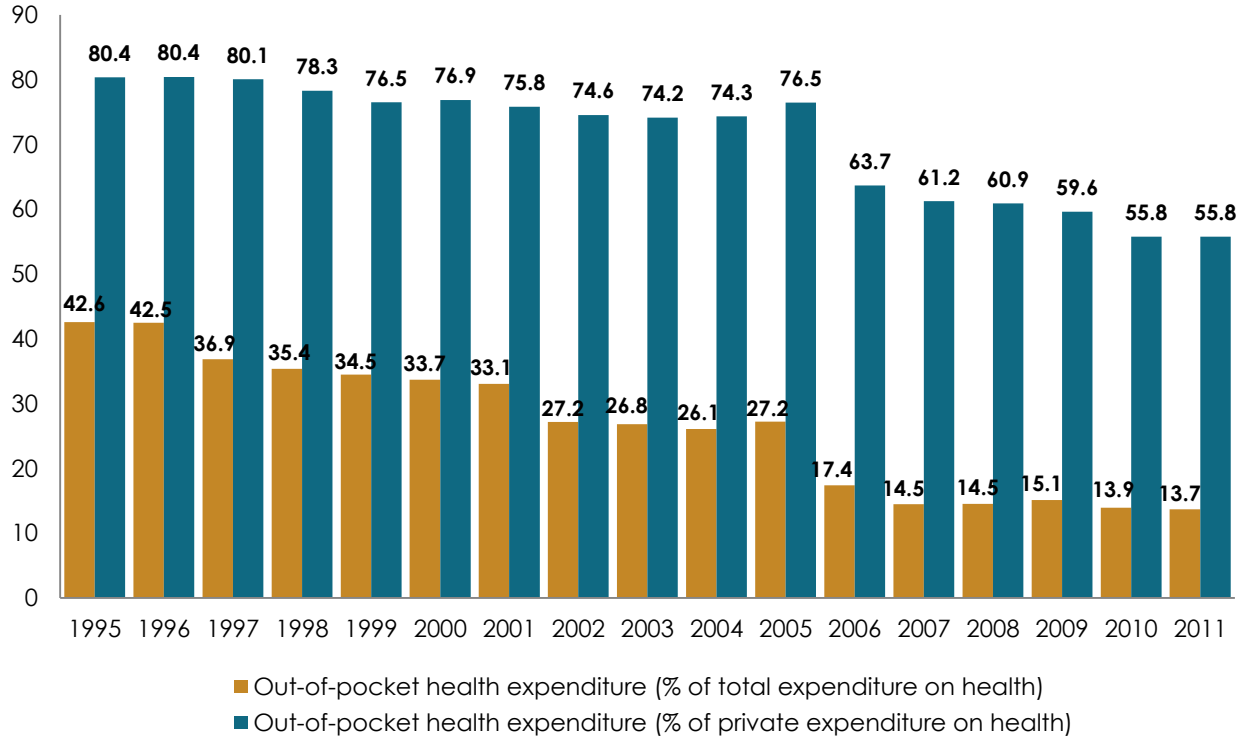
During the early years of UCS implementation, a number of researchers estimated the change in household medical spending and found that the average ratio of household medical expenditures to total income decreased from 2.1–2.2 percent during 1999–2001 to 1.8 percent in 2002 [70, 77]. As a result, the estimated maximum total expenditure each household could reduce was 8,178–9,432 baht (or about 518.18–597.64 constant PPP$) per month in 2002. A more recent study estimated that OOP expenditures were reduced by one-third, on average, and the probability that a household would spend more than 10 percent of its budget on healthcare declined [74]. These results suggest that the UCS has been successful in protecting households financially.

**Figure 4: Health Expenditures in Thailand, 1995–2011**




Source: World Bank, 2013 [9].

**Figure 5: Out-of-pocket Health Expenditure in Thailand, 1995–2011**




Source: World Bank, 2013 [9].

*Thailand after initiating the Universal Coverage Scheme*

The current situation in Thailand's healthcare sector is, to some extent, a result of the implementation of the UCS initiated in 2001. In 2001, Thailand's economy and population were not much different statistically than they were in 2011; perhaps owing in part to its relatively peaceful history, its GDP per capita was more than four times greater than the current GDP per capita in Afghanistan. Thailand's health expenditure per capita in 2001 was 167 constant PPP$, which was only about three times greater than Afghanistan's health expenditure per capita in 2011. During 2001–2011, health expenditure per capita in Thailand increased more than 40 percent. In addition, Thailand's public health expenditures as a percentage of government expenditure increased from 10.4 percent in 2001 to 14.5 percent in 2011. On the contrary, OOP health expenditure decreased from 33.1 percent of THE in 2001 to about 14 percent in 2011. This suggests that the adoption of the UCS reduced household OOP health expenditure, whereas public health expenditure increased only slightly.

Access to healthcare in Thailand increased significantly, with dramatic impacts on mortality. The proportion of children immunized for measles and for diphtheria, pertussis, and tetanus increased, infant mortality decreased, and tuberculosis incidence decreased. Life expectancy is increasing continuously, though population growth is now under replacement level.

### *Lessons learned for Afghanistan*

UHC's successful implementation in Thailand began in the 1970s, with economic transitions over time. Thailand's experience shows that UHC is possible in low- and middle-income countries. Appendix 2 compares Afghanistan with Thailand. The following factors enabled the success of the UCS: (1) political commitment and strong social support; (2) ability to control costs by using a closed-ended payment mechanism, together with a focus on primary healthcare; and (3) beginning in 2001, a firm foundation in

the Thai healthcare system, including an extensive network of government-owned district health facilities, well-established health policy and systems research institutions, public health administration capacities, and a computerized civil registration system [66].

Without political commitment and strong support from the general public, the adoption of the UCS in 2001 might not even have been possible. Recovering from the 1997 financial crisis, the government's decision to implement the UCS in the six pilot provinces and expand the program throughout the country within a year was a crucial step in reforming Thailand's healthcare system. The capitation payment under a fixed budget, together with an emphasis on primary care, helps to control the cost of healthcare and prevents supply-side moral hazard. This kind of payment method is particularly suitable for countries with limited resources. However, without appropriate budget allocation and a careful monitoring system, the fixed-payment method can easily place a financial burden on healthcare providers, consequently harming the quality of care.

The MOPH also has subsidized the education of health professionals and requires new graduates, such as physicians, dentists, and nurses, to work in rural areas for three years after graduation. This compulsory service helps retain healthcare workers in the public sector to meet an increasing demand for healthcare. Last, a computerized civil registration system has allowed for the development of a national beneficiary registration database.

## Part 5. Overall Lessons and Suggestions for Universal Health Coverage in Afghanistan

### *Challenges in Afghanistan*

Although the current situation in Afghanistan may not permit the full implementation of a system such as Thailand's UHC, or even the Kyrgyz Republic's system, their experience and certain principles of all three case studies can be applied to the Afghan healthcare system. The following SWOT analysis (strengths, weaknesses, opportunities, threats) in Table 9 addresses key factors in Afghanistan favoring implementation of UHC, as well as the barriers preventing the country from adopting such a system.

**Table 9: SWOT Analysis of the Afghan Healthcare System**

| Strengths | Weaknesses |
|---|---|
| Established network of healthcare facilities<br>Current practice of community health workers | Limited health delivery capacity and lack of medical supplies<br>Inadequate numbers of healthcare workers, particularly female workers and workers in rural areas<br>Inefficient use of healthcare resources<br>Use of post-payment methods |
| **Opportunities** | **Threats** |
| Opportunity to promote the primary care-based system<br>Support from various international and nongovernmental organizations | Dependence on external (or donor) funding<br>Insufficient domestic healthcare financing<br>Large informal sector<br>Low investment in the education of health professionals and research and development<br>Lack of security when providing healthcare in remote areas<br>Uncertain level of political commitment |

Major weaknesses of the Afghan healthcare system are limited health delivery capacity, inadequate numbers of health workers and amounts of medical supplies, inefficient use of healthcare resources, and the post-payment method of paying for healthcare. Supply-side constraints, such as inadequate supplies of essential medicines and few health workers in rural areas, inevitably pose limitations on the expansion of healthcare access and the extent of the healthcare services that can be provided under UHC, let alone the quality of care. Moreover, inefficient uses of healthcare resources, such as prescriptions for unnecessary services and the failure to prescribe generic drugs, lead to high household OOP health expenditures. This rising healthcare cost problem can only be exacerbated if patients still must pay up front for medicines or services, and appropriate prepayment mechanisms are not investigated.

In addition, economic resources in Afghanistan are limited; the health system depends heavily on donor funding. This insufficient domestic healthcare financing, together with dependence on external sources of funding, casts doubt on the feasibility of UHC and its sustainability in the long run. Also, lack of security in remote areas can threaten health workers and hinder the ability to expand healthcare access in these areas. In the longer term, the inadequate number of health professionals and insufficient medical supplies may persist if investments in education and research development in the healthcare sector remain low. Last, and most important, political commitment to improve healthcare access in Afghanistan is not strong. The fact that public health expenditure accounted for less than 4 percent of total government expenditures in 2011 suggests that healthcare budget allocation is not a priority for the Afghan government.

### *Overall lessons*

Afghanistan's system currently does not exactly match any of the three examined here. Nevertheless, sufficient similarities exist that important lessons can be learned.

**First, health insurance reforms take time.** The systems we reviewed are works in progress. For the Thai system, this characteristic is manifested in the phasing in of a system that gradually covered increasingly larger portions of the population. For microinsurance in India, this has meant flexibility in either adopting a local model, as originally intended, or extending the model to permit the inclusion of a governmental role in its financing and administration. For the Kyrgyz Republic system, this has meant backing away from the inherited Soviet system and revamping it to adjust to current realities. For the Afghan system, this suggests that reforms probably should begin modestly, perhaps phasing in coverage levels, types of enrollees, or geopolitical jurisdictions, in a gradual but methodical way and allowing for and even expecting modifications in the system as challenges emerge and new opportunities present themselves.

**Second, co-payments for primary care are of limited desirability.** Co-payments have been an important part of health policy in many developed countries, mainly to curb overuse (inefficient moral hazard spending) but also to share in the financing of healthcare at the time of provision. In developing countries, both of these functions are more problematic. The intent of implementing a health system is to increase the use of healthcare, so it is not clear whether a system should simultaneously create a barrier to access by imposing co-payments. Moreover, while the use of co-payments to enhance provider reimbursements and partially finance care is perhaps a more justifiable reason for including co-payments, the access issues they generate may be of overriding importance. The Thai system originally required what was considered a nominal 30-baht payment for all services, but it was eliminated when officials realized its impact on access. The Kyrgyz Republic system also imposed co-payments but permitted exemptions that were applied to more and more of the population. In the microinsurance model, co-payments occur as payments over an insurance cap (what has been called "balance billing" in the United States). That is, the provider is paid up to a certain amount by the microinsurance program and then may ask for an additional payment in excess of that amount; this represents a co-payment. This part of the microinsurance system is far from ideal but is a way for providers to obtain additional revenues and may not hurt access, assuming that the additional fees charged are commensurate with income and wealth. Afghanistan originally desired to impose co-payments but has eliminated them. This appears to be a

reasonable position for now, but it may need to be revisited in the future as the system matures and requires additional funding or as issues with overuse arise.

**Third, access to drugs is vitally important.** Pharmaceuticals in all forms, including vaccinations, can be of unparalleled effectiveness in improving health. They are also portable and thus can be transported to remote, mountainous, and dangerous areas more easily than other more labor- or capital-intensive health technologies. In Afghanistan, drugs currently represent an access problem even in cities, where hospitals cannot keep an adequate supply. Successfully solving this issue likely would generate major health gains and concomitantly increase political support for a new system. In the Kyrgyz Republic, the ADP has been a major success. In Thailand, the importance of pharmaceuticals is reflected in the national formulary (National List of Essential Medicines) and the attention that lack of access to new drug technologies has drawn to the way in which (and the amount) physicians are paid. One of the issues with microinsurance is that, because it is prototypically a local supply model, it does not provide a national vehicle for obtaining and distributing pharmaceuticals. For that reason, its usefulness as a model for Afghanistan would be limited.

**Fourth, data are necessary to run any system.** One of the reasons we chose the Thai system to review is that years of data have been collected on its various aspects. With these data, Thai analysts have been able to evaluate successes and failures, and predict the future course of the system. In this review, we thought the data from the Thai system would be useful for Afghanistan in making rough estimates of the increases in use, expenditures, and providers that would occur if the country implemented a new system. Also, the system for collecting data can itself be a vehicle for administering the system. The Thai system of eligibility is based on various identity cards that permit access to specific providers and allow data to be collected on each individual. Of the microinsurance systems, perhaps the most successful is the RSBY system, in rural India; its success is based in large part on the use of smart cards, which contain an individual's biometric and medical records. If such cards were distributed nationally in Afghanistan, the data they yielded would be of such high quality that virtually real-time system monitoring would be possible. This would solve many of the issues associated with administering a system in a country with a small formal economic sector and a remote population.

Afghanistan, of course, faces special challenges in the healthcare arena. The most important of these are the following:

**After years of war, Afghanistan is suffering from a massive depletion of its provider community.** While this also occurred in Kyrgyzstan after the demise of the Soviet system, the path back is not clear. How to stimulate the growth of an indigenous provider community in Afghanistan is an important goal for which no easy roadmap exists.

**Because of the lack of local providers, wealthier Afghans have sought care abroad.** These individuals represent a source of financing for any new system, and thus could be an opportunity to create one. A mechanism to staunch the flow of these funds abroad has not emerged.

**The persistence of armed conflict and terrorism in Afghanistan makes implementing a health insurance system difficult, if not impossible, at least in some geographical areas.** It is not clear that any developing countries have successfully implemented a health insurance system under similar circumstances.

**Afghanistan is a poor country that overwhelmingly relies on external NGOs to provide both actual care and money to pay for that care.** It would be difficult to identify another country with an economic situation similar to Afghanistan's that has moved successfully from such a high level of reliance on external sources of healthcare financing and provision to a totally, or even largely, internal system of financing and provision.

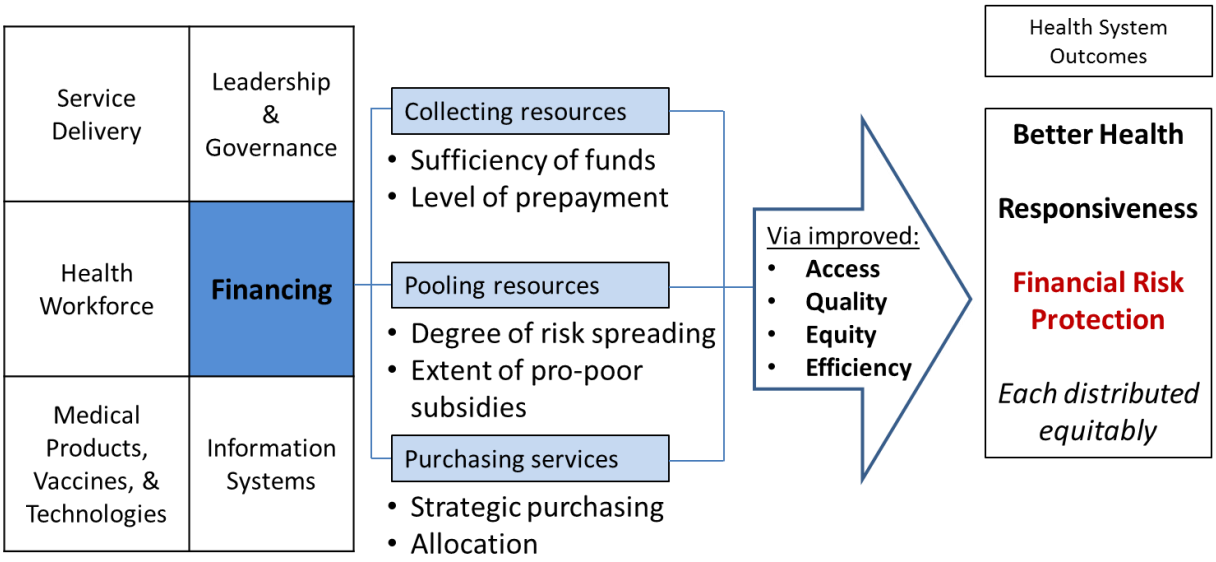
### *The prospects for universal healthcare for Afghanistan*

In its 2012–2020 Health Financing Policy report, the MOPH stated its intention to implement UHC in Afghanistan [8]. The 2010 WHO report *Health Systems Financing: The Path to Universal Coverage* suggests that the health financing decision process involved in reaching UHC involves three dimensions: (1) Population: Who is covered? (2) Services: Which services are covered? and (3) Financing protection: Proportion of the costs covered [67]. To achieve UHC in any country, policymakers must know the starting point of that country's healthcare system and assess the system's financial status and current constraints. In Afghanistan, limited health resources and supply constraints suggest that achieving UHC must involve trade-offs among these three dimensions of coverage. As illustrated in the case of Thailand, the path to UHC is long and requires many inputs.

UHC is regarded as a means to achieve several goals: expanding healthcare access and quality, increasing the use of services and community participation in the system, and pooling the financial risk of health expenses. In Afghanistan, a strictly defined plan has not been put in place to implement UHC but the MOPH has established a broad outline. According to Afghanistan's health financing strategy for 2014–2018, a new benefits package, known as the Universal Package of Health Services (UPHS), will be designed to be available to the entire population free of charge [78]. To cover additional services, a contributory system will be established and an "equity fund" will be set up so the poor can access it. This is quite similar to the approach that the Kyrgyz Republic has used over the past two decades [29]. To oversee the system, a National Health Fund (NHF) will be established. The NHF's responsibilities will be to pool financial resources for the UPHS and for the contributory system and to contract with healthcare providers [79].

The left panel of Figure 6 shows the six elements of a health system. Afghanistan is weak on all six and is working to improve them. No doubt more efforts are needed. Given this review's focus on health insurance, we will not pay much attention to the other five elements here, although this does not lessen their importance.

**Figure 6: Health Financing and Health System Outcomes**




Source: World Health Organization, 2010 [67]; Roberts et al., 2008 [80].

To make UHC in Afghanistan more likely, we have identified a number of directions that we think should be considered, based on our understanding of the state of the Afghan health system and the experience of other low-income countries in expanding access to healthcare. We list these below.

*Build political will through a phased approach to health financing reform*. Health financing reform is a long-term process; Thailand's experience has shown that it can take up to three decades to introduce targeted schemes for subpopulations to create universal access. A new administration in Afghanistan, following the 2014 presidential elections, opens up an opportunity to begin advocating the introduction of financial protection schemes and increasing government allocations to the health sector.

*Address bottlenecks in the health system for health insurance (legal, human resources, quality, access, awareness)*. To expand healthcare access to every citizen in the country, particularly those living in rural areas and having limited access to the BPHS, the country must develop a reliable registration system. A long-term investment in education and research and development is needed to ensure adequate numbers of healthcare workers, medicines and supplies, and health facilities. Drug shortages and long waiting lines are obstacles that prevent many Afghans from accessing the healthcare services covered by the BPHS [13]. Moreover, lack of infrastructure, unsuitable hospital conditions, and a shortage of trained healthcare workers—especially women—are some of the main challenges to rebuilding Afghanistan's healthcare system.

Thus, before a universal coverage scheme is adopted, the supply of healthcare requires extensive development. This includes increasing the numbers of health facilities, improving their condition, improving coordination between government and healthcare providers, and training more health workers. Policy options to allocate equitable healthcare resources, such as policies to retain health workers in rural areas, should also be considered. One of the successes of Thailand's UCS was the incentive-based medical education system: free education is contingent on serving in rural public health facilities for three years after graduation. Currently, higher education in Afghanistan, including medical and allied health professions, is free and funded by the government. Innovative efforts are needed to transition health professionals into the public sector to serve vulnerable populations.

As the UPHS and the contributory system expand incrementally, the MOPH needs to ensure that access to healthcare is increased sufficiently before stimulating demand. Properly increasing supply before increasing demand was an integral part of the "30-baht" expansion of health insurance in Thailand [51]. Although 90 percent of the population currently has some access to the BPHS system, this access is impeded by drug shortages, distance from district hospitals, and poor quality of services [13]. These issues should be improved before providing Afghans with health insurance, which will mean little without proper access to the healthcare system.

*Increase the fiscal space and use a combination of approaches to finance healthcare*. More resources must be devoted to the Afghan health sector to make UHC possible, especially given the uncertainty of future donor contributions. This will be possible only with continued economic growth. This is not an unreasonable proposition, given that Afghanistan's GDP has nearly quadrupled, from $4.5 billion in 2003 to $18 billion in 2011 [58]. The Kyrgyz Republic again offers a similar model [29]. UHC's implementation is unlikely to be an immediate fix for quality, access, and affordability concerns. Instead, it can be a way for Afghanistan to make a transition to a modern healthcare system. The benefits packages of the UPHS and the contributory system will need to adapt over time as per capita GDP increases. For example, Colombia expanded its health services in this manner, gradually expanding the scope of its health coverage as a function of available resources, with some means testing components [51].

The Afghan government must examine possible health financing models, including national health funds financed by tax revenues, social health insurance (SHI), and community-based insurance. Thailand's

experience with its UCS suggests that financing a health insurance scheme by using general tax revenue is suitable for a country with a large informal sector, from which it is hard to collect contributions from beneficiaries. One limitation of a tax-finance scheme is that the budget allocated to pay for healthcare is highly dependent on the country's economic growth as well as negotiations between the national health fund and government. In Afghanistan's case, raising resources for healthcare by pooling general budget revenues while collecting small, fixed co-payments from wealthy populations might be a good option, as it is virtually a form of compulsory health insurance contributions. Nevertheless, in the early phases of implementation, the country would need both financial and technical support from donors, and poorer households would have to be subsidized, or at least exempted from user fees.

The unique difficulties associated with delivering healthcare to the remote poor population mean this group will need special attention. Besides addressing issues of quality of care and the physical accessibility of health facilities (i.e., construction of roads and health centers), perhaps the most impressive model for providing healthcare to poor, rural, and remote populations that Afghanistan could follow comes from India. India successfully delivers healthcare to remote poor populations by implementing RSBY and the Andhra Paradesh program—government-run community health insurance schemes. The cornerstones of the programs are that they are cashless, paperless, and portable, with all of these elements intended to improve access to the healthcare system. These approaches are particularly well-suited to nomadic populations, such as those in Afghanistan's remote regions. The BPHS has had some success in portability with health subcenters and mobile health teams. The MOPH could consider RSBY and the Andhra Paradesh in the implementation of UHC, to improve healthcare access in remote areas of Afghanistan [81].

*Take a step-by-step approach and design schemes targeting a particular population*. UHC should provide healthcare access to all citizens in the country. However, in practice, it is almost impossible to provide access to UHC simultaneously, particularly when patients are unable to contribute funds. Thailand took more than 30 years to merge its different insurance schemes into one; Taiwan had 10 insurance schemes covering particular subsets of the population before it established a single national health insurance scheme in 1995 [82]. In establishing health insurance schemes, Afghanistan needs to consider both the capacity to collect resources from beneficiaries and the health needs of the most vulnerable populations. Health insurance could start from the formal sector and those vulnerable populations often subsidized by the government. Healthcare must be provided to the more disadvantaged groups of the population either at a nominal cost or free, due to their vulnerability to catastrophic loss [67]. For instance, the Thai MWS, the predecessor of the UCS, was launched to provide healthcare access to the disadvantaged groups in the population, including the elderly, children, and the disabled. In Afghanistan's case, in addition to enrolling formal sector employees, disadvantaged groups, including the poor, disabled, and residents in remote areas, should receive some kinds of subsidized care. Nonetheless, as subsidized healthcare services are provided to more people, the extent to which health services are covered under a universal coverage policy might be compromised.

### *Design health insurance tailored to Afghanistan for sustainability.*

**Emphasize family-based insurance.** The contributory system in Afghanistan should issue insurance policies to families rather than individuals. This is in accordance with typical CBHI [19]. The large portion of Afghans under the age of 15 and high unemployment rates both would cause individual-based plans to exclude much of the population from participation in the contributory system. For similar reasons, when considering provision of health insurance through employers in the formal sector, policymakers shou*ld target families rather than individuals, to expand the coverage.*

**Limit user fees for primary care.** User fees are not intended to be a part of the UPHS, given its mission to be free; however, the contributory system has no such restriction as long as the MOPH's 2008 user fee ban does not extend beyond the BPHS. For this reason, any reintroduction of user fees should be means

tested to allow for access by the poorer segments of the population and avoid a popular backlash. Afghanistan's sole lengthy experience with user fees in healthcare financing produced such a negative reaction that it led to a uniform ban on them [15]. Thus, UHC in Afghanistan should not seek to rely on cost sharing as a significant source of revenue, although user fees could be considered for secondary and tertiary care with supplemental policies to subsidize the poor.

**Focus on secondary care.** Inpatient OOP expenses cannot decrease without a program directed at increasing the quality of secondary care throughout Afghanistan. Perhaps because of the dismal state of Afghanistan's national hospitals [16], India has become a medical tourism hub for Afghans. Since 2010, more than 100,000 medical visas have been issued by the Indian government to Afghans. Quality inpatient care is cited as a key factor in Afghan demand for Indian healthcare services [83]. This issue constitutes a huge portion of OOP expenses: 38.2 percent of OOP funds in the private sector are spent on inpatient care, and 73 percent of households seeking healthcare abroad want inpatient care [10]. The number of Afghans seeking healthcare abroad represents an opportunity for local suppliers to enter a presumably lucrative market.

**Include prescription drugs in the benefit design and monitor prescription drugs.** Modern prescription drugs are effective in improving health and curing disease, so access to them should be promoted. Stockouts of drugs represent a major issue in Afghanistan; they drive patients to seek care in private clinics and hospitals. Drug availability is also a major driver of Indian medical tourism [83]; this could be partially decreased by simply reallocating funds to the provision of prescription drugs. This also will be required to achieve a significant reduction in OOP expenses. If purchasing drugs is handled by a collective buyer, such as the NHF, increased market power could enable a reduction in total expenses on pharmaceuticals. The NHF, due to the large quantity of drugs it potentially could buy, would be able to exert pressure on pharmaceutical suppliers and thus pay less for pharmaceuticals per unit. Experience from the Kyrgyz Republic shows the beneficial impact of including drug benefits in a health insurance plan.

At the same time, the BPHS has placed considerable emphasis on monitoring and evaluation to improve its service delivery [84]. Through the creation of the NHF, monitoring and evaluation should be extended to oversee the prescribing of drugs to patients. Concerns have been raised that providers are too liberal in prescribing drugs to patients, leading to an excess demand for some drugs [10].

**Limit the initial services provided to those for whom coverage is financially feasible.** Guaranteeing the benefits of the BPHS, and especially the EPHS, to the entire population will be costly, particularly with respect to secondary and tertiary care. It may be that the UPHS, once developed, initially would include fewer covered services than those currently provided in the BPHS and EPHS. It also may well be that providing the benefits of modern hospitals to all Afghan citizens is simply not within the MOPH's current logistical and financial capacity. Further cost analyses will be needed to determine the coverage scheme of the UPHS. If it is to be truly universal, it likely will cost considerably more than the current BPHS and EPHS. In addition, limiting initial services to certain populations may be necessary. Thus, any program probably would need to be phased in regarding both services covered and populations served.

**Promote efficiency through payment to and engagement of providers.** One of the most important management tools to promote efficiency is the appropriate provider payment mechanism. The lesson from Thailand's UCS suggests that a prepayment method can help contain healthcare costs, particularly in resource-constrained developing countries. However, for Afghanistan, specific reimbursement mechanisms for different healthcare services (such as outpatient and inpatient care) need to be decided based on the availability of healthcare providers and other institutional factors of the Afghan health system.

The main strength of the current Afghan healthcare system is the established network of healthcare facilities through the BPHS and EPHS; although perhaps not yet fully developed, this could help contain healthcare costs, as a primary care-based system did in Thailand. In each of the four schemes prior to the UCS in Thailand, benefits packages were set and linked to contracted providers in networks (either a public network or one of private health facilities). The current health packages in Afghanistan still can serve as guidelines for the healthcare services to be covered under a universal coverage policy. Decisions to include other health interventions or exclude expensive treatments should be made based on careful cost-effectiveness analyses and recognizing that extending even these basic packages to the entire population of Afghanistan is far from complete.

UHC in Afghanistan should encompass the private sector, to give beneficiaries an option for higher-quality yet affordable and equitable care. At present, patients with concerns about the quality of public facilities, access to pharmaceuticals, and medical needs for specialized inpatient care have no choice but to use the private sector [16], although the quality of the private sector needs to be enhanced, too. This is unlikely to change in the short term. Perhaps more important, OOP costs cannot be controlled without the inclusion of the private sector in a UHC scheme. Sixty-eight percent of OOP payments—almost 6 percent of average annual income—are spent on healthcare at private facilities [10].

# CHAPTER II: LEGAL ASSESSMENT OF HEALTH INSURANCE IN AFGHANISTAN

## Background

Social health insurance is insurance managed by the government through independent, semi-independent, or governmental entities. Enrollment in SHI is often mandatory. Over the past decades, many developing countries have implemented SHI successfully. WHO recommends SHI as a means to move a country toward UHC [67].

The purpose of this legal assessment is to provide an overview of the key regulatory components of successful SHI schemes in other developing countries; ascertain the legal opportunities and barriers for SHI in Afghanistan; and recommend a way forward. The assessment also examines laws and regulations to prepare for a nonprivate voluntary insurance scheme as a supplement.

## Method

After consulting with government officials, we collected and reviewed the following relevant laws, treaties, regulations, and policies that affect the implementation of health insurance in Afghanistan:

- Constitution of Afghanistan
- Public Health Law
- International Covenant on Economic, Social and Cultural Rights
- Convention on the Elimination of All Forms of Discrimination against Women
- Convention on the Rights of the Child
- Labor Code
- Civil Code
- Law on State-Owned Enterprises
- Ministry of Finance Privatization Policy
- Public Finance and Expenditure Management Law
- Insurance Law
- Afghanistan Investment Support Agency Private Hospital Licensing Procedures (Regulations)
- Pharmacy Regulation
- Regulation on the Manufacture and Importation of Medicines and Medical Equipment
- The Regulation on Private Medical Laboratories
- Regulation on Private X-ray Clinics
- National Essential Drugs List

Further, laws that are not related to SHI but can serve as models or shed light on the components of an SHI scheme were also identified, collected, and reviewed. These laws are:

- Private Investment Law
- Afghanistan Telecommunications Regulatory Act (ATRA)
- Road Toll Law
- Municipality Law
- Procurement Law and Regulations
- Income Tax Law and Regulations

Our review of practices and regulations in other developing countries that have successfully implemented SHI revealed the following main tasks, and we analyzed Afghanistan's legal framework in light of them:

- Establishing an implementing institution
- Collecting revenue
- Pooling resources
- Purchasing services
- Exercising regulatory authority

The relevant laws, policies, and regulations were identified and gathered from government agencies and stakeholders, open source materials, as well as from personal libraries. We further requested laws, policies, and regulations from relevant stakeholders, such as the MOPH and the MOF. Visits to the Ministry of Justice (MOJ) and the National Assembly and Ministry of Labor and Social Affairs (MOLSA) were not fruitful in this regard.

A review of the research briefings and reports from the World Bank's Universal Health Coverage Studies Series, the Afghan Ministry of Public Health's Public Policy, and the Afghanistan Research Evaluation Unit was conducted to establish the context of health insurance in developing countries and in Afghanistan.

Integral to this study were interviews with representatives of key stakeholders in establishing SHI schemes. The officials represented the following agencies:

- MOF
- Grants Contract Management Unit (GCMU), MOPH
- Microfinance Investment Support Agency
- Afghanistan Investment Support Agency (AISA)
- National Assembly
- Health Economics and Finance Directorate, MOPH
- Futures Group
- Judicial Affairs Office, MOLSA

These interviews provided institutional history of health insurance in Afghanistan, an assessment of the political will to undertake the tasks that SHI requires, and perspective on issues that arose in establishing other governmental entities. The interviews were also a source of information about laws, regulations, and policies in Afghanistan and other developing countries. They focused on the main SHI tasks listed above that were relevant to each stakeholder's area of expertise.

## Lessons Learned from the Legal Experience of Developing Countries

The concept of SHI as a way to promote health coverage for the poor has steadily gained acceptance throughout the developing world. Notably Thailand and Kyrgyz Republic—discussed in the first chapter—have implemented SHI schemes, as have Costa Rica, Georgia, Laos, Nigeria, and Vietnam. There is much in the legal and regulatory experience of these countries that can be applied in Afghanistan.

### *Establishing a central entity or institution to implement SHI*

Most of the SHI schemes reviewed were set up by law or presidential decree [85–90]. This has the effect of allowing the government clear authority to implement an SHI scheme. The law also usually clarifies the right to health and healthcare services [85–90]. Often, health insurance laws include the establishment of a supervisory board of directors, made up of high-level governmental officials [86–88]. The law authorizes the establishment of a central entity to manage the health insurance scheme.

*Independence of the central health insurance authority*

Most of the central entities that implement SHI schemes are independent or semi-independent. Some central entities have shifted from independent to semi-independent status in response to the political climate at the time.

Independent entities are usually directly accountable to the head of the government or a high level authority, and not subordinate to a health ministry or its equivalent. The independence of an entity is accompanied by a similar level of authority and responsibility to implement the health insurance scheme. In the Kyrgyz Republic, the central health insurance entity, the MHIF, is independent and has broad authority to purchase services and pool resources from the government and funds earmarked from the mandatory health insurance contribution [88]. Thailand's NHSO, which implements the UCS, is also an independent entity [91], with the authority to register beneficiaries, contract with service providers, and administer the fund [91].

In many countries, the central entity managing the health insurance scheme is largely independent but within the purview of the health ministry. In Brazil, for example, the Unified Health System (Sistema Único de Saúde, SUS) largely manages its own affairs but is overseen by the MOH [92]. Semi-independent entities in other countries have much less authority than Brazil's. In Georgia, for example, the Medical Insurance Program is the responsibility of the Ministry of Labor, Health and Social Affairs and its implementing agency, the Social Services Agency. The program has no titular head; it gives contracts to private insurance companies to purchase the services of health providers. The Social Services Agency, for its part, has very little responsibility beyond managing the contracting process. The authority for policymaking, financing (through tax revenue), and program monitoring lies with the ministry [93].

It is usually beneficial for a central health insurance entity to have at least some independence from the government. The advantages of independence are as follows:

- Budgetary independence ensures that the population is more willing to contribute financially
- Decision-making independence allows the fund to set policies focused on long-term objectives rather than short-term political interests
- Management and structure can be organized in a more efficient manner

Either way, government support is needed, especially when the central entity is being established, to put legal frameworks in place [94].

### *Collecting revenue*

Many countries have instituted a mandatory payroll or excise tax earmarked for health insurance as the main source of SHI funds and separate from the government's general tax revenue [93, 95]. Evidence from developing countries [80, 83] indicates this is an equitable way for members of the formal economic sector to participate in SHI, with contributions proportional to enrollees' income [93, 96].

In addition, most countries have mandated compulsory prepayment of SHI premiums collected both from the formal and informal sectors. Others have instituted a mixture of compulsory and voluntary payment of premiums to fund SHI [93, 96]. Some have mandated the compulsory collection of prepaid premiums from the civil service and private sector and allow voluntary prepayment from those without formal-sector employment [93, 95]. Table 10 shows the mandatory contribution to SHI in five countries in Central and Eastern Europe.

**Table 10. Earmarked contribution to social health insurance in five countries in Central and Eastern Europe**

| Country | Year of Introduction | Contribution Rate |
|---|---|---|
| **Albania** | 1995 | 3%–5% of wages, split equally between employers and employees |
| **Bosnia and Herzegovina** | 1997 | 18% of net salary; 13% paid by employee and 5% by employer |
| **Bulgaria** | 1999 | 15% paid entirely by employee since 2003 |
| **Kyrgyzstan** | 1996 | 2% paid entirely by employer |
| **Georgia** | 1995 | Employers 3%, employees 1% of salary |

Source: Rechel, et al., 2009 [96].

### *Pooling resources*

Another task of SHI is pooling resources from sources other than beneficiaries' premiums, such as government subsidies and funds from international donors. In Laos, Article 7 of the Decree on the National Health Insurance Fund stipulates the fund's revenue sources:

*(1) Contribution of individuals, juristic entities, and local and international organizations;*
*(2) State budget;*
*(3) Health insurance fund from State Authority for Social Security (SASS) for civil servant;*
*(4) Health insurance fund from Social Security Organization (SSO) for enterprise employee;*
*(5) Community Based Health Insurance (CBHI) for informal sector;*
*(6) Health Equity Fund (HEF) for the poor;*
*(7) Other related fund;*
*(8) Interest from saving account of the National Health Insurance Fund.*

The SHI schemes of Colombia, India, and Mexico pool both taxes and mandatory premiums from the general population [88]. Resource pooling has varying levels of complexity. In China, resources are pooled at the county level. Georgia and Mexico pool resources at the state or regional level and the Philippines pools resources at the national level [88]. For the purposes of this legal analysis, the important point is the authority of the central health insurance entity to pool resources.

### *Purchasing services*

Purchasing health services for those who are publicly insured is vital to an SHI scheme. A central health insurance entity must have the authority either to purchase services or delegate that responsibility, as in Georgia [93]. Most SHI schemes—Nigeria's and Thailand's, for example—explicitly allow the central health insurance entity to contract with both public and private qualified health services providers for enrollees' services [86, 89]. A flaw in the Kyrgyz Republic's healthcare system is that state budget funds cannot be used to purchase medical services from private health providers [30]. Evidence from these countries shows that when a single entity is the purchaser of services, it can exert significant policy influence on service providers, as well [30]. The separation of purchaser and health provider also improves efficiency in using available health resources.

### *Exercising regulatory authority*

Regulatory authority varies significantly from country to country, in step with the degree of independence of the central health insurance entity.

For countries whose health insurance entity is largely independent, such as the Kyrgyz Republic, regulatory authority is fairly wide-reaching. In the Kyrgyz Republic, the health insurance entity is responsible for managing contracts, administering payments to health providers (purchasing services), monitoring the quality of health services, and guarding patients' rights [88].

In countries whose health insurance entity is semi-independent and subordinate to the health ministry, regulatory authority decreases. In most countries, the health ministry or equivalent governmental institution is tasked with overall authority to license and regulate healthcare providers. Common examples of a health ministry's regulatory authority are setting financial policy, advocating revenue allocation to the health insurance entity, and monitoring and evaluating the health insurance scheme. Some regulatory authority is entrusted to the central health insurance entity to implement and manage the policy of the health insurance fund. In some instances, the regulatory authority of both entities, meaning the health insurance entity and the health ministry, causes tension. In Thailand, for example, there has been friction between the supervisory board of the health insurance fund and the health ministry, which has complained that the supervisory board infringes on the ministry's core duty of guarding the public health. This lack of clarity on roles has caused some animosity toward the SHI scheme [91].

Whether held by a health insurance entity or a supervisor such as a health ministry, key authorities are licensing, auditing, and protecting patient rights [86, 30].

## The Potential in Afghan Law for a Social Health Insurance Scheme

Three of the chief tasks of an SHI system just discussed—pooling resources, purchasing services, and exercising regulatory authority—will be relatively easy to implement, as they largely depend on the legal structure that the central health insurance entity is given.

Establishing a central health insurance entity to conduct these tasks, however, will be difficult. Under current Afghan law, there is no easy way to endow such an entity with the authority it will need to implement SHI effectively.

The biggest challenge for SHI will be the power to collect revenue. Afghanistan's adoption of international treaties obliges the state to provide emergency health services for abused women and primary healthcare to children. This legal justification for free primary healthcare may interfere with the government's ability to introduce SHI and collect revenue to fund it, by including primary services in a health insurance benefits package, as many other developing countries have done.

In addition to this fundamental hurdle for revenue collection, dedicating a source of revenue for SHI will also be difficult. Although introducing legislation that earmarks certain taxes for an SHI scheme is possible, passing laws in Afghanistan is a long and cumbersome process.

If the source of revenue is not an earmarked tax, the MOPH, or the central health insurance agency yet to be established, will have to advocate appropriation of general government funds during the annual governmental budgetary process detailed in the Public Finance Expenditure Management Law. If the agency is set up to be under the MOPH, it will submit its budget to the ministry for approval and inclusion in the ministry's larger budget request. If the agency is set up to be independent, it will request its budget directly from the MOF [97]. This, in turn, exposes the SHI to the risk of being de-funded by the Afghan Parliament. A nongovernmental source of revenue will protect the SHI scheme considerably.

In the rest of this chapter, we shall again review each task crucial to a successful SHI scheme—this time with respect to the current legal framework in Afghanistan, down to the regulatory level—and discuss the options available to set the stage for that task to be conducted. First, though, let us look more closely at the legal right to health and the potential threat it poses to an SHI scheme.

### *The right to healthcare*

The strongest legal basis for Afghanistan to provide free health services is Article 52 of the Afghan constitution [98], which states:

*The state shall provide free preventative healthcare and treatment of diseases as well as medical facilities to all citizens in accordance with the provisions of the law. Establishment and expansion of private medical services as well as health centers shall be encouraged and protected by the state in accordance with the provisions of the law. The state shall adopt necessary measures to foster healthy physical education and development of the national as well as local sports.*

There is ambiguity here on the interpretation of "free preventative healthcare…." The clause "in accordance with the law" allows for interpretation of this article by legislation. Article 2 of the Public Health Law [99] provides such interpretation, as follows:

*Provision of Free Medical Services*

*The Ministry of Public Health is responsible to provide means of prevention and treatment of contagious diseases, natural disasters and free primary health services to citizens of the country.*

*Provision of secondary curative services is done within the financial limits of the government against a certain wage according to relevant statutory document.*

*Foreign citizens and non-citizens, resident in the Islamic Republic of Afghanistan shall receive the same level of medical services as those provided to the citizens of the country.*

Here, there is clear justification for provision of free primary health services and the means of prevention and treatment of contagious diseases and injuries from natural disasters. The government agrees with this analysis, in that it already provides fully subsidized health services to the Afghan public. Currently, the government covers approximately 65 percent of the population through the provisions of the BPHS and the EPHS, which are fully subsidized by international donors [100].

There is a legal gap in comprehensive health coverage, in that secondary curative services are limited by the government's financial means "against a certain wage." This clause introduces the limitation of the government's financial means and opens the door to charging patients user fees and payments and collecting premiums.

This gap has led to ambiguity and conflicting opinions on the extent of health services the Afghan government is required to provide. Briefly, if the Afghan government is mandated to provide free medical services to the public, collection of premiums may be in conflict with the law, depending on how "free care" is defined. This issue is discussed more thoroughly below, in the section on revenue collection.

Articles 53 and 54 of the constitution offer further support for the provision of health services. Although they do not clearly mandate free provision of healthcare, they do mandate that the state provide a wide range of aid to women, children, orphans, survivors of martyrs, and missing persons as well as ensuring the physical health of families.

Article 53 of the Constitution states:

*The state shall adopt necessary measures to regulate medical services as well as financial aid to the survivors of martyrs and missing persons, and for reintegration of the disabled and handicapped and their active participation in society, in accordance with the provisions of the law. The state shall guarantee the rights of retirees, and shall render necessary aid to the elderly, women without caretaker, disabled and handicapped as well as poor orphans, in accordance with the provisions of the law.*

Article 54 of the Constitution states:

*Family is the fundamental pillar of the society, and shall be protected by the state. The state shall adopt necessary measures to attain the physical and spiritual health of the family, especially of the child and mother, upbringing of children, as well as the elimination of related traditions contrary to the principles of the sacred religion of Islam.*

Here, the state is tasked with regulating medical services and reintegrating the disabled and handicapped. It can be further extrapolated that the term "necessary aid" in Article 53 encompasses healthcare for the elderly, the disabled, the handicapped, and poor orphans. Article 54 provides further justification for social protection, by mandating that the state adopt necessary measures to attain the "physical" health of the family. Given the positive impact that SHI has had on the health of marginalized groups in other developing countries, SHI in Afghanistan can be expected to fulfill the state's need to protect marginalized groups and help them obtain health services.

Below the Afghan constitution in legal authority, but above Afghan law, are international treaties ratified or acceded to by the Afghan government. Many of these treaties provide support for the provision of health services. Whereas the International Covenant on Economic, Social and Cultural Rights provides for the right of everyone to healthcare, other treaties, such as the Convention on the Elimination of All Forms of Discrimination Against Women and the Convention on the Rights of the Child, mandate special measures to meet the needs of women and children [101–103].

Below the Afghan constitution and international treaties in legal authority are national laws that support the overall right to healthcare. While these laws do not clearly support the provision of health services, they do justify provision of health services to certain members of the Afghan population. The Civil Code mandates health services for civil servants [104], and the Law on the Elimination of Violence against Women [105] mandates free emergency health services to victims of violence, for whom mechanisms other than SHI could be developed.

The Health Law also mandates free primary health care. How the term "free" is interpreted will determine whether revenue collection under an SHI scheme will conflict with the constitution and associated laws.

### *The legal environment for establishing a central entity or institution to implement SHI*

Legally, a health insurance scheme may be established under the current legal framework or by new legislation. The current legal framework offers the opportunity for quicker establishment of a central entity but one with weak and ambiguous legal authority. New legislation will allow the Afghan government to clearly set its intention and provide strong legal backing for an SHI scheme. The downside here is the country's slow and complex legislative process.

Neither of the two options available under the current legal framework would permit the establishment of an implementing agency that meets the Organisation for Economic Cooperation and Development's standard for SHI:

*…a legally mandatory system that covers the majority or the entire population through health insurance run by a designated third-party payer, and involves non-risk related contributions that are kept separate from taxes.*

Option one under the current legal framework is setting up a central entity as a state-owned enterprise. Under the State Owned Enterprise Law, the set-up is relatively easy [106]. It may be established by request of the MOPH and approval of the Council of Ministers. However, there is a strong move toward privatization of state-owned enterprises; thus a new state-owned enterprise is not politically feasible [107].

Option two under the current legal framework would be to follow the path of other semi-independent bodies established in Afghanistan: the Afghanistan Investment Support Agency, the Microfinance Investment Support Facility Agency, and the Afghan Telecommunications Regulatory Authority. All were established by presidential decree, but this happened before the National Assembly was constituted,

Despite the defects of the legislative route to a central health insurance entity, new legislation is what is needed. New legislation would definitively lay out the government's intention to enact SHI in Afghanistan; establish the central health insurance entity necessary to manage and implement the health insurance program; and clarify the rights and responsibilities of that entity and of related institutions, such as the MOPH and MOF.

*The legislative process*

According to Article 95 of the constitution, the National Assembly or the Afghan government may propose laws. The processes are detailed below.

As detailed in Article 79 of the Constitution of Afghanistan, in case of immediate need and during the recess of the House of Representatives (Wolesi Jirga), legislative decrees may be issued by the government and endorsed by the president. Upon endorsement by the president, a decree acquires the force of law. However, legislative decrees, also commonly called presidential decrees, must be presented to the National Assembly within 30 days of its first session. If the National Assembly rejects a decree, it becomes void. Some argue that presidential decrees must be approved by the National Assembly after it convenes. Although this interpretation is arguable—the text of Article 79 does not state this explicitly—it has weakened the implementation of more controversial decrees, such as the Law on the Elimination of Violence against Women. Article 79 states:

*During the recess of the House of Representatives, the Government shall, in case of an urgent need, issue legislative decrees, except in matters related to budget and financial affairs. Legislative decrees, after endorsement by the President, shall acquire the force of law. Legislative decrees shall be presented to the National Assembly within thirty days of convening its first session, and if rejected by the National Assembly, they become void.*

Passing a health insurance scheme by means of a presidential decree during the recess of the National Assembly is inadvisable, because the scheme might then be considered illegitimate by the public, as is the case with the Law on the Elimination of Violence against Women. Further, it is unlikely that a strong legal argument can be made that a health insurance scheme fulfills the "urgent need" that Article 79 stipulates.

Under the constitution, the National Assembly may also propose new laws. According to Article 97, if drafting a law is proposed by 10 members of either the Wolesi Jirga ("the house of the people") or the Meshrano Jirga ("the house of elders"), and approved by one fifth of the initiating house, it will be included in the agenda of the initiating house.

Neither presidential decrees nor the proposal of new laws in accord with Article 97 are used as often as the following legislative process:

A ministry sends a request to the MOJ for new legislation to be included in the MOJ's work plan. The MOJ either accepts or rejects this request based on its capacity. If it accepts, the MOJ then includes the new legislation in the legislative work plan that it submits to the Council of Ministers, which usually approves the plan and sends it to the President's office for confirmation.

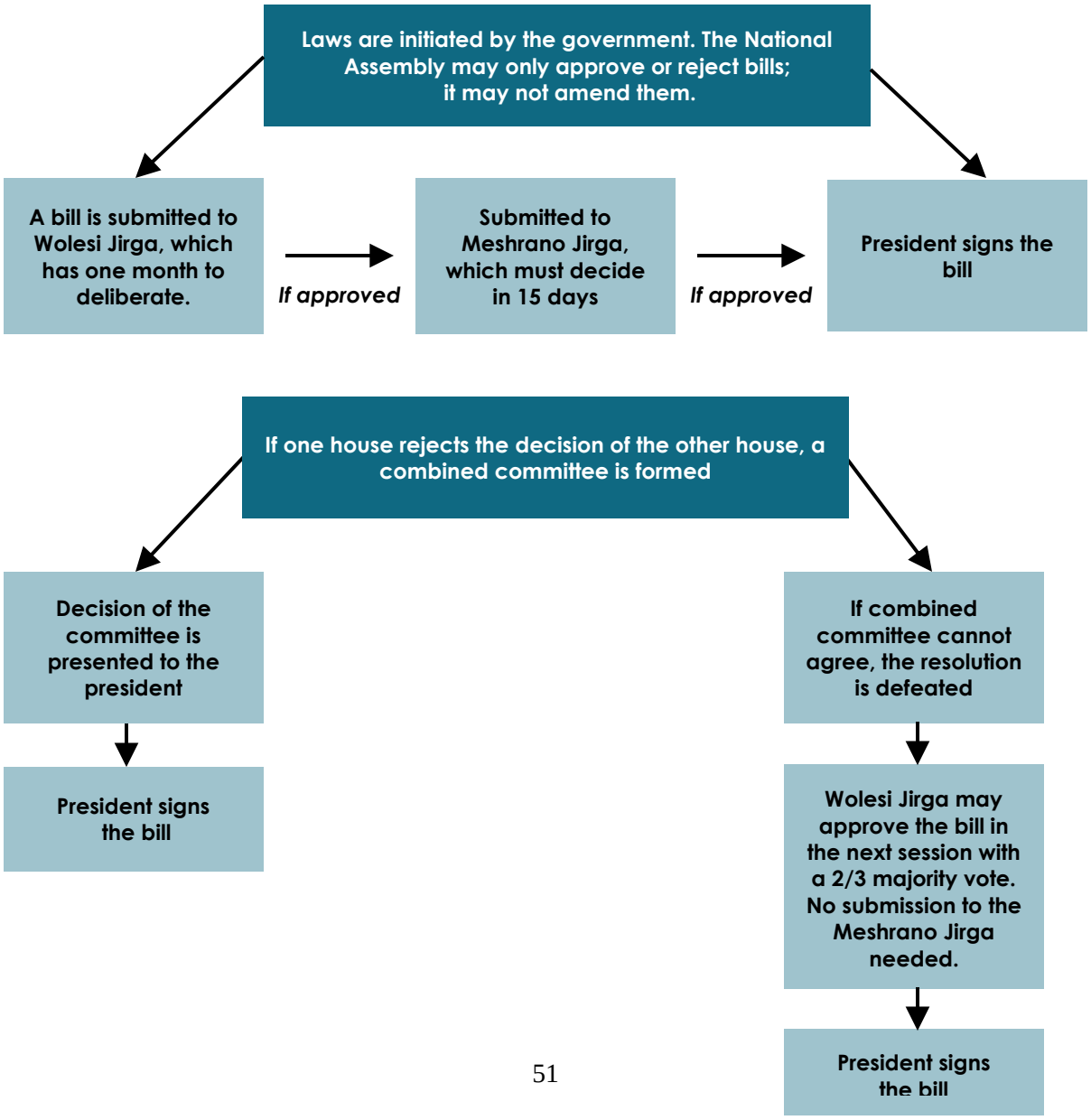
The ministry then sends the draft of the law it is proposing to the MOJ's Taqnin (legislative affairs) Department. (In some instances, the proposing ministry sends the draft law to the MOJ's Taqnin

Department prior to the approval of the MOJ's work-plan detailed above.) The Taqnin Department reviews and analyzes the law for compliance with and possible contradiction of other laws and the Afghan constitution. If appropriate, the MOJ sends the draft law to the MOF and other relevant ministries for approval. There is a significant backlog of laws at the MOJ.

If approved by the Taqnin Department, the proposed law is transferred to the Ministry of Parliamentary Affairs. This ministry then introduces the draft law to the Wolesi Jirga, which must approve, reject, or amend the bill within one month. If approved, the bill is submitted to the Meshrano Jirga, which must review and decide on the bill within 15 days. In reality, there is a significant backlog of laws at both houses. But if they both approve the draft law, the Ministry of Parliament then sends the approved law to the President's Office, as described in Article 97 of the constitution. The President then has the right to approve or reject the law within 15 days. If rejected, Article 94 of the constitution says that a two-thirds majority of the Wolesi Jirga may override the veto.

Article 95 of the constitution states that only the government may propose drafting the budget or financial affairs laws.

**Figure 7: Afghanistan's Law-Making Process**



If the law is approved by the aforementioned entities, the Taqnin Department is tasked with ensuring the accurate printing in both Dari and Pashto in the Official Gazette.

The speed of the process is indicated by the backlog. More than 100 draft laws are pending in Parliament. At least eighty are pending in the Taqnin Department. The number of draft laws pending at the various ministries is unknown.

Another concern raised by new legislation is the strong possibility that stakeholders such as the Taqnin Department or Members of Parliament will change the law a ministry proposes. Strong ownership by the MOPH to guide SHI law through the legislative process without changes will be essential. According to a legal expert in the Parliamentary Affairs office, without close shepherding by both the MOPH and the President's Office through the legislative process—and especially through the MOJ's Taqnin Office and the National Assembly—new legislation is unlikely ever to be approved.

Notwithstanding these impediments, a new law can clarify the right to health, set up the implementing agency in a clear and organized fashion, clarify the authority and responsibilities of all entities involved, and set up a central governing council made up of high-level governmental officers [86, 87, 93]. Prior to any new legislation, the buy-in of all key stakeholders—the MOPH, the President's Office, the MOF, and Public Health committee members in the National Assembly—must be gained. Alliances with women's rights groups, children's rights groups, health advocacy organizations, and international donors should be explored.

*The central health insurance entity's degree of independence*

Ideally, the central health insurance agency should have the autonomy to collect revenue or have a reliable source of revenue, separate from general tax and budget; to pool funds; and to purchase services [88]. An entity constituted outside of the Afghan government, in the private sector, is unlikely to be able to fully execute these functions, due to the public nature of SHI.

Although the aforementioned Afghanistan Investment Support Agency, Microfinance Investment Support Facility Agency, and Afghan Telecommunications Regulatory Authority all have significant autonomy, all are subject to government supervision to some extent. For example, the Afghanistan Investment Support Agency (AISA) was set up under the Private Investment Law as a limited liability company, owned by the Afghan government [108]. AISA collects business registration fees from Afghan companies and is required to provide financial reports to the Ministry of Commerce but has budget authority to spend the collected fees at will. The agency initially had international donor funding but is now supported by the revenue it generates. There is significant legal ambiguity surrounding AISA's legal structure; indeed, many consider it to be legally unsound, even though it was constituted by the Private Investment Law. Because AISA is a limited liability company but owned by the government, some argue that AISA is, in fact, a state-owned enterprise, contrary to government policy. The extent of AISA's tax exemption as a quasi-governmental entity has also been questioned. Efforts are underway to clarify AISA's status. Therefore, setting up the SHI entity as a government-owned limited liability company is inadvisable.

The Afghanistan Telecommunications Regulatory Authority (ATRA) was set up by the Telecommunications Law [109]. ATRA is under the Ministry of Communications but has an independent budget and an independent organizational structure. The board consists of ministers who are responsible for regulating ATRA. This would be an ideal model for an SHI scheme. It would encourage the MOPH's buy-in, by putting the potential central SHI entity under the MOPH's aegis, but also give the entity an independent budget and organizational structure.

### *The legal environment for collecting revenue*

Currently, only the MOF has authority for mandatory collection of revenue from Afghan citizens or legal bodies in Afghanistan. Therefore, giving a central SHI agency such authority will require new legislation. Some potential sources of revenue collection are the following:

- General tax
- Mandatory collection of prepaid premiums or earmarked tax
- Voluntary prepayment of premiums
- Either mandatory or voluntary payment of premiums by employers on behalf of their employees

Donor funding for health services is another option, though less secure and sustainable [110]. Each type of revenue triggers legal responsibilities and complications under the Afghan legal framework.

#### *General tax*

In some countries, government subsidizes a health insurance fund, primarily through taxes. A tax may be an efficient means to collect revenue from the formal sector in Afghanistan. As evidenced in other developing countries [90, 93], it is an equitable way for members of the formal sector to participate in SHI [93, 30].

Under Article 42 of the Afghan Constitution, all general taxes must go the Afghan government's central account. It states:

*Every Afghan shall pay taxes and duties to the state in accordance with the provisions of the law. No taxes or duties shall be levied without legal representation. Tax rates and duties as well as the method of payment shall be determined, with due respect to social justice, by law. This provision shall also apply to foreign individuals and organizations. Every kind of tax, duty as well as paid incomes shall be deposited to a single state account.*

The Public Finance Expenditure Management (PFEM) law will then apply [97]. This law places funds from the central state account under the jurisdiction of the Wolesi Jirga, in the National Assembly. This house would have the authority to decrease the budget for health or defund it altogether. Article 91.2 of the Afghan Constitution states:

*The House of People (Wolesi Jirga) shall have the following special authorities:*

*2. Decide on the development programs as well as the state budget*

This, in turn, exposes SHI to potentially significant risk.

#### *Mandatory prepayment of premiums or earmarked tax*

In conversation with the Deputy Minister of Finance, a way around this risk emerged. A new earmarked tax for SHI could be modeled after the recent Road Toll Law. This law applies one Afghani tax per imported liter of fuel, instead of a toll tax. The funds will still have to be collected by the MOF and turned over to the Ministry of Public Works. Similarly, a tax could mandate that the funds raised should cover the costs of both primary and secondary health services for Afghans.

In most countries implementing SHI, the main source of funding for it is through compulsory prepayment of premiums from enrollees. The compulsory prepayment of premiums may be collected from the formal sector and the informal sector. An alternative is the compulsory collection of prepaid premiums from the formal (civil service and private sector) sector and voluntary prepayment from those without formal-

sector employment. A third scenario is to allow a gradual roll-out, with voluntary payment at the start and gradual mandatory prepayment as the health insurance scheme gains credibility.

Mandatory prepayment of premiums is often labeled an earmarked tax, even though it does not fit the exact definition of a tax. Article 1(2) of the Income Tax Law [111] defines a tax as follows:

*(2) Tax is a compulsory payment collected from natural and legal persons in accordance with the provisions of this Law for the purposes of financing of government and social welfare without the taxpayer receiving any direct goods or services from the government.*

Because the taxpayer would receive healthcare services from the government, the mandatory payment of premiums may not be considered technically a tax. Legislation would still be necessary to clarify this. But compulsory prepayment of premiums will require legislation, in any case, to be in compliance with Article 42 of the constitution, which states:

***Every Afghan shall pay taxes and duties to the state in accordance with the provisions of the law**. No taxes or duties shall be levied without legal representation. Tax rates and duties as well as the method of payment shall be determined, with due respect to social justice, by law. This provision shall also apply to foreign individuals and organizations. Every kind of tax, duty as well as paid incomes shall be deposited to a single state account.*

Therefore, any attempts to levy earmarked taxes or duties on the Afghan public must be in accordance with the law.

### *Voluntary prepayment of premiums*

If the prepayment of premiums for health services is voluntary, then the funds cannot be considered a tax, which, by definition, is mandatory.[15] However, funds generated this way will likely not be sufficient to support SHI, due to adverse selection. As just described, a variety of scenarios may apply, ranging from full voluntary participation to some mix of voluntary and mandatory prepaid premiums. Voluntary or involuntary payment of premiums may still conflict with the constitutional mandate of free healthcare, depending on what services are included in a "free" package and how "free care" is defined.

### *Premiums from employers*

There may also be a way to collect revenue from companies and employers, either mandatory or voluntary, under the Labor Code. The Labor Code provides justification for an integral element of socially insured provision of health services: mandatory coverage. This code provides for significant workers' rights with respect to medical services, albeit with a limitation based on the financial capacity of the institution.[16]

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[15] Please note the definition of *tax* under Article 2 of the Income Tax Law.

[16] Labor Code, Islamic Republic of Afghanistan, Official Gazette: Article 11: In the economic and social areas workers have the right to be provided with health services, safely work and produce, receive vocational training, skills development, improve their professional knowledge and be provided with social protection. Article 111 (1) The person in charge of the organization is obliged to give continuous training to employees about safety, health, first-aid service and firefighting rules and techniques, as well as other employees protection rules. Article 113: 1. Those employees who are engaged in arduous work, in types of work carried out under conditions that are harmful to health and also the work connected with driving vehicles, must undergo periodic health and medical examinations during the service period in order to see that they are fit for work and to prevent occupational diseases. 2. The employees and personnel of food material industries, public catering establishments, transaction of food materials, as well as the workers and personnel of water supply installations, preventive and curative institutes, institutes concerned with children, other organizations and organizations concerned with public works, must undergo the medical examinations provided for in paragraph 1 of this article in order to safeguard public health and hygiene. 3. The conditions and the manner of the medical examinations of employees of the paragraph 1 and 2 of this article will be drawn up and set by the MOPH and MOLSAMD. Article 114(1) In the event that untoward accidents and unexpected diseases occur at the worksite, the

Provision of medical services is rarely enforced.[17] The provision of health services scheme will bolster the argument for mandatory payment of premiums for workers, as this will ensure compliance with the Labor Code. Article 14.3 of the Labor Code allows for changes to the contract, as long as the benefits provided are not less than what the Labor Code mandates. In this way, the Labor Code provides support for the payment of healthcare premiums for workers, based on revenue.

*Conflict with the justification for free healthcare services*

As detailed above, there is significant justification for free primary healthcare services and prevention and treatment of contagious diseases in Afghanistan. If the premium or tax is collected for primary services and contagious diseases, collection of premiums may be in conflict with the law, since the Afghan government is mandated to provide free medical services to the public.

The MOPH currently does not collect premiums for the services detailed under the BPHS or EPHS, which are supported by donor funding. While studies have shown that payments are made, they are not mandated by law, policy, or regulation by the MOPH. Some stakeholders state that the Afghan constitution, which mandates free health services, prevents the collection of premiums. But there is ambiguity regarding the meaning of *free*. On the one hand, *free* may be defined as "free care at the point of service," which would therefore not conflict with the mandatory collection of health insurance premiums. On the other hand, free care may also be defined as "paid for by the government and not the citizen," which would conflict.

Despite this ambiguity, there is some room for interpretation to allow charging premiums, either mandatory or voluntary, and even user fees for secondary services. The Afghan legal framework provides justification for free provision of primary health services under Article 52 of the constitution. Article 2 of the Public Health Law limits the provision of secondary curative services "against a certain wage." The operative language under Article 2.2 is "against a certain wage." This could be interpreted as allowing prepayment of premiums and/or user fees for those who can afford it. The interpretation could be handled by regulation since Article 2.2 of the Public Health Law also states it is "according to the relevant statutory document." Because regulations are passed upon the approval of the Council of Ministers, setting the standard this way would be much easier.

Amending Article 52 of the constitution to clarify its ambiguity is not recommended. Amendment of the Constitution is difficult, requiring a commission of the government, National Assembly, and constitution formed by presidential decree. This commission would prepare a draft proposal. A Loya Jirga would then be convened by presidential decree and would have to approve the amendment with a two-thirds majority and subsequent presidential approval, following Article 150 of the constitution. This is unlikely to occur for one amendment.

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organization would be obliged, as the case may be, to: 1. provide first aid services and conditions; 2. transfer the employee concerned to medical centres and provide for treatment conditions ; 3. when the employees is cured, transfer him to his/her place of residence; (2) If the treatment of the employee will not be possible in the country, the organization will be duty bound to send the employee, on its own expenses, to overseas medical centers. (3) The organization is duty bound to ensure the financial expenses of the employee and his escorting person during the trip. Article 115: Establishment of fixed and mobile medical centers - In order to carry out medical examination and to provide first aid for employees and, to the extent possible, for the members of their families, a room(s) for first medical aid, mobile pharmacy shop, and health unit or center shall be established in the organization with due regard to the number of employees and personnel and in accordance with the standards set by the Ministry of Public Health in concurrence of MOLSAMD. Article 134 – Types of Social Protection (1) Employees and in some cases their family members can benefit from the following social protections: 4. Medical services (3) Medical services or their equivalent shall be provided to the employee and his/her family members according to financial capacity of the institution.

[17] Phone conversation with MOLSA Judicial Affairs Office.

However, if a Loya Jirga to amend the Constitution is convened in light of the recent agreements by the National Unity Government, that would be an opportunity to amend Article 52 to clearly allow for the collection of premiums for SHI.

*Donor funding*

We may draw lessons from the regulatory framework used by the international donor community for the EPHS and BPHS. No official MOPH regulations cover external donor funding of the EPHS and BPHS.

Until recently, each donor provided funding through its own processes. The World Bank funded the EPHS/BPHS through the GCMU of the MOPH; USAID through a private contractor and, later, WHO; and the EC through its own internal processes (no outside funding) [112].

By July 2015, all three donors are planned to fund the MOPH's EPHS/BPHS through a central "basket." A contract has been signed with the funding to go through the MOF, via the Afghanistan Reconstruction Trust Fund. The project is called SEHAT, for System Enhancement for Health Action in Transition. The fund is supported by 33 donors and administered by the World Bank. All funds are channeled through government systems with ministries and government agencies responsible for implementing all projects [112]. This process will be considered an "on budget" expenditure in the "developmental budget" subheading.

This experience demonstrates that donor funding operates largely on its own, albeit with input from the Afghan government. If an SHI scheme uses donor funding, the legal framework of Afghanistan will not significantly hamper it. Instead, the rules and regulations of the donor community will apply.

*Way forward for revenue collection*

A sustainable SHI scheme in Afghanistan requires as many revenue streams as possible. Most countries use earmarked taxes (payroll or excise tax) as the main sources of funding for SHI, supplemented by the state's general revenue, either to pay in full for healthcare services for their populations or to subsidize them [88]. Although existing health services in Afghanistan are largely paid for by the international donor community, this may not be the case in the future. The use of general revenue, however, exposes the SHI scheme to the risk of budget cuts and defunding.

In addition to state revenue, most SHI schemes use the mandatory prepayment of premiums to fund SHI. A new law is needed in order to enforce earmarked tax for health insurance. In addition, clarification of "free primary care" would help policymakers determine what services could be included in a health insurance benefits package.

The solution is to carefully draft a new law that:

- Clarifies the definition of free primary health services provided by the Afghan government
- Defines the mandatory contribution of premiums as an earmarked tax, to generate funds for the SHI scheme clearly stating the law's intention and how funds will be used
- Allows for the mandatory and voluntary contribution of premiums for secondary services
- Allows for revenue collection from all sources, including donor funds, for health insurance

### *The legal environment for pooling resources*

The laws and regulations governing resource pooling in Afghanistan hinge on the legal structure of the central health insurance entity. If the central health insurance entity and the accompanying public health insurance scheme are set up under the existing structures available under Afghan law, without new

legislation being passed, all facets of the health insurance scheme will be severely limited. If the SHI scheme is set up by new legislation, the authority to pool resources can be clearly defined.

Pooling of resources is not specifically prohibited for independent or semi-independent government entities. Under the PFEM law, any funds granted to the state subject to conditions on how they may be spent are deemed "special funds" [97]; donor funds channeled through the Afghan government budget will probably be categorized this way. However, the PFEM law mandates that these funds will still be under the MOF's authority, but under a separate ledger. So pooling of resources from state revenue to health insurance is allowed, but will still be subject to the Afghan government's budgetary authority. In this scenario, the donor must be explicit in attaching conditions to the funding.

For other, semi-independent or quasi-independent governmental entities, there is no prohibition, because for these, funding is regulated by the law that set them up. For example, the AISA has no prohibitions against pooling resources and is not subject to the PFEM law. Similarly, the ATRA, which was established by the Telecommunications Act, also has no such prohibitions.

One special case is the state-owned enterprise. Article 26 of the State Owned Enterprise Law specifies only the following as sources of its funding: internal resources of the enterprise development budget of the state and bank loans [106]. Since there is no specific mention of international donor funding, the funding would have to be channeled through the development budget of the state. However, this is a moot point, as official government policy prohibits the establishment of state-owned enterprises [107].

The Afghan government's transfer of general funds to a potential central health insurance entity would have to go through the yearly budgetary process. If the potential health insurance entity is under the MOPH, that ministry would provide for the central health insurance entity in the annual budget it submits to the MOF. If the central health insurance entity is a stand-alone agency, it would prepare its own annual budget for submission to the MOF. Either way, the finance ministry, after conducting the audit and reconciliation process mandated by the PFEM law, would present the budget to the National Assembly, in accord with Article 98 of the constitution, and the process would continue as described earlier in this chapter. Current regulations prohibit the transfer of funds from one region to another. Instead, under the constitution all revenue raised must go to the Afghan government's central bank account.

For external funding and pooling of donor resources, the World Bank's rules and regulations would likely apply. Whether donor funding could be pooled for health insurance may depend on negotiation between donors and the government.

*Way forward to pool resources*

The legal issues involved in pooling resources are easier to resolve than those in collecting revenue. Nothing in the Afghan legal framework explicitly prohibits pooling resources. New legislation establishing SHI in Afghanistan should state that pooling of resources is allowed and encouraged.

### *The legal environment for purchasing services*

Here again, the laws and regulations governing purchasing health services in Afghanistan hinge on the legal structure of the central health insurance entity. If that entity and the accompanying SHI scheme are structured as current Afghan law permits, with no new legislation passed, all facets of the health insurance scheme will be severely limited. If there is Afghan government funding, or if the compulsory prepayment of premiums is deemed a general tax, spending the funds will be governed by the Procurement Law [113]. Article 5 of this law states:

*Scope of application: (1) This Law regulates the procurement of goods, works and services, both domestic and foreign, for government administrations and institutions, and mixed companies. (2) Where procurement requires confidentiality to ensure the interests and protection of the nation, the provisions of*

*this law are not applicable and shall be subject to special procedures of the relevant entities. (3) Where the procurement rules of an international institution conflict with this Law, the government may, taking into consideration national interests, agree to procure the goods, services or works funded by the agreement in accordance with the mentioned rules.*

The Procurement Law does not prohibit the purchase of services from private or public health providers. Currently, three provinces—Kapisa, Parwan, and Panjsher—have "contracted in" health services with the MOPH. That is, the health services there, including clinics and hospitals, are purchases from provincial health offices [110]. If donor funding is involved, the donor may attach explicit instructions regarding the spending of the funds.

Other, semi-independent or quasi-independent governmental entities have no prohibitions on purchasing, because they are regulated by the law that established them. For example, both AISA, established by the Private Investment Law, and ATRA, established by the Telecommunications Act, are free to purchase private resources, because these agencies are not subject to the PFEM law.

The MOPH currently abides by the processes of the donor community to purchase the services of healthcare providers for its current programs. Article 4.2 of the Procurement Law allows this:

*Where the procurement rules of an international institution conflict with this Law, the government may, taking into consideration the agreement in accordance with the mentioned rules, agree to procure the goods, works or services funded in accordance with the provisions of the agreement…*

As discussed, each donor has its own processes for funding. The BPHS and EPHS were funded by the World Bank through the GCMU. USAID funded them through a private contractor and then through WHO. The EC funded them through its own internal processes. Initially, all services for 31 provinces were purchased from NGOs [110].

The donor community will soon purchase all services for the BPHS and EPHS through the World Bank's SEHAT program. If health insurance received funds from donors, then the requirements of donors would apply.

*Way forward to purchase services*

The main legal issue that purchasing services raises is the application of the Procurement Law to the use of state-funded general revenue. Although Afghanistan's current financial situation may not trigger the use of the procurement law, because the Afghan government is largely funded by international donor funds, this may become an issue later.

Ideally, the purchase of services should be exempt from the Procurement Law to circumvent its lengthy bureaucratic process. Instead, the law establishing an insurance program should state that the budget is independent, with regular reporting to the MOPH, MOF, and the President's Office. It should also allow for regular auditing. To maximize limited resources and improve the effectiveness of health service delivery in Afghanistan, the new legislation should allow the SHI scheme to purchase services from both public and private healthcare providers.

### *The legal environment for exercising regulatory authority*

The level of regulatory authority granted to the health insurance entity tasked with implementing an SHI scheme will largely depend on the entity's independence and its relationships with other government entities, especially the MOPH. Other countries have entrusted the following responsibilities and authority to their central health insurance entities:

- Protection of patient rights [93, 30]
- Liability insurance for financial protection of healthcare providers [86]

- Arbitration board [86]
- Ability to impose administrative fines [89]

Currently, the MOPH has the authority to license providers and ensure the quality of care. This is done under the official government *tashkeel*, or organizational authority and organizational chart. A health service provider obtains a business license from AISA. Prior to a license's issuance or renewal, the MOPH must approve it in accord with private hospital licensing regulations.

Interestingly, under the BPHS and EPHS offered by the Afghan government, no specific regulations grant authority to the MOPH and the donor agency for quality assurance. Instead, this is accomplished through contracts. Each contract signed by the MOPH, donor agency, and contracting agency (whether the public or private sector or NGOs) has several clauses that allow for assessment, identification of deficiencies, and ultimate suspension because of deficiencies.

Under the soon-to-be-expanded SEHAT program, quality assurance regulations will also be through contract. According to a source in the GCMU, these will link payments to performance and allow for third-party verification and financial audits. Because the SEHAT program is funded by the Afghanistan Reconstruction Trust Fund, financed by World Bank, the World Bank's requirements generally apply.

*Insurance law*

A previous health insurance law from the 1970s allowed the state to deduct 2 percent of a civil servant's wage for health insurance. The civil servant was then allowed to ensure three additional family members. However, subsequent laws and the most current law do not mention this deduction or benefit.

The current private insurance law is not related to SHI but may impact the potential SHI system. Article 6 of the 2008 Insurance Law says that private insurance companies may be established and licensed by the MOF [114]. The law also specifies that insurance companies may be established upon request by the MOF and with the government's approval:

*Article 6 (1) The Insurance Companies shall be established at the request of the Ministry of Finance and approval of the government. 2) Private Insurance Companies may be established in Afghanistan according to the investment Law: License of the activities of the Insurance Companies will be issued by the Ministry of Finance. 3) To implement the objectives mentioned in this Law and support the property of the insured, a five-member insurance board shall be established. 4) The Ministry of Finance shall develop special procedures to regulate the affairs of the insurance board.*

While this pertains to insurance companies and not an SHI entity, it is still likely that the MOF will expect to be involved closely in an SHI scheme, given the issues with revenue collection and the insurance law.

*Way forward for the exercise of regulatory authority*

The new legislation should clearly authorize the central health insurance entity to carry out its obligations by developing and implementing regulations. The law should also clarity the insurance entity's relationships with the MOPH and the MOF.

## Recommendations

This analysis of Afghanistan's legal framework establishes the necessity for new legislation to set up an effective SHI scheme. To that end we offer the following recommendations:

- Clarify primary, secondary, and tertiary health services package
- Clarify the definition of "free" primary health services to be provided by the Afghan Government

- Set up a central agencies to manage the health insurance program
- Allow as many streams of revenue as possible, including those that may be used in the future (This includes government tax revenue, mandatory prepayment from earmarked tax, voluntary contributions, and donor funds.)
- Define the mandatory contribution of premiums as an earmarked tax to generate funds for the SHI scheme, specifying the law's intention and how funds will be used
- Allow and encourage pooling of resources
- Exempt the scheme from the Procurement Law to circumvent its lengthy bureaucratic process (Instead, the law should state that the budget is independent, with regular reporting to the MOPH, MOF, and the President's Office. It should also allow for regular auditing.)
- Authorize the SHI scheme to purchase services from qualified health providers
- Grant the central health insurance entity clear regulatory authority to implement its obligations (The central health insurance entity should have the authority to create and implement regulations under the new legislation.)
- Clarify the relationships among the MOPH, MOF, and the health insurance entity
- Clarify the definition of "free" primary healthcare, which will amend the current Public Health Law and resolve the constitution's ambiguity on this point

If "free" primary healthcare means that primary care services should be fully supported by the government's tax revenue, allowing health insurance to cover primary care, we also recommend adding the amendment of Article 52 of the constitution to the agenda of the next Loya Jirga. This amendment should allow all revenue generation, including mandatory prepayment of premiums, for SHI for primary care. The next Loya Jirga is presumed to occur in two years as a result of the agreement of the National Unity Government. If a Loya Jirga does not come about in this way, it is not advisable to devote any resources to proposing one solely to amend Article 52.

As stated earlier, new legislation, while necessary for an effective SHI scheme, will be a long process requiring the support and buy-in of high-level Afghan government officials, international donors, and advocacy organizations. High-level governmental involvement will also be necessary to push the draft legislation expeditiously through the processes of the MOJ and the National Assembly.

### *A legislative agenda*

Here are the steps that need to be taken to write and pass laws establishing health insurance (these can include an amendment of the Public Health Law):

- Gain buy-in of the MOPH, MOF, president, and CEO through advocacy
- Draft law with necessary elements (Please note: To avoid delay, a preliminary draft should be prepared without input from outside stakeholders.)
- Circulate draft law for discussion
- Conduct stakeholder consultations with the following entities to further elicit discussion and buy-in:
    - MOF
    - MOJ
    - Relevant donors

  - Private sector health: medical professionals
  - Private sector: business owners
  - Public health officials
  - Women's rights activists
  - Children's rights activists
- Prepare final review of all relevant comments from the above
- Finalize draft to be sent to the MOJ's Taqnin Department (Ideally, the introduction of the law would be from the President's Office to ensure expediency.)
- Once approved by the Taqnin Department, formally introduce to Parliament
- Once the law is approved by Parliament, set up preliminary board to draft terms of reference and job descriptions for board and staff; set up governance training to draft a board manual, code of conduct, conflict of interest policy, and so forth.
- Draft health insurance regulations

**Table 11. Timeline to Address Legal Barriers for Health Insurance**

| Action | Expected Timeline |
|---|---|
| **Gain buy-in of MOPH through educational presentations and meetings** | 3-6 months |
| **Gain buy-in of MOF, President, and CEO** | 6-12 months |
| **Draft law with necessary elements (Please note: a preliminary draft should be prepared without input from outside stakeholders.)** | 4 months (Please note: this can be done concurrently with gaining buy-in.) |
| **Circulate draft law for discussion** | 3-4 months |
| **Conduct stakeholder consultations with the following entities to further elicit discussion and buy-in:**<br>• **MOF**<br>• **MOJ**<br>• **Relevant donors**<br>• **Private sector health – medical professionals**<br>• **Private sector – business owners**<br>• **Public health officials**<br>• **Women's rights activists**<br>• **Children's rights activists** | 6-12 months |
| **Prepare final review of all relevant comments from the above** | 3-6 months |
| **Send finalized draft to the MOJ's Taqnin Department (Ideally, the introduction of the law would be from the President's Office to ensure expediency.)** | 12-24 months |
| **Once approved by the Taqnin Department, formally introduce to Parliament** | 3-12 months |
| **Parliament reviews and deliberates** | 12 months |
| **Once the law is approved by Parliament, send to President's Office for. . .** | 3-6 months |
| **. . . implementation and set-up of central health insurance entity, likely through an allocation of international donor funds, initially** | 12 months |
| **Establish preliminary board to draft terms of reference and job descriptions for board and staff** | 6 months |

# CHAPTER III. STAKEHOLDER ANALYSIS OF THE FEASIBILITY OF HEALTH INSURANCE IN AFGHANISTAN

## Background

The experiences described in the first chapter's case studies support research showing that health financing reform and the introduction of health insurance are complex, long-term processes requiring strong technical and management capacity as well as political commitment from stakeholders [115-117]. Health sector stakeholders have a strong influence on policy development and moving reforms forward in a country [118]. The inclusion of stakeholder perceptions, understanding, behaviors, interests, and intentions around health financing and health insurance should inform the feasibility of introducing health insurance schemes, how the schemes are designed, and next steps in moving forward. This task is particularly important in Afghanistan, where the health sector is shaped largely by donors as funders, NGOs as providers, and the government as the regulator and provider. Although Afghanistan had health insurance programs for brief periods in the 1970s and in 2005, current awareness, knowledge, and the capacity to design, manage, and regulate such a program are very limited. Furthermore, the country is in transition with the military draw down and a new presidential administration, and the introduction of such reforms in the future needs to be understood within this context of change.

Because the government is considering introducing health insurance to reduce the high financial burden on households and increase the country's independence from external healthcare donors, HPP/Afghanistan, in collaboration with the MOPH, conducted an analysis to document stakeholders' opinions on establishing health insurance schemes in the country.

## Methods

To assess stakeholders' interest in health insurance, investigate the feasibility of introducing health insurance, and inform the design of health insurance schemes, HPP conducted a comprehensive stakeholder assessment using qualitative key informant interview (KII) and focus group discussion (FGD) techniques. To implement this assessment, HPP adapted the framework that the International Labor Office developed for strategies and tools for the social exclusion and poverty global program on microinsurance schemes [119]. The KIIs and FGDs focused on (1) the need to introduce health insurance schemes, (2) leadership and political commitment, (3) the legal and regulatory environment, (4) quality of care, (5) population awareness, (6) ability to pay and government fiscal space, and (7) technical capacity to operate a health insurance scheme.

We conducted 16 KIIs to solicit information from 21 people in positions of high authority and/or with special knowledge, chosen in collaboration with the HEFD, given that directorate's extensive knowledge of the healthcare system and roles within it. The stakeholders we interviewed were high-level government officials from ministries and Parliament (MOPH, MOF, MOJ, MOLSA, and Parliament); international donors and organizations (WHO, the European Commission [EC], USAID, and the World Bank); and two private insurance companies.

To document the perceptions, opinions, and attitudes around health insurance of stakeholders who perform the same or similar functions in the healthcare system, we also conducted five FGDs. Again, we identified participants for these (30 in all) in collaboration with the HEFD: managers of BPHS implementers, directors of public hospitals, directors of private hospitals, organizations working on community savings projects, and HEFD staff. Each FGD had five to seven participants. As examples, Appendix 3 presents KII guidelines for the MOPH; Appendix 4 presents guidelines for FGDs with private hospitals. Appendix 5 lists all participants in the KIIs and FGDs.

We set up the interviews by sending official requests to government agencies and international organizations. The KIIs and FDGs were conducted between mid-July and mid-August, 2014. The interviewers explained the purpose of the study to all participants and obtained informed consent at the beginning of each interview. They conducted all interviews in a quiet place. The interviewers used semi-structured interview guidelines to frame questions and solicit stakeholders' interest and opinions on health insurance.

The KIIs and FGDs asked interviewees about (1) their understanding of the health financing situation in Afghanistan, (2) opinions regarding introducing health insurance schemes in Afghanistan, (3) reasons for supporting or not supporting the establishment of health insurance, and (4) the potential design of a health insurance scheme. The interviews focused on different aspects of the health system as they relate to health insurance and to the interviewees' organizational affiliations. For example, for the MOJ and parliamentary survey participants—entities more familiar with regulations and legal issues regarding health insurance—the interviews focused more on regulatory and legal constraints and opportunities for implementing health insurance. Interviews with participants from private health insurance companies focused on understanding the insurance market, the operation of health insurance, insurance benefit design, and the capacity needed to implement/manage health insurance.

The KIIs and FDGs generally lasted an hour and were conducted in the participant's preferred language. Two experienced researchers conducted and facilitated most of the KIIs and FDGs. Both researchers are health financing experts with a strong understanding of the Afghan health system. The researchers had assistance from local staff to conduct interviews in Dari as needed. The local staff member had significant experience working on health sector activities in Afghanistan and was trained by the researchers to ensure high-quality interviews. In total, HPP conducted 22 KIIs and FGDs. The researchers then transcribed and reviewed the interviews before importing them into Atlas.ti for analysis.

HPP sought and received permission for this study from the institutional review board at the MOPH in February 2014. (The assigned approval number is 979614.) HPP submitted an amendment, approved in July 2014, after the HPP technical team revised the interview tools.

## Results

Most stakeholders were aware of the country's high OOP spending and reliance on donor funding, as well as the challenges of healthcare delivery. Stakeholders also acknowledged that health insurance could be an instrument either to address or mitigate these challenges and noted that introducing health insurance could make the health system more sustainable. However, stakeholders differed in their beliefs about how and when a health insurance scheme could be initiated.

### *Perception of the need for health insurance*

The government states that healthcare is a right of citizenship and that it is committed to providing health services for the population. Stakeholders referred to the government's inability to protect people from financial hardship as one of the current health system's key issues. People have to sell their assets or borrow from relatives and communities to seek healthcare in Afghanistan or other countries, such as India and Pakistan. Introducing health insurance could provide financial protection against catastrophic health expenditures, particularly for the poor.

*This* [health insurance] *should be our priority—to promote insurance services so that we could cover or bring more people under our insurance coverage.*

Health insurance could also bring about increased equity of healthcare in the country. The rising cost of health services due to new technology and changes in disease patterns has exacerbated inequality in the utilization of healthcare. Whereas the wealthy can obtain healthcare from private health facilities or go

abroad, the poor have limited options. Health insurance could be an important tool for promoting greater equity of health service utilization.

*I think* [health insurance] *is a good idea ... we need to have that [health insurance]. We have people who cannot afford private health insurance and who cannot find easy access to services." "I think if we want to make services accessible to all the population, and if we need to make services equitable—if we are talking universal health coverage—I think insurance would be one of the options that we need to* [engage in].

Despite a consensus on the need for sustainable methods for health financing, the stakeholders had various opinions of the country's current readiness for implementing health insurance, the government's willingness and capacity to do so, and the population's awareness of health insurance.

### *Leadership and political commitment*

Healthcare reform and the successful implementation of health insurance schemes require strong political will and government stewardship, particularly in the case of Afghanistan, where additional challenges exist due to insecurity, poverty, and a large informal work sector. If political will is weak, little can be accomplished in establishing the legal framework and revenue generation systems needed to run a health insurance scheme. A majority of stakeholders acknowledged that strong leadership, multisectoral political commitment, and effective collaboration are essential to begin implementing health insurance in Afghanistan, but noted that the current political commitment should be strengthened, especially at the highest levels of government. This is particularly needed given Afghanistan's lack of a legal and regulatory environment for health insurance and lack of agreement on the constitution's stipulations related to healthcare delivery.

*… political will and political support are very important for establishing health insurance systems in every country. But besides this, for Afghanistan especially, I think it's more important … because of the constitution, because of the law and the regulations we currently have, especially in terms of having all health services free. So we really need a very strong* [political] *will and support at different stages and in different entities of the government* [to overcome the barriers].

To be successful, advocacy efforts aimed at increasing support for and political commitment to health insurance must target stakeholders across different sectors and at different levels of government: "It requires a lot of lobbying with Parliament, the cabinet of Afghanistan, ministries, and the people." Implementation of health reforms in Afghanistan also will require effective collaboration to design, implement, and manage a health insurance scheme. Discussions are taking place in ministries and Parliament about whether health insurance should be introduced; a concrete plan is needed to give these discussions focus.

### *Legal and regulatory environment*

As the second chapter explains, health financing reforms, including the introduction of health insurance mechanisms, must be supported by legal provisions and a strong regulatory environment. The government has shown a commitment to creating legal foundations that support the health sector, including ongoing discussions about amending the Public Health Law. Still, stakeholders identified the legal and regulatory conditions for health financing as major challenges that need to be addressed in the short term if a health insurance scheme is to be developed. In particular, as discussed in the previous chapter, the ambiguity of Article 52 of the constitution, which addresses the state's obligation to provide healthcare to its citizens, leaves the law open to interpretation.

*According to the constitution, the health facilities are free for the people…it is clearly defined in … article 52 of* [the] *constitution:* [paraphrase of constitution] *"The government, in accordance to the law, provides preventive care, treatment, and health facilities free of charge to all the people."*

Varying interpretations of the law and differing opinions exist—even among high-level government officials—about whether the law mandates that the government provide services for free to all Afghan citizens and what those services may include or at what level. Whereas many understand Article 52 as a mandate for the provision of free services, some interpret it as only requiring free facilities (i.e. building and equipment); others believe that only certain services must be provided free of charge. "We have the constitution … but interpretation has been an issue. So far, we have not been able to interpret it." The ambiguity surrounding Article 52 and the legal basis for fee collection and government provision of services must be addressed to ensure a consensus among stakeholders, a strong legal foundation, and increased political will in support of health insurance. This is particularly important, because the legal ambiguity is closely linked to the current level of political commitment for health insurance in Afghanistan:

*You cannot see* [improvements] *… there are improvements but not that much … constitutionally speaking, there is a big problem at that* [presidential] *level. Policymakers and politicians believe that health insurance is something that gets money from people, which is against the law.*

Strong regulatory systems and the capacity to enforce regulations are essential for a successful insurance scheme. Government regulation can guarantee sufficient oversight of private healthcare providers and insurance organizations to ensure equity and access to care, and promote economic efficiency. Regulatory systems and capacity in Afghanistan need to be strengthened and enhanced for the government to successfully implement and oversee a health insurance scheme:

*We always have issues of accountabilities, transparency, and the more important is* [the] *regulatory framework. That needs to be taken care of first. In Afghanistan, that can be a major issue, because* [the country] *lacks proper legal systems, not just in the health sector, just in general.*

### *Quality of health services*

The majority of interviewees identified quality of health services as a key issue for implementing health insurance. Health insurance is feasible when beneficiaries can access an acceptable quality of care. In Afghanistan, the population perceives the quality of care to be low. Although the BPHS and EPHS are theoretically free, because of stockouts of medications and lack of medical equipment and lab tests, patients must buy medications from pharmacies and go to private providers for lab tests and examinations, for which they pay much higher fees for the services: "Patients mostly pay for medicine and diagnostic examinations that are not available in [the] majority of our hospitals." The low quality of healthcare services in Afghanistan presents a challenge for the institution of a health insurance system and affects people's willingness to participate in an insurance scheme or pay for services at any level.

*My suggestion, before implementing health insurance, is that first and foremost we need to strengthen our health service performance so that our people feel that now that they have insurance, they receive quality health services when they need it. So I suggest that health insurance is important once our health system performance is strengthened.*

Poor quality of services goes beyond the implementation of a health insurance scheme and affects health financing as a whole. Afghan citizens leave the country for services, thereby spending those funds outside of the Afghan economy: "For some procedures and surgeries, like laparoscopy, our people still go to other countries, like India, Pakistan, and Turkey." Seeking care abroad due to poor quality of services often results in high levels of OOP expenditure: "The studies that are done on out-of-pocket expenditures on health should be more publicized—that people are already paying a lot. That is just because the services are poor."

Security also plays a role in accessibility and quality of care. Health facilities hardly exist in insecure areas, and there populations cannot obtain needed and timely care.

### *Population awareness and trust*

Although Afghanistan had experience with health insurance for civil servants in the 1970s and community-based health insurance in five districts in the early 2000s, health insurance is a new concept for most of the population. Many think that paying money for insurance is worthless. The high illiteracy and poverty rates pose further challenges to educating the population about health insurance. Even highly educated people who work in the formal sector, such as NGOs, would rather receive a medical allowance from their employers than join health insurance programs. In smaller communities and rural areas, much of the population has never heard of health insurance. A great deal of sensitization and education effort is needed to prepare the country for the implementation of health insurance. The government and civil society can play an important role in educating the population about the general concepts and benefits. Some NGOs have worked on community-based programs for many years and built close relationships with these communities, through which sensitization and education initiatives on health insurance could be delivered.

Our interviews found that communities not only lack trust in Afghan insurance systems, but also lack trust in the government generally. "There is reluctance from those stakeholders to contribute to [a] public insurance scheme, because there is no equation of trust of government." This prevalent lack of trust extends to the private sector, as well, and is related to the lack of security and volatile economic situation. This general distrust creates an interesting phenomenon, in which the government feels the public does not trust private health insurance programs and private companies feel the public does not trust government programs.

*It also goes back to the institutions' capacity and transparency, because corruption is also a big problem and the people don't trust* [the government].

This lack of understanding and trust among the population presents a challenge to starting a health insurance scheme and then scaling it up. Raising public awareness and providing necessary information to increase transparency would be helpful in developing the required levels of trust in insurance and government-run programs.

### *Fiscal space and willingness and ability to pay*

To reduce reliance on donor funding, domestic resources must be increased, either from government sources or households. As the country moves toward a system in which primary care will be funded largely by the government and donors, and healthcare for the poor will be subsidized by the government—as reflected in the health financing strategy 2014–2018 [78]—the government will play a more prominent role in financing healthcare. "There are many [challenges]—but the financial barriers [are large]—taking into account the capacity to tax the country and then to collect the funds." Given the high poverty rate, a public health insurance scheme would also entail the input of government resources. Most participants noted the financial constraints within the government and said the ability of the government to collect taxes to fund the health system needs to be strengthened if the health sector is to become more self-sufficient.

In addition to the government's lack of institutional capacity to collect revenues, the country's large informal economy challenges revenue generation. In Afghanistan, where more than 65 percent of the population is jobless, collecting contributions to healthcare funds would be hard to achieve. The informal working sector also does not allow for effective collection of taxes on small, private enterprises.

*Not all people have a regular salary and* [they] *don't know their income. In this country, the income of a farmer is not predictable. It depends on the rain level. It changes from year to year.*

Stakeholders had mixed opinions of the population's willingness to pay. On the one hand, the demand for health insurance is increasing in the private market. Large organizations working in Afghanistan are

actively looking for suitable health insurance plans for their employees, largely because of the insecure working environment in Afghanistan. In addition, health is often the second most important issue for the population, after food security. Many people spend money to seek care abroad. On the other hand, the high poverty rate, low awareness of health insurance, and low quality of healthcare limits the population's willingness to pay for it: "… quality again is an issue. Everyone would be willing to pay for quality services but [for] bad quality services, no one would be willing to pay; at least I'm not willing to pay." Various stakeholders also expressed concern for ensuring protection for the poor should new financing strategies be enacted.

*It's a willingness to pay … Are the people willing to pay? Poverty and hunger are critical issue*[s] *in Afghanistan. Thirty-six percent of the Afghan population is living under* [the] *poverty line*.

### *Capacity to run a health insurance system*

A high level of technical and managerial capacity is needed to successfully design, implement, and administer a health insurance scheme. At present, Afghanistan lacks this capacity, partly because no insurance system has existed for the past 30 years and most of the population has no personal or professional experience with formal insurance systems. This will be a challenge, not only for those who will be in charge of design and implementation but also in generating awareness and trust among the population.

Clearly, given that no SHI exists in the country, sufficient qualified manpower is not available to manage a health insurance scheme. The number of people dedicated to working on insurance issues is limited to a few select government units, further highlighting the current lack of capacity: "In all of the MOPH, only 1 percent or 2 percent [are] working in health insurance." To date, there has been limited capacity building and training related to health insurance design and management, resulting in a lack of capacity at all levels of the government: "We don't have the capacity to manage the scheme … and unfortunately there is no capacity even at the central level." A consensus exists among stakeholders that donor support for health insurance should focus on technical assistance and capacity building: "We need a lot of help from donors and government to train us and teach us about insurance topics." In addition to building technical capacity, management and regulatory capacities are also needed, particularly related to management and oversight of the private sector:

*My perspective is to build the capacity of the government with assistance. Like we need to take into account the fears of private health insurance … this is the problem of some specific schemes,* [so we need] *to work with the government and ensure that they have the capacity to manage and govern.*

With economic growth and the development of the education sector, this gap could be addressed. In fact, some stakeholders were optimistic about getting young talent to engage in operating health insurance. Private insurance companies that have begun to provide health insurance products also expressed willingness to support such an operation.

[In the past], *we had health insurance—especially within the government framework, but* [my staff] *did not have that experience. About 90–95 percent of my employees graduated after 2001 and they started to work in the insurance sector after 2007.*

### *Benefits package design*

A benefits package should take into account Afghanistan's disease burden, its capacity to deliver services, the cost-effectiveness of interventions, and the needs of the poor. Currently, Afghanistan's resources are limited and its ability to internally generate revenue is low. When designing a benefits package, policymakers will have to make difficult choices between covering services that are more likely to improve health status across the population versus services that may protect individual families from

catastrophic health expenditures. The general consensus among stakeholders is that any benefits package instituted in Afghanistan will be limited in scope and focus on larger public health issues.

Regarding benefit design, stakeholders generally agreed that primary care should be free or substantially discounted—either explicitly defined in the benefits package or generally provided for free. The difference arose largely due to their different understandings of the implementation context of health insurance. Stakeholders engaged in community programs advocated a benefits package focusing on good-quality primary care, which would have the biggest impact on reducing the country's disease burden. Many other stakeholders believed that primary care should be provided for free, whereas health insurance schemes should focus on secondary and tertiary care, for which most households spend large amounts of money when people fall ill.

*In Afghanistan because of the poverty, primary healthcare should be free. Services such as emergency care, obstetrical care, chest infection, family planning, and* [the] *like. … These should be free in Afghanistan.*

*Probably if we define the services—national health services—then we have an insurance system. Then the national health system would provide services that are free … but maybe for secondary and tertiary services and some defined benefits packages for health insurance.*

## Discussion and Suggestions

This stakeholder analysis tried to answer three questions:

1. Are stakeholders in Afghanistan interested in health insurance?
2. Why do stakeholders support or resist the introduction of health insurance in the country?
3. If stakeholders are interested, what are the next steps for the country in moving toward establishing health insurance?

Almost all of the stakeholders from government agencies, the private sector, donors, and United Nations agencies are interested in the idea of introducing health insurance in Afghanistan and acknowledge the current health system's incapacity to provide adequate healthcare and financial protection to the population. With the expected drop in donor funding in the next few years, obtaining alternative sources of funding for healthcare and introducing prepayment mechanisms are more imperative than ever; this is reflected in the latest health financing strategy developed in Afghanistan [78].

Despite their interest, stakeholders foresee great challenges, such as ambiguity in the constitution and low quality of care, and acknowledge that many efforts, which are discussed in detail in this and previous chapters, are required to address those challenges to prepare the country to establish health insurance schemes.

In moving toward introducing health insurance schemes in Afghanistan to achieve a more sustainable health financing system, provide financial protection for the population, and improve health outcomes, we recommend that the MOPH, MOF, and international organizations consider the following suggestions, drawn from the stakeholder analysis, to strengthen Afghanistan's healthcare system. However, this is by no means to suggest that health insurance can solve all of the challenges affecting the country's healthcare system, nor can it be established successfully in a short timeframe.

### *Build strong political commitment to health insurance*

Establishing and implementing a health insurance scheme, whether public or private, in a developing country depends on strong political commitment [120]. In Afghanistan it will be necessary to build consensus among high-level government officials that health insurance will strengthen the healthcare

system and increase sustainability. The great interest in health insurance that stakeholders—particularly those from government agencies—showed in these interviews demonstrates that momentum exists.

HPP has helped the MOPH initiate efforts to build political will. We are sponsoring a health financing event for high-level government staff to develop a common understanding of the needs and challenges in Afghanistan. HEFD has advocated on health financing issues and risk pooling to MOPH colleagues and government officials at other ministries. These activities have given the government a better understanding of the benefits and applicability of health insurance in Afghanistan.

It should be noted that political commitment must go beyond the MOPH. Implementing health insurance likely will involve multiple government agencies (i.e., the MOF, MOJ, MOLSA, and MOPH). The MOPH will need to collaborate closely with other ministries and agencies to address barriers to implementing health insurance in the country, as outlined in the results section of this report. In addition, given that Afghanistan is heavily dependent on donor financial and technical support, donors and international agencies such as the World Bank, USAID, the European Union, and WHO should use their unique positions in the health system to move health insurance onto the government's agenda. A task force on health insurance, comprising both international and domestic stakeholders, could be established to coordinate and plan work in this area. The existing working groups on revenue generation and overall healthcare financing meet irregularly, as needed. These groups can be strengthened with a broader base of stakeholder participants so they can continue to foster dialogue and planning specifically related to health insurance.

Achieving UHC is a long journey; Turkey's experience is an instructive example. In that country, after 30 years of slow progress in health system reform, government leadership in 2002 accelerated healthcare reform efforts. The Justice and Development party included "improving access to health services" as part of its election campaign platform [121]. Figure 7 presents the history of Turkey's progress toward UHC.

**Figure 8: Turkey's Progress Toward UHC**

| 1993-1999 | 2002 | 2003 | 2004 | 2006 | 2008 | 2009-2013 |
|---|---|---|---|---|---|---|
| Legal Framework | Leadership & Political Commitment | Comprehensive financing strategy | Health Governance – user rights and satisfaction | Enhanced equity & increased health expenditures | Continuous monitoring & learning | Leading role in global health |
| •Health Law **<br>•Laws on health financing institution establishment and process<br>•Law of personal health insurance system<br>•Law of health fund institution<br><br>**Laws not implemented due to lack of political will | •"improving access to health services" in election platform | •National Health Accounts implemented<br>•Health Transformation Program designed, building on previous work from 1990s<br>•Introduced higher salaries and performance incentives for clinicians<br>•Expanded benefits to include outpatient department & pharmaceuticals<br>•Conditional cash transfers to women and children to use services | •Contract-based employment for rural areas<br>•Changes in pharmaceutical policy<br>•Introduced international reference price system for drugs<br>•Patient Rights Directive – electronic system for patient complaints | •Universal health insurance legally adopted as part of broader social security reforms<br>•Global budgets introduced | •Social Security Institution established as a single organization for financial pooling and purchasing<br>•Cost-sharing in private hospitals for complex conditions<br>•Demographic Health Survey | •Tracking system for drugs<br>•MoH Strategic Plan 2010--2014 developed<br>•Taxes for cigarettes and alcohol raised<br>•Laws on hospital autonomy<br>•Unified social health insurance scheme implemented<br>•MoH Strategic Plan 2013--2017 developed |

Source: Atun R, et al., 2013 [121].

Rwanda's government-run CBHI program is another example of the need for political will. Strong commitment by Rwanda's government contributed greatly to the program's success. At the program's inception, CBHI coverage was tied to the performance of the governors, which was directly reviewed by the president. Engagement by the president and first lady, leadership by the Rwandan MOH, and donor support empowered this exemplary program [122].

### *Overcome legal barriers to establishing health insurance*

As explained in the second chapter, ambiguous language in Article 52 of the constitution is a major barrier to Afghanistan's pursuit of health insurance and alternative potential health financing mechanisms. High-level government officials interpret the law differently. Some believe the constitution mandates that all health services should be provided for free, whereas others believe that free health facilities include only the physical buildings and equipment. Even among the most knowledgeable ministries and agencies, this difference of opinion has not yet been reconciled.

The constitution encourages private medical facilities to be included in health services delivery. Although the government would like to commit to free care, in fact, health services are not free. Households finance more than 70 percent of total health spending. This signifies that it is not clear under the constitution which services should be provided for free and which should not, and to what extent the constitution limits the use of health insurance. Health insurance, as a financial protection mechanism, collects premiums from the beneficiary population and provides health insurance schemes contracted with providers who perform reimbursed services at an agreed rate. The beneficiaries could receive this care without additional OOP expenses, aside from minor co-payments; the poorest would be exempt from any OOP expenses.

The MOPH has begun to discuss drafting an amendment to clarify health services that should be free of charge and those for which payments can be collected. As the stakeholder interviews showed, general agreement exists that primary healthcare services through the BPHS should remain financially accessible to all. Additional services at the BPHS level beyond the basic package may be considered chargeable, as well as secondary- and tertiary-level healthcare services. Stakeholders need to discuss and clearly agree about these services. To ensure continued support, engagement, and momentum within the legal framework, all stakeholders should be involved from the beginning.

Furthermore, although an insurance law exists, it is not specifically for health insurance, and its implementation is more suitable for the private sector. Additionally, a draft private health insurance law exists and is at present under MOF review, but it does not cover the public sector. International experience shows that governments often play an important role in regulating and financing health insurance schemes, making it crucial to develop a legal framework with clear guidelines on establishing health insurance in both the public and private sectors. The donor community could provide technical assistance to draft these necessary regulations using best practices from other countries. Similarly, donors are indispensable in designing and implementing health insurance.

### *Improve the quality of healthcare*

The low quality of health services has been widely criticized in Afghanistan as being inadequate to meet the population's health needs. Although the quality of services has improved substantially in the past decade through the BPHS and EPHS [123], further strengthening and standardizing of health services is needed. Whether public or private, services should be provided by health facilities according to the minimum required quality standards for attracting patients. High OOP expenditures point not only to lack of access to healthcare but also to low quality of care. Only when the quality of services improves will people be confident enough to seek care at health facilities. Shortages of drugs and medical equipment are fundamental areas for redress. The government already has begun working on this issue at the tertiary level, by decentralizing budget, procurement, and hiring processes in certain national hospitals; also,

some interventions to improve the health system do not require substantial financial input. HPP is supporting the rollout of minimum required standards at private hospital facilities through self-regulation by the Afghan Private Hospitals Association and monitoring by the MOPH. In addition, HPP is helping the ministry to map a five-year plan to implement accreditation at private and public facilities.

**Strategic contracting with providers.** Currently, health services are provided primarily by NGOs, the government, and private providers. The MOPH contracts with NGOs to deliver BPHS and EPHS services, in a process known as "contracting out," (MOPH also contracts for services with some facilities operated by the government in three provinces; this is known as "contracting in.") Contracting out with NGOs is important for improving the quality and efficiency of service delivery and has been the model for the past decade. Strategically contracting with NGOs (i.e., contractual decisions based on quality and cost) should be enhanced further, by encouraging competition among NGOs and by invoking a credible threat of sanctions if an NGO does not perform well [123]. To optimize this mechanism, the government needs to strengthen the execution of funds in a timelier manner and improve performance monitoring and response (i.e., payment awards or penalties).

**Decentralization and autonomy of hospitals.** Recent findings from the Public Expenditure Tracking Survey (PETS) show that granting autonomy to hospitals has improved the quality of care, by allowing hospitals to purchase drugs and equipment independently from the centralized MOPH procurement system [124]. The previous, rigid line-item budget did not provide hospital management with the flexibilities needed for procurement, and the hospitals were not able to adjust procurement to patients' needs swiftly. Such a government direct-service provision model, in which the MOPH assumes the role of both the financing and provision of services, often results in low efficiency [125]. Future directions for improving the quality of hospital care could be: (1) changing the direct provision model to an indirect model, using contractual mechanisms; (2) enhancing contracting out mechanism to reward good performance and penalize low performance among NGOs; and (3) granting more autonomy to hospitals in finance (i.e., global budget).

**Incentives for quality of care.** The results-based financing (RBF) program, supported by the World Bank, has been implemented in select provinces in Afghanistan since 2009. Despite its controversial results globally [126], RBF is one approach that has potential to enhance the quality of care. The implementation of RBF should be strengthened and refined, not only to increase the use of care but also to improve quality, by means of a better design of quality indicators (i.e., more objective quality indicators and inclusion of procedure and outcome quality indicators). In addition, strengthening the monitoring and evaluation capacity of the MOPH, particularly to oversee RBF programs in remote facilities, is necessary to ensure that any future RBF program functions efficiently and responsibly and that incentives are appropriately applied.

**Public-private partnership.** Given the situation in Afghanistan, where most health services are provided by contracted NGOs and about half are provided by the private sector [127], health insurance will not be successful without including the private sector in service delivery. The government could explore contracts with private clinics and hospitals with good track records on quality to deliver BPHS and EPHS services.

**Accreditation.** In the long run, accrediting both public and private health facilities would help to institutionalize quality assurance. This requires establishing an independent accreditation agency in the country. Several low- and middle-income countries, including Rwanda and Jordan, have introduced accreditation procedures with positive results [128-130]; these examples offer valuable lessons for Afghanistan on quality improvement for both ambulatory and hospital care. HPP conducted a comprehensive assessment and determined that the country is ready for such an initiative and should take the necessary steps to establish a system immediately. Recently, HPP led a delegation of high-level

stakeholders from the government and private sector on a study tour in Jordan to meet with that country's Health Care Accreditation Council and learn about its development and role in Jordan's health system. We also supported the development of a five-year strategy for establishing a healthcare accreditation system.

### *Educate the public on health insurance*

The large informal sector, high illiteracy rate, and remote mountainous areas pose challenges to disseminating information on health insurance. Our interviews with private health insurance companies showed an increasing demand for health insurance in the country, particularly among the wealthy population who work for international organizations, banks, and NGOs. The existence of large donor-funded programs in the country, as well as other formal employment sectors such as civil servants and military forces, creates a sizeable population of this kind.

It is important to share information on health insurance with the population through the media to educate them on what health insurance is, what benefits it offers, and why it is important to buy and use it. Given the country's high illiteracy rate, radio, television, and graphic posters are suitable means to educate the public on health insurance. The MOPH has experience in promoting anti-tobacco and health behavior messages through different means. Although the content of health insurance may be somewhat more complex to communicate, the mechanisms for distributing messages and developing materials are available in the MOPH's Health Promotion Department. More support is needed to develop appropriate and salient messages on health insurance and financial protection.

Additionally, healthcare should be considered one of the major topics of political campaigns, such as presidential or parliamentary elections. People who are campaigning for office should recognize that healthcare is not free; someone pays for it—whether through public (taxes), donor, or private funding. As donor funding decreases in the future, the combined share of government and private spending will have to increase. The more important question is who pays for healthcare? Without health insurance, private payments inevitably will come from those who are sick and must pay at the point of service. The financial risks will not be distributed among the entire population; individual households with ill family members will suffer most, by incurring catastrophic health spending. Political candidates must understand and address these issues.

### *Address other technical gaps*

Initiating health insurance will not be possible without international financial and technical support. Although the government is growing stronger in every respect, its capacity to begin a health insurance scheme remains limited—not only the capacity to design and operate health insurance but also to increase the fiscal space of the healthcare system and gain people's trust in publicly funded programs. Gaining trust requires strengthening anti-corruption and taxation systems.

The country's overall capacity to operate health insurance is very low but initial efforts to enhance health sector capacity are underway. Private health insurance may be premature; there are a few private insurance companies just starting health insurance products or acting as a broker and transferring financial risks to reinsurers outside Afghanistan. However, the private sector, given the increasing interest in insurance, is building its capacity to manage health insurance schemes, by recruiting young talent and receiving technical support from their overseas reinsurance companies. In the public sector, few government staff have been trained on how to operate health insurance. As the government considers establishing health insurance in the future, it is advisable to start building technical capacities for health insurance early. The knowledge of governance, risk management, actuarial analysis, forecasting, contracting, claims processing, and financial information systems could be applied to both health and nonhealth insurance markets and could be integrated into the current education system. International

partners could also help the government to increase its capacity through on-job training or providing opportunities for technical officials to receive formal education on operating insurance.

As in many countries, the general population has mixed feelings about public programs for healthcare. The history of ethnic and political conflict and fragile governance in Afghanistan has created a mix of expectations and distrust of the government. On the one hand, the population expects the government to take a big role in providing and financing healthcare. On the other hand, people are concerned about the implementation and effectiveness of such programs and distrust public programs generally because of the prevalence of corruption. Improving the transparency and accountability of the government to the general public would mitigate these concerns. Under HPP, the MOPH conducted the NHA and PETS, and developed the Expenditure Management Information System. These activities contribute to anti-corruption efforts in the country and should be communicated in a way that is easy for people to understand.

The government's taxation capacity should also be strengthened. Revenue collection has increased significantly since 2002. Revenue collection totaled US$2.04 billion in 2011–2012, with an annual increase of 16 percent, and more than nine times the level of revenue collected in 2002. Revenue as a proportion of GDP was more than 11.6 percent in 2011–2012, up from 11.3 percent in 2010–2011 and compared to only 3 percent in 2002 [131]. The MOPH should coordinate with the MOF and the new USAID tax revenue collection project, particularly to gain a better understanding of how tobacco taxes will be collected and allocated to public health services. Additionally, anti-corruption efforts, institutionalization and automation of tax administration processes, and expansion of the number of taxpayers would improve the government's financial situation and create fiscal space for healthcare, thus alleviating concerns caused by severe budget constraints, such as lack of medical equipment and weak health infrastructure (i.e., poorly maintained buildings).

Other concerns, such as physical inaccessibility and insecurity, are equally important for implementing health insurance schemes and should be considered in planning and piloting activities.

## Recommendations for Moving Forward with Health Insurance

Given the existence of major barriers for health insurance, such as legal restrictions and low quality of care, Afghanistan cannot be expected to establish a health insurance scheme in one or two years. However, the government and donors must work together to prepare the country for the introduction of health insurance.

The next four years will be critical in reshaping Afghanistan's healthcare system, as they will provide a limited period of donor-funded BPHS and EPHS services during which the government could develop alternative mechanisms to generate domestic resources for healthcare. Afghanistan will need to progressively address the major concerns that impede the establishment of health insurance in the country and take an incremental approach to building a health insurance system. Once the legal concerns are addressed—with technical and/or financial support from donors for designing and operating health insurance—pilot insurance schemes could be introduced and tested, starting with those employed in the formal sector and their families and providing free care for the poor. Quality of care challenges must be addressed to ensure long-term success of insurance schemes, but pilot schemes could start in areas where reasonable quality of care currently exists. If the pilot programs perform well and efforts are made to address barriers to insurance, the pilot schemes could be scaled up gradually from the formal to the informal sector, from urban to rural populations, and from a more limited benefits package for hospital care to a more comprehensive package. Given the limited capacity for health insurance in Afghanistan, development partners' technical and financial support of the government is indispensable in designing and implementing health insurance. Finally, establishing a national health insurance system is a long-term process and requires significant political commitment throughout the reform process. The most

imperative tasks are to address legal regulation barriers for health insurance and to improve the quality of healthcare.

Although the country is not ready to introduce health insurance immediately, efforts to lay the groundwork for future insurance schemes should be prioritized. The introduction of health insurance aims to address two of the problems in Afghanistan's health system: (1) high OOP spending at the point of service and the population's consequent need for financial protection, and (2) high dependence on donor funding. Ideally, the prepayment mechanism (health insurance) would reduce OOP spending by allowing the healthy to subsidize the sick and the rich to subsidize the poor. Because all members participating in health insurance schemes—except the poor—contribute to premiums, there is the potential to reduce dependence on donor funding and to generate domestic revenues for the health sector.

When the groundwork for health insurance is in place, we suggest that health insurance start in the formal sector, with a population with regular income, while providing a separate mechanism for the poor. Many countries that have achieved UHC, such as Taiwan and South Korea, initiated their health insurance programs with the formal sector for three reasons: (1) this sector's income is traceable; (2) collecting premiums from this sector is easier; and (3) this sector has the greatest ability to pay. Similarly, health insurance in Afghanistan could start with the formal sector—those who work for international organizations, banks, NGOs, civil servants, and the military. To maximize the coverage of the population enrolled in health insurance and minimize the risk of adverse selection, benefits also should be extended to family members. To further minimize adverse selection, a compulsory health insurance scheme would be optimal.

One possible concern is that health insurance coverage of employees in the formal sector and exclusion of the poor will increase existing inequalities in health service use and exacerbate disparities in health outcomes between the rich and the poor. Thus, a separate scheme should be designed specifically for the poor—for example, a health equity fund or use of premium exemptions—to address this unintended consequence. As it is unlikely that the BPHS and EPHS will end by 2018, those services should remain free to the poor. How free care is delivered to the poor (health equity fund, voucher scheme, or premium exemptions) will affect the quality of care and patients' responsiveness. Policymakers thus need to think more strategically regarding the implementation of free care.

As for the benefits package, that often depends on the financial capacity of the country and the overall purpose of the health insurance scheme. Since donors will continue supporting BPHS and EPHS at least until 2018, and because governments often take more responsibility for primary care in developing countries, the next four to five years are a golden opportunity for Afghanistan to focus on hospital care. Also, inpatient care constitutes a huge portion of OOP expenses: 38.2 percent of OOP funds in the private sector are spent on inpatient care and 73 percent of households seek inpatient care abroad [10]. For the purposes of addressing financial protection, it is more appropriate to start with inpatient care.

Donors' financial support will still be needed even if health insurance schemes are established. The estimated per capita costs (in USD) for providing care in Afghanistan are as follows: BPHS, $4.04 [37]; EPHS, $1.07 [133]; and national hospital care, $0.94 [134]. The combined total per capita cost of care is $6.06. With an average household size of 7.8 [135], an estimated total cost for provision of care per year is $47.30 per household. Given the low capacity of the population to pay for services, it is unlikely that a premium could fully cover the estimated $47.30 needed for the costs of BPHS, EPHS, and tertiary care. With technological advancement and quality improvement, the cost will increase. Consequently, the need for donor and government funding will not disappear.

# CHAPTER IV: OVERALL CONCLUSIONS AND ROADMAP OF HEALTH INSURANCE

Each of the preceding chapters outlines recommendations and suggestions for introducing health insurance in Afghanistan. We gather and summarize these findings here.

## Needs for health insurance

Afghanistan's current health financing system is not sustainable. The average health expenditure of $54/per capita is very low according to international standards and insufficient to meet the population's need for healthcare. In addition, structural issues exist in the sources of funding for health: the country relies heavily on donor funding, government funding for health is low, and households contribute by far the largest share to THE. The high household OOP spending indicates that the two free health packages (BPHS and EPHS) largely funded by international partners do not give households sufficient financial protection. In addition, the expected decline in donor funding creates an urgent need to mobilize more domestic resources for health. To improve this situation and achieve UHC, Afghanistan should design strategic alternative financing approaches. Introducing prepayment mechanisms (i.e., health insurance) is one approach that can increase both sufficiency and efficiency within health financing systems to achieve both health and nonhealth goals in the country.

## Readiness for health insurance

Despite many Afghan stakeholders' great need for health insurance and interest in it, establishing health insurance schemes in the short term faces several main challenges: legal barriers, inadequate understanding and awareness of health insurance at the community and governmental level, lack of technical capacity, poor quality of care, a large informal work sector, and low ability to pay among sectors of the population. These challenges make it unlikely that the Afghan government can establish health insurance schemes any time soon. But the government should begin now to address these barriers and lay the groundwork to implement a system in the future.

## Preparation for health insurance and roadmap

The experiences of Thailand and Rwanda demonstrate that strong political commitment by the highest authorities is crucial to the successful implementation of healthcare reform. Such commitment will be needed all the more in Afghanistan, where a major barrier identified by stakeholders is the absence of a clear and universal interpretation of Article 52 of the constitution.

The interpretation of Article 52 should be clarified and institutionalized among policymakers to pave the way for health insurance. Then a new law or regulation specifically related to health insurance should be developed and enacted to provide clear guidance on revenue collection, benefit package design, quality assurance, management and administration of health insurance, use of health insurance funds to pay providers, and any associated liabilities and responsibilities of a new health insurance agency.

Equally important is ensuring that the MOPH is equipped with sufficient technical capacity to provide evidence to inform decision making on the design and establishment of a health insurance mechanism. This study lays the foundation for further investigation of the feasibility of establishing health insurance in Afghanistan. Additional evidence and indicators should be covered in future studies and are needed for the following tasks:

- Designing benefits packages

- Estimating the costs of a benefits package
- Conducting actuarial analysis to assess the financial affordability of health insurance and to determine premiums
- Assessing the willingness of target populations to pay
- Establishing regulations and laws on health insurance
- Establishing a central health insurance agency

In addition to working on the technical design of a health insurance scheme, the MOPH must also address the perceived low quality of care, low accessibility of care, and lack of awareness related to health insurance among the population. Thus, actions to improve healthcare infrastructure and stimulate demand for healthcare should take place concurrently with the technical efforts to design a system.

Health insurance in Afghanistan cannot be a stand-alone policy or initiative; supplemental policies, such as establishing an equity fund, will be necessary to support implementation. For example, the MOPH must pay particular attention to the poor during the design phase. Without subsidies for the poor, the most vulnerable part of the population will not be financially able to participate in a health insurance program. Supplemental policies should be researched and implemented to ensure that the poor are integrated in the system.

When implementing a health insurance scheme, Afghanistan should consider taking a step-by-step approach and design schemes that reach specific portions of the population. Given the country's large informal work sector, multiple health insurance schemes should be considered for different population groups. To begin, Afghanistan can roll out health insurance to workers in the formal sector and their families; income is stable in this group and premiums will be easier to collect. Gradually, health insurance can be expanded to cover populations in the informal work sector.

Health insurance and health financing constitute only one of the six building blocks of a healthcare system as defined by WHO [136]. A well-functioning health system also depends on reliable leadership and governance, human resources, information systems, service delivery, and medical products and technologies. When Afghanistan designs a health insurance scheme, it should follow a multidimensional approach that takes into account all six of these building blocks. Introducing health insurance to improve health financing and increase funds for health can improve these other areas of the health system, as well, and make the health system as a whole stronger.

Figure 8 is a preliminary roadmap to prepare Afghanistan for health insurance, showing the sequence of activities that must take place to establish a sound and equitable system. The most imperative tasks are to eliminate the legal barriers to health insurance and to improve the quality of healthcare. Afghanistan's ability to implement health insurance depends on addressing these two factors in the near term.

**Figure 9: Preliminary Roadmap for Health Insurance in Afghanistan**

| Key Activities/Steps | Y 1 | Y 2 | Y 3 | Y 4 | Y 5 |
|---|---|---|---|---|---|
| Raise awareness of government/community | | | | | |
| ➢ Advocacy | | | | | |
| ➢ Learning opportunities | | | | | |
| Strengthen political will and capacity | | | | | |
| ➢ Advocacy | | | | | |
| ➢ Establishment of health insurance reform task force | | | | | |
| ➢ Evidence generation | | | | | |
| Build technical capacity of operating health insurance | | | | | |
| ➢ Training | | | | | |
| ➢ Site visit | | | | | |
| Address legal and regulatory barriers | | | | | |
| ➢ Advocacy | | | | | |
| ➢ Stakeholder analysis | | | | | |
| ➢ Amendment of the health law | | | | | |
| ➢ Development of health insurance law and relevant policies | | | | | |
| Address barriers to quality of care | | | | | |
| ➢ Improvement of contract mechanisms for BPHS | | | | | |
| ➢ Increased decentralization and autonomy of hospitals | | | | | |
| ➢ Incentives for quality of care | | | | | |
| ➢ Public-private partnerships established | | | | | |
| ➢ Accreditation | | | | | |
| Conduct actuarial analysis | | | | | |
| ➢ Benefit design | | | | | |
| ➢ Willingness to pay study | | | | | |
| ➢ Actuarial modeling | | | | | |
| Pilot health insurance among those working in the formal sector and their families | | | | | |
| ➢ Establishment of a health insurance body | | | | | |
| ➢ Establishment of policies to regulate health insurance | | | | | |
| ➢ Implementation of pilot health insurance schemes | | | | | |
| Scale up health insurance if successful and continue addressing barriers to expand insurance to other sectors | | | | | |

# APPENDIX 1. TYPES OF COMMUNITY-BASED HEALTH INSURANCE SCHEMES

**Table 1.A: Types of Health Microinsurance Schemes, by Title and Country**

| Type of Health Microinsurance Scheme | Scheme's Title and Country |
|---|---|
| Community-based health scheme | Gonosasthya (Bangladesh)<br>SEWA (India)<br>Bla and Sikasso scheme (Mali)<br>Les mutuelles de santé (Senegal)<br>Uplift Health (India)<br>BAIF (India) (2 schemes)<br>Nidan (India) (2 schemes)<br>Shramik Bharti (India)<br>Niramaya (India)<br>Women's Association's Medical Insurance Fund (India)<br>Nouna CBHI (Burkina Faso)<br>Assurance Maladie à Base Communautaire (Burkina Faso)<br>Mediclaim (India)<br>Health Insurance Fund (Nigeria)<br>SKY Health Insurance (Cambodia)<br>Sanjivani (Nepal)<br>Saubhagya (Nepal) |
| Provider-based health insurance schemes | Nkoranza hospital insurance scheme (Ghana)<br>Bwamanda hospital health insurance (Congo)<br>Masisi Referral Hospital (Congo)<br>Grameen (Bangladesh)<br>ACCORD (India)<br>Community Health Fund (Afghanistan) |
| Government-run, community-involved health insurance | Yeshasvini (India)<br>RCMS (China)<br>URBMI (China)<br>NCMS (China)<br>Shandong Province Medical Scheme (China)<br>Fengshan Township CBHI (China)<br>Hanang district health fund (Tanzania)<br>Igunga District Health Insurance Fund (Tanzania)<br>Prepayment scheme (Zambia)<br>Bla and Sikasso (Mali) (4 schemes)<br>Seguro Popular (Mexico)<br>ADMHIS (Ghana)<br>NHIS (Ghana)<br>Employees' State Insurance Scheme (India)<br>Voluntary Health Insurance (Vietnam)<br>Mutuelles (Rwanda)<br>Byumba, Kabyagi and Kabutare prepayment plan pilot (Rwanda)<br>Anambra State CBHIs (Nigeria)<br>Parwan and Saripul Community Health Insurance Funds (Afghanistan)<br>Sisattanak District CBHIs (Laos) |

**Table 1.B: Key Features of Different Types of Community-based Health Insurance Schemes**

| Type of CBHI | Design Features | Management Features | Organizational and Institutional Features | Role of Government and NGOs | Community Role | Strength of the Scheme | Weakness of the Scheme |
|---|---|---|---|---|---|---|---|
| Community-based health insurance (CBHI) | Financed by contributions from members; small financial contributions, mainly to cover primary healthcare services; membership is on a voluntary basis | Strong community involvement in decision making and supervision | The provider is not involved in the administration of the scheme; the scheme may sign contractual agreements with local providers to obtain preferential prices and ensure quality of services | NGOs often provide technical assistance and provide start-up funds; governments provide legal recognition and encourage their establishment | Pay premiums; all-around community involvement in design, implementation, and supervision | Trust and feeling of ownership | Small-scale in nature and low ability to pool enough resources; lack of technical and managerial skills regarding health insurance administration |
| Provider-based health insurance schemes | Designed by local healthcare providers (hospitals) to encourage service utilization; often cover expensive inpatient care; membership is on a voluntary basis | Providers involved in scheme management | Providers administer the schemes and collect premiums; providers may obtain technical assistance from the government and NGOs | NGOs and governments may improve the facilities of the providers | Pay premiums; provide feedback on quality | Does not require management and technical skills from the community; scheme management and service provision are integrated | Limited scale; relatively slight power of the community to influence benefits package and quality of care |

| Type of CBHI | Design Features | Management Features | Organizational and Institutional Features | Role of Government and NGOs | Community Role | Strength of the Scheme | Weakness of the Scheme |
|---|---|---|---|---|---|---|---|
| Government-run, community-involved health insurance | Designed by governments as part of the health financing system; often includes both primary care and hospitalization; membership may be voluntary or mandatory | Schemes are organized and managed through a top-down approach by central and local governments; the community may also be involved in decision making processes | Governments strongly involved in the design, implementation, and evaluation of the scheme | Governments and NGOs may subsidize the scheme and provide exemptions from premium payment for lower-income groups | Pay premiums; communities may be involved in design and administration of the schemes | The possibility of subsidized premiums; large scale of scheme and enhanced sustainability | Limited feeling of community ownership; potentially high administrative costs |

Source: Adapted from Mebratie, A.D., Sparrow, R., Alemu, G., and Bedi, A.S. 2013. "Community-based Health Insurance Schemes: A Systematic Review." Working Paper No 568. Rotterdam, the Netherlands: International Institute of Social Studies, Erasmus University.

**Table 1.C: Thailand's UCS Capitation Budget, 2003–2011**

| Items | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|
| 1. Basic capitation (Baht/per capita) | 1,202.40 | 1,308.50 | 1,396.30 | 1,659.20 | 1,899.69 | 2,100.00 | 2,202.00 | 2,401.33 | 2,546.48 |
| Outpatient services | 574.00 | 488.20 | 533.01 | 582.80 | 645.52 | 645.52 | 666.96 | 754.63 | 795.39 |
| Inpatient services | 303.00 | 418.30 | 435.01 | 460.35 | 513.96 | 845.08 | 837.11 | 885.94 | 954.72 |
| Additional budget for specific settings | | 10.00 | 7.07 | 7.00 | 30.00 | 30.00 | 72.25 | 72.25 | 64.09 |
| Prevention and promotion services | 175.00 | 206.00 | 210.00 | 224.89 | 248.04 | 253.01 | 262.06 | 271.79 | 312.50 |
| High cost & disease management | 57.00 | 86.00 | 124.21 | 244.38 | 260.58 | 145.26 | 187.08 | 205.70 | 211.70 |
| Capital replacement | 83.40 | 85.00 | 76.80 | 129.25 | 142.55 | 143.73 | 148.69 | 148.69 | 148.69 |
| Emergency medical service | 10.00 | 6.00 | 6.00 | 6.00 | 10.00 | 12.00 | | | |
| Rehabilitation services | | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 5.00 | 8.08 | 2.00 |
| No-fault compensation | | 5.00 | 0.20 | 0.53 | 0.53 | | 1.00 | | 2.68 |
| Health personnel compensation for work- related injuries | | | | | 0.40 | 0.40 | 0.85 | 0.78 | 0.97 |
| Pay for performance | | | | | 20.00 | 20.00 | 20.00 | 40.00 | 25.00 |
| Compensation for abolition of 30-Baht co-payment | | | | | 24.11 | | | | |
| Thai traditional medicine | | | | | | 1.00 | 1.00 | 2.00 | 6.00 |
| Incentives for primary care development | | | | | | | | 10.63 | 11.24 |
| Incentives for targeted tertiary care development | | | | | | | | 0.84 | 1.50 |
| 2. Antiretroviral therapy | | | | 58.56 | 83.70 | 94.29 | 63.45 | 58.66 | 62.46 |
| 3. Renal replacement therapy | | | | | | | 32.54 | 30.81 | 67.22 |
| 4. Secondary prevention of chronic diseases | | | | | | | | 6.45 | 13.14 |

| Items | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|
| 5. Supporting targeted psychiatric care | | | | | | | | | 4.24 |
| Total (Baht/per capita) | 1,202.40 | 1,308.50 | 1,396.30 | 1,717.76 | 1,983.39 | 2,194.29 | 2,297.99 | 2,497.25 | 2,693.54 |
| US$ (34 Baht: 1 US$) | 35.36 | 38.49 | 41.07 | 50.52 | 58.34 | 64.54 | 67.59 | 73.45 | 79.22 |
| Constant PPP international $[a] | 6.69 | 83.15 | 87.64 | 105.60 | 120.98 | 131.30 | 135.92 | 144.21 | 152.17 |
| % growth | | 8.8 | 6.7 | 23.0 | 15.5 | 10.6 | 4.7 | 8.7 | 7.9 |

Source: NHSO, cited in Srithamrongsawat, 2012 [68].

Calculated based on World Bank's World Development Indicators (WDI) GDP PPP conversion factor (LCU per international $).

# APPENDIX 2. COMPARISON OF AFGHANISTAN AND THAILAND

Although Afghanistan and Thailand differ greatly in many respects, a number of features of and experience from Thailand's UCS can be adapted to health financing reform in Afghanistan. Although UCS was established in 2001, one of the contributions to its success was the foundational system already in place. One of the three components of the UCS is the Civil Servant Medical Benefit Scheme (CSMBS), which was initiated in 1978 to provide a benefits package for civil servants and their dependents; it continues to play a significant role in providing access to health services and protecting beneficiaries from financial risk. Appendix Table 2.A provides snapshots of Thailand's health system in 1978, when the CSMBS was established; in 2001, when UCS was established; and in 2011, reflecting the current situation. This highlights two major phases in the reform of Thailand's health financing system—pre- and post-UCS establishment.

## Comparison of Pre-UCS Initiation and Afghanistan Today

Afghanistan is assessing the feasibility of introducing health insurance mechanisms in its current situation and aims to learn from countries that already have gone through the decades-long processes of health financing reform. This requires an examination of Thailand's situation at the start of its reform in the 1970s. At that time, Thailand was also a low-income country with a largely youthful population (and a similar population of older people—over 65 year old—to that of Afghanistan currently), as well as a similar population growth rate (2.2%) as Afghanistan (2.5%). Three-quarters of Thailand's population lived in rural areas, and its GDP per capita placed it in the developing country, low-income category. The physician-to-population ratio was the same as Afghanistan's today, though there was a greater distribution of hospital beds in Thailand. Immunization rates were high, but the infant mortality rate was significantly higher in 1978 (50.9 per 1000 live births) than in 2011 (11.8). The life expectancy of men and women in Thailand in 1978 was comparable to the current life expectancy of men and women in Afghanistan. Although the two countries today look drastically different in their economic and health situations, Thailand's starting place for its health financing reform was not too different from Afghanistan's current situation.

**Table 2.A: Comparison of Health-related Indicators in Thailand and Afghanistan**

| Indicator | Thailand | | | Afghanistan |
|---|---|---|---|---|
| | 1978 | 2001 | 2011 | 2011 |
| **Population and GDP** | | | | |
| Total population (millions) | 45.4 | 63.1 | 66.6 | 29.1 |
| Population growth (annual %) | 2.2 | 1.2 | 0.3 | 2.5 |
| Population ages 65 and above (% of total) | 3.7 | 6.8 | 9.1 | 2.2 |
| Population living in rural areas (% of total population) | 74.4 | 68.6 | 65.9 | 76.5 |
| GDP per capita, PPP (constant 2005 intl $) | - | 5,623.6 | 7,972.4 | 1,224.8 |
| GDP per capita (current US$) | 528.6 | 1,831.9 | 5,192.1 | 614.0 |
| GDP growth (annual %) | 10.3 | 2.2 | 0.1 | 6.1 |
| **Health expenditures** | | | | |
| Health expenditure per capita, PPP (constant intl $) | - | 167.0 | 353.3 | 52.2 |
| Total health expenditure (% of GDP) | - | 3.3 | 4.1 | 9.6 |
| Private health expenditure (% of GDP) | - | 1.4 | 1 | 8.1 |
| Public health expenditure (% of GDP) | - | 1.9 | 3.1 | 1.5 |

| Indicator | Thailand | | | Afghanistan |
|---|---|---|---|---|
| | 1978 | 2001 | 2011 | 2011 |
| Public health expenditure (% of govt expenditure) | - | 10.4 | 14.5 | 3.3 |
| Out-of-pocket health expenditure (% of THE) | - | 33.1 | 13.7 | 79.4 |
| External resources for health (% of THE) | - | 0.1 | 0.4 | 16.4 |
| Health workers and health facilities: | | | | |
| Physicians (per 1,000 people) | 0.2[g] | 0.3 | 0.3[a] | 0.2[a] |
| Nurses and midwives (per 1,000 people) | - | 1.4[b] | 1.5[c] | 0.1[a] |
| Hospital beds (per 1,000 people) | 1.6[g] | 2.2[b] | 2.1[a] | 0.4[a] |
| Access to healthcare: | | | | |
| Immunization, DPT (% of children ages 12–23 mo) | 92.0[g] | 96.0 | 99.0 | 68.0 |
| Immunization, measles (% of children ages 12–23 mo) | 80.0[g] | 94.0 | 98.0 | 65.0 |
| Births attended by skilled health personnel (%)[e] | - | - | 99.4[f] | 36.3 |
| **Health outcomes** | | | | |
| Life expectancy at birth, female (years) | 66.2 | 74.9 | 77.4 | 61.4 |
| Life expectancy at birth, male (years) | 60.4 | 67.5 | 70.7 | 58.8 |
| Mortality rate, infant (per 1,000 live births) | 50.9 | 18.3 | 11.8 | 72.7 |
| Incidence of tuberculosis (per 100,000 people) | 138[g] | 173 | 124 | 189 |

Source: World Bank, 2013 [9].

[a] Data from 2010; [b] data from 2002; [c] data from 2004; [d] data from 2008; [e] data from WHO's Global Health Observatory Data Repository; [f] data from 2009; [g] data from 1990.

# APPENDIX 3: KEY INFORMANT INTERVIEW GUIDE FOR MINISTRY OF PUBLIC HEALTH

### *Interviewer Information*

Name: Date: ___/___/_____

Time: Location:

### *Introduction*

The Health Policy Project is conducting a study on behalf of the Ministry of Public Health to examine the feasibility of re-introducing health insurance in Afghanistan. Afghanistan experienced health insurance in the 1970s. The health insurance was abolished due to decades-long conflict. Since then, no health insurance schemes have been established. Currently, health services are provided free of charge by NGOs and government facilities under the Basic Package of Health Services and the Essential Package of Hospital Services. Patients also seek care in private clinics and hospitals.

We would like to solicit your opinions on implementing health insurance schemes and what impact such schemes could have on population health outcomes and the health system in Afghanistan. We will ask a list of questions about health insurance and implementing health insurance in the country. There are no right or wrong answers in this discussion. We are interested in knowing what you think, so please feel free to be frank and to share your point of view, regardless of whether you agree or disagree.

### *General Information*

Position:_____

Length of time in position (years/months):_____

Responsibilities of the ministry in Afghanistan and the position

The ministry's priorities in the health sector

### *Health Financing and Health Service Delivery in Afghanistan*

Are you familiar with the health financing situation and health service delivery in the country?

What are the major opportunities and challenges to provide health services to the population? How can these challenges or risks be addressed or mitigated in the future? *Probe for availability of domestic funds, ability and capacity of government to pay, legal constraints to introducing user fees, etc.*

### *Perceptions of Health Insurance*

What is your opinion of introducing health insurance in Afghanistan? *Probe for perceptions of health insurance, experience, where opinions are coming from, feasibility, why they think it's feasible or not, why they support or not, etc.*

If you do not support, what are the major reasons for not supporting?

*Probe for:*

Concerns on legal framework and political stability and commitment

Concerns on institutional capacity to manage health insurance schemes (regulation and monitoring) and provide quality services (human resources and infrastructure)

Concerns on sustainable financing

Concerns on quality of services

Concerns on acceptability of population (trust of health insurance agencies and government, ability to pay, access, and culture)

Other concerns (e.g., security)

What strategies can address your potential concerns?

Do you think the country will ever be ready for health insurance? Why? If so, when and how? What are some ways to reduce high out-of-pocket payments by households for health services?

If you support, what are the major reasons? *Probe.*

The same dimensions mentioned above.

What is the health insurance model that you think is best applicable in Afghanistan? *Probe about who will finance (government, household, donors, or combination of them), who should manage the health insurance (independent, semi-independent agency), who should be covered, what services should be covered, who should provide services. In particular, probe health insurance model for the poor.*

What are potential challenges to implementing your proposed health insurance? How can they be overcome?

What is the most important priority, from the MOPH's perspective, to successfully implement health insurance schemes in Afghanistan?

In Afghanistan, in the past few years, some private health insurance companies have been established. Which, if any, health insurance companies have you heard about or are you familiar with, and what are your opinions?

Please describe current government policy about health insurance.

Are there any lessons learned from this current experience with private health insurance?

### *Healthcare Reform*

What are the healthcare reform activities that are ongoing and planned?

In your opinion, what is the most imperative reform that should be done for providing health services and protecting households from financial risks?

What is your opinion of ongoing reform activities? What are the successes and challenges?

How do you envision the establishment of health insurance to be integrated into ongoing healthcare reform activities?

# APPENDIX 4: FOCUS GROUP DISCUSSION GUIDE FOR PRIVATE HOSPITALS

### *Interviewer Information*

Name: Date: ___/___/_____

Time: Location:

### *Introduction*

The Health Policy Project is conducting a study on behalf of the Ministry of Public Health to examine the feasibility of re-introducing health insurance in Afghanistan. Afghanistan experienced health insurance in the 1970s. The health insurance was abolished due to decades-long conflict. Since then, no health insurance schemes have been established. Currently, health services are provided free of charge by NGOs and government facilities under the Basic Package of Health Services and the Essential Package of Hospital Services. Patients also seek care in private clinics and hospitals.

We would like to solicit your opinions on implementing health insurance schemes and what impact such schemes could have on population health outcomes and the health system in Afghanistan. We will ask a list of questions about health insurance and implementing health insurance in the country. There are no right or wrong answers in this discussion. We are interested in knowing what you think, so please feel free to be frank and to share your point of view, regardless of whether you agree or disagree.

### *General Information*

The purpose of this section is to obtain general background information about the respondents:

| SN | Position (Note: should all be managers or directors) | Duration |
|---|---|---|
| 1 | | \|__\|__\| years; \|__\|__\| months |
| 2 | | \|__\|__\| years; \|__\|__\| months |
| 3 | | \|__\|__\| years; \|__\|__\| months |
| 4 | | \|__\|__\| years; \|__\|__\| months |
| 5 | | \|__\|__\| years; \|__\|__\| months |
| 6 | | \|__\|__\| years; \|__\|__\| months |
| 7 | | \|__\|__\| years; \|__\|__\| months |
| 8 | | \|__\|__\| years; \|__\|__\| months |

### *Service Delivery Situation*

How is your health facility currently financed and paid?

*Probe*: The source of revenue (government funding, user fees, direct donations, etc.); existence of funding from the government to the health facilities and in what mechanism; financial situation of health facility; how the revenue is spent.

Please explain people's access to healthcare services provided by private hospitals?

*Probe:* Who uses private hospitals, why they use private hospitals, market share of private providers, and role of private provider in health delivery systems.

What is your perception of the quality of healthcare services provided by your hospitals? *Probe for challenges.*

How do your patients pay for healthcare services in your hospital?

*Probe*: In Kabul and other urban areas, rural areas; the poor; those employed in the formal sector vs. informal sector; monetary or goods/services? Borrow money from relatives or sell land? Estimate of how much households are burdened by costs of healthcare (clarify that these are in-country costs).

What are the major challenges and opportunities for service delivery?

*Probe*: Human resources, procurement of drugs and equipment, autonomy, financial resources, quality of care, absenteeism, and service coordination.

### *Opinions on Health Insurance*

Are you familiar with health insurance? Can you explain what you think health insurance is?

In Afghanistan, in the past few years some private health insurance companies have been established. Which, if any, health insurance companies have you heard about or are familiar with, and what are your opinions?

Does your hospital currently contract with any health insurance agencies to provide healthcare for its enrollees? Or does your hospital currently provide some form of health insurance to patients?

If yes, what is the name of agency, what services are covered, how is your hospital paid?

If no, will your hospital be willing to a join service provider network to contract with a health insurance agency to provide services once health insurance schemes are established?

What is the private health sector's experience with health insurance in Afghanistan? *Probe for how these are currently regulated; size; benefits packages; premiums; etc.*

What is your opinion of introducing health insurance in Afghanistan as a way to finance health services? *Probe for perceptions of health insurance, experience, where opinions are coming from, feasibility, why they think it's feasible or not, why they support or not, etc.*

If you do not support, what are the major reasons for not supporting?

*Probe for:*

Concerns on legal framework and political stability and commitment

Concerns on institutional capacity to manage health insurance schemes (regulation and monitoring) and provide quality services (human resources and infrastructure)

Concerns on sustainable financing

Concerns on quality of services

Concerns on acceptability of population (trust of health insurance agencies and government, ability to pay, access, and culture)

Other concerns (e.g., security)

What strategies can address your potential concerns?

Do you think the country will ever be ready for health insurance? Why? If so, when and how? What are some ways to reduce high out-of-pocket payments by households for health services?

If you support, what are the major reasons? *Probe.*

The same dimensions mentioned above.

What is the health insurance model that you think is best applicable in Afghanistan? *Probe about who will finance (government, household, donors, or combination of them), who should manage the health insurance, who should be covered, what services should be covered, who should provide services. In particular, probe health insurance model for the poor.*

What are potential challenges to implementing your proposed health insurance? How to overcome them?

What is the most important priority, from a hospital perspective, to successfully implement health insurance schemes in Afghanistan?

Once health insurance is established, how likely is your health facility to join a service provision network and contract with health insurance agencies (either government entity or private entity)? Will you be willing to join the service provision network? How would you like to be paid from the health insurance agencies (outpatient services and inpatient services)?

How do you think health insurance will affect the delivery of health services?

*Probe for perceived positive impact, negative impact, and reasons why. Ask for specific examples of how the service delivery setting might change.*

# APPENDIX 5. STAKEHOLDERS WHO PARTICIPATED IN KEY INFORMANT INTERVIEWS AND FOCUS GROUP DISCUSSIONS

| SN | Type | Affiliation | Number |
|---|---|---|---|
| 1 | FGD | Community savings groups implementers: Aga Khan Development Network, AfghanAID, Mercy Corps, Madera, ACTED | 5 |
| 2 | FGD | BPHS implementers | 5 |
| 3 | FGD | Ministry of Public Health: HEFD | 7 |
| 4 | FGD | Private sector: Private hospitals, private insurance companies, Afghan Investment Support Agency, Afghan Medical Association | 7 |
| 5 | FGD | Public hospitals | 6 |
| 6 | KII | Ministry of Finance | 4 |
| 7 | KII | Ministry of Justice | 1 |
| 8 | KII | Ministry of Labor and Social Affairs | 1 |
| 9 | KII | Ministry of Public Health: ministers, Department of Civil Servant Health Insurance, Department of Policy and Planning | 4 |
| 10 | KII | Parliament: Health Commission and Sport Affairs, Commission on Legislative Affairs | 2 |
| 11 | KII | Afghan Global Insurance | 2 |
| 12 | KII | Insurance Corporation of Afghanistan | 2 |
| 13 | KII | USAID | 1 |
| 14 | KII | WHO | 2 |
| 15 | KII | World Bank | 1 |
| 16 | KII | European Commission | 1 |

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