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IN AFGHANISTAN



*Phase One Summary  
Findings*

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# Health Insurance Feasibility Study in Afghanistan

## *Phase One Summary Findings*

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**JUNE 2015**

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## INTRODUCTION

In the last decade, the health status of Afghans has drastically improved due to implementation of the Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS). However, the health financing system in Afghanistan is fragile and faces challenges in ensuring the sustainability of service delivery due to three interrelated challenges: (1) low government contributions to healthcare—the government contributes 5 percent of total health expenditure (THE); (2) high reliance on donor funding—the BPHS and EPHS are largely supported by donors, and donor funding constitutes 20 percent of THE; and (3) high household out-of-pocket (OOP) spending on health—OOP represents 75 percent of THE (Ministry of Public Health, 2013). To improve the status of the country’s health financing system, the Ministry of Public Health (MoPH) developed health financing strategies (MoPH, 2014), aiming to generate more domestic resources for healthcare, reduce donor dependence, and provide financial protection for households. Health insurance is being considered as a strategy to ensure that the health system becomes more sustainable. To assess the feasibility of introducing health insurance in Afghanistan and shed light on the steps needed to prepare the country to build a more sustainable health financing system, the USAID-funded Health Policy Project (HPP) conducted a health insurance feasibility study. Phase one of this study included: (1) a literature review of health insurance in three countries; (2) a legal assessment of health insurance in Afghanistan, and (3) a stakeholder analysis of health insurance in Afghanistan.

## CASE STUDIES

**Case study of Kyrgyz Republic:** The Kyrgyz Republic undertook health reforms by funneling a variety of revenue streams to a single-payer system responsible for funding and decision making at a national level. Initial efforts to establish 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 service accessibility throughout the country (Jakab, 2008).

To achieve significant reform in healthcare system financing, changes to the provider payment mechanism must also be considered. The Kyrgyz Republic facilitated a simultaneous financing and compensation transition by building on its existing infrastructure. Continued support of paying hospitals through global budget eased the conversion of case based payments. Furthermore, global budget allowed for less complexity in case groupings, easing the administrative and bureaucratic burden of establishing diagnosis-related groups (DRGs).

Identifying and selecting which basic services are covered under the government's insurance plan remains a challenge for the Kyrgyz Republic. Differential access based on risk (such as dental services provided to pregnant women and children) helps limit costs, but cuts against the core values of the system (Joint Learning Network for Universal Health Coverage, 2013; Lewis, 2007). Nonetheless, beginning with a smaller and easily defined population may be the easiest way forward for implementing long-term reforms. The Kyrgyz Republic has aimed to improve health in the nation by targeting the highest-burden diseases first.

The Additional Drug Package (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 also made it cost-effective (Ibraimova et al., 2011). Such a program could be implemented rapidly in Afghanistan; efforts in this area would likely focus on supply chain integrity. Creating a list of approved drugs that require little or no monitoring by medical personnel would be the first step in implementing such a program. These drugs should have a strong history of cost-effectiveness or even cost saving.

Like nearly every country that faces ballooning healthcare costs, 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 goal of universal access to healthcare has continued to move the project forward, however. With limited financial resources, the Kyrgyz Republic has successfully created a universal health financing system, enrolling 80 percent of its population in the mandatory health insurance fund (MHIF) and connecting 95 percent of its citizens with a primary care point of contact (Joint Assessment of National Health Strategies, 2012). Many of these achievements could be replicated in Afghanistan.

**Case study of Thailand:** Thailand started a health insurance program in 1970s. From 1975 to 1993, four health insurance schemes were established, including a medical welfare scheme (MWS) for elderly, children, the disabled, veterans, and monks; a civil servants' medical benefit scheme (CSMBS) for government employees and dependents; a social security scheme (SSS) for the formal private sector; and a voluntary health card scheme (VHCS) for the near-poor and poor. In 2001–2002, the Thai government launched a universal coverage scheme (UCS) and expanded its coverage to include people under the MWS and VHSC or previously uninsured. In 2010, approximately 75 percent of Thai citizens were covered by UCS, 9 percent were covered by CSMBS, and 16 percent were covered by SSS (Health Insurance System Research Office, 2012).

The successful implementation in Thailand proves that universal health coverage (UHC) is possible in a low- and middle-income country. Factors that enabled the success of Thailand's UCS include the following: (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 policies and systems, research institutions, public health administration capacities, and a computerized civil registration system.

Without political commitment and strong support from the general public, the adoption of the UCS in 2001 might not have been possible. Recovering from the 1997 financial crisis, the government's decision to implement the UCS in 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 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 impose a financial burden on healthcare providers, consequently harming the quality of care.

Thailand's Ministry of Public Health has also 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.

**Case study of community-based health insurance (CBHI) in India:** During the past two decades, microinsurance has been implemented widely across developing countries, aimed at encouraging community involvement in health risk protection and reducing out-of-pocket spending at the point of seeking healthcare. In India, several community-based health insurance schemes were implemented, but the results of these schemes are mixed. Schemes initiated by nongovernmental organizations (NGOs) alone often fail due to the small size of pooling, limited benefits, adverse selection, low capacity of management, and lack of trust (Purohit, 2014). Conversely, a few CBHI programs, such as the Andhra Pradesh program and Rashtriya Swasthya Bima Yojana (RSBY), which target the poor and are run and subsidized by the government, have increased in popularity. A recent review of CBHI in India concluded that "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" (Purohit, 2014).

CBHI has the potential to be an alternative resource for the health system, other than tax, social insurance, and donor funding. The facts that the capacity to collect taxes is weak, social and private health insurance are limited, and donor funding may not be sufficient for low-income countries necessitate communities' involvement in generating financial resources for health risk protection. 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 could consist of technical support to the community regarding how to operate health insurance and a subsidy for premiums. Rwanda and Ghana have had the most success with CBHI schemes. CBHI in both countries receives strong government and/or donor support. Without a subsidy, the premiums collected from those without regular jobs will likely be inadequate to sustain a CBHI program in the long run.

Strong government leadership in implementing CBHI is also critical in ensuring the success of such programs. While many countries have implemented CBHI, the program results have not shown significant impact. The reasons for this failure are lack of a clear framework, inadequate financial support, unrealistic enrollment requirements, and failure to engage beneficiaries. Effective government control and support are essential in addressing those bottlenecks, as reflected in the cases of Rwanda and Ghana.

Government and donor involvement, raise the issue of community distrust of health schemes managed by the government. 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. 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 range of services that can be covered by a CBHI program, to focus on the most pressing health issues and sustain the 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. Therefore, in designing CBHI programs, it is important to foster the growth of the private sector and include it in service delivery through public-private partnerships.

It should be noted that very few countries use CBHI alone to finance their health systems, and some inherent limitations of CBHI, such as the limited size of pooling and low capacity of communities to manage health funds, yield controversial results. However, CBHI provides a potentially powerful tool to protect against financial risks stemming from the rural and poor population in the informal sector. Countries could strategically design CBHI schemes that overcome common limitations. Combined with economic growth, CBHI programs could then be integrated with other government-run health insurance programs, thus serving as an intermediate tool toward UHC.

**Lessons learned for Afghanistan:** Afghanistan has made remarkable progress in improving its health system during the past decade, but it must continue to search for ways to improve the financing mechanisms. The three case studies in this review present the features of various types of health systems. Kyrgyz Republic provides a Bismarck model of healthcare reform, relying heavily on taxation and employers' and employees' contributions, whereas micro-insurance in India uses blended models to target health insurance to the poor, and Thailand's universal health coverage shows the evolution of health insurance schemes over time. The key lessons drawn from these three cases are: (1) political commitment is paramount for successful health financing reform; (2) health financing reform is a lengthy process and requires the close collaboration of multiple stakeholders, including donors, government agencies, and communities; (3) no single health financing source can solve all health system issues, so Afghanistan needs to consider designing multiple health financing sources to fund its health system; and (4) 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. As the government works toward designing and implementing an Afghan-specific health insurance program, these three case studies provide relevant information and examples of financing schemes for Afghanistan to consider and analyze.

# LEGAL ASSESSMENT OF HEALTH INSURANCE IN AFGHANISTAN

The legal assessment drew on lessons learned from other countries and included a comprehensive review of relevant laws, treaties, regulations and policies that affect the implementation of social health insurance (SHI) in Afghanistan. The review of practices and regulations in other developing countries that have successfully implemented social health insurance identified key components of regulations that should include, at a minimum

- Establishment of a central health insurance institution by law or decree
- Independence of the central health insurance entity
- Sustained and reliable revenue collection
- The ability to pool resources from various sources
- The ability to purchase services from healthcare providers
- Exercising regulatory authority

**The potential in Afghan law for a social health insurance scheme:** Within the context of Afghanistan's constitution and laws, the right to health is clear. The strongest legal basis for the country to provide free health services is Article 52 of the Afghan constitution (GIROA, 2004), 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.*

Unfortunately, there is ambiguity as to the interpretation of Article 52 and associated health laws, particularly in the definition of "free preventative healthcare...." The clause "in accordance with the law" allows for interpretation of this article by legislation, which Article 2 of the Public Health Law (GIROA, 1984) provides:

*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. However, 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 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, the collection of premiums may be in conflict with the law, depending on how "free care" is defined.

This ambiguity must be clarified by new legislation. If Afghanistan plans to pursue health insurance, new legislation on social health insurance should be drafted and enacted. Although the process of creating and enacting new legislation is often cumbersome and lengthy, it is necessary to ensure that a social health

insurance scheme will have the appropriate authorities to be successfully established and implemented in Afghanistan. The following are key recommendations for establishing an effective SHI scheme:

- Clarify primary, secondary, and tertiary health service packages
- Clarify the definition of “free” primary health services to be provided by the Afghan government
- Establish a central agency 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, Ministry of Finance (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.)

Establishing social health insurance in Afghanistan will require significant and coordinated high-level government buy-in and support for the long term. The passing of legislation and establishment of a managing authority will require the sustained focus of Afghan government leadership to ensure expeditious processing by the Ministry of Justice (MOJ) and National Assembly, and to ensure that the central health insurance body has the needed authority to implement social health insurance effectively.

# STAKEHOLDER ANALYSIS OF THE FEASIBILITY OF HEALTH INSURANCE IN AFGHANISTAN

As part of the stakeholder analysis, HPP researchers conducted key informant interviews with officials from the MoF, MoPH, MoJ, Ministry of Labor and Social Affairs (MoLSA), Parliament, donors, and staff from two insurance companies. The project also conducted five focus group discussions among community savings group implementers, BPHS implementers, public hospital managers, MoPH Health Economics and Financing Directorate (HEFD) staff, and private enterprises (i.e., private hospitals and insurance companies). In total, the HPP interviewed 51 participants. 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 well-known security concerns, they saw lack of clear legal guidance, low quality of healthcare, low awareness and understanding of health insurance among the general population, and limited technical capacity and willingness to pay as the major barriers to establishing a successful nationwide health insurance scheme, despite increasing demand. Of all the identified barriers, stakeholders regarded 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, the ambiguity of Article 52 of the constitution, which is discussed above.

These identified barriers prevent Afghanistan from establishing health insurance schemes in the short term (1–2 years). The next four years, before the end of 2018 when the World Bank SEHAT project ends, will be critical in reshaping Afghanistan's healthcare system. During this short period, while donors continue to fund BPHS and EPHS services, the government must develop alternative mechanisms to generate domestic resources for health. Afghanistan will need to progressively address these major concerns and take an incremental approach to building a health insurance system. The immediate steps toward introducing health insurance are building strong political commitments and addressing legal and regulatory barriers to health insurance. Once the legal concerns have been addressed, with support from donors, pilot insurance schemes could be introduced and tested in places where quality of care is acceptable, starting with those working in the formal sector and their families, while providing 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 limited benefits package for hospital care to a more comprehensive one.

## CONCLUSIONS AND ROAD MAP FOR HEALTH INSURANCE

The findings and recommendations are coherent across the three components. Here, we summarize the key findings from each of the three components.

**Needs for health insurance:** As it functions now, the health financing system in Afghanistan is not sustainable. The overall health spending of US\$54 per capita is very low according to international standards, and is not sufficient for the government to be able to meet the population's need for healthcare. In addition, Afghanistan faces structural issues related to sources of funding for health: heavy reliance on donor funding, low government spending on health, and households making up the largest share of health spending. Despite the implementation of the BPHS and EPHS, the two free health packages largely funded by international partners, high out-of-pocket spending among households indicates that the two packages do not provide sufficient financial protection among populations. In addition, there is an urgent need to mobilize more domestic resources for health as donor funding is expected to decline. To achieve universal health coverage, Afghanistan needs to design alternative financing approaches strategically to improve its health financing situation. Introducing prepayment mechanisms (i.e., health insurance) is one approach that can improve both sufficiency and efficiency within health financing systems to achieve both the health and non-health goals.

**Readiness for health insurance:** Despite the great need for and interest in health insurance expressed by stakeholders, Afghanistan faces challenges in establishing health insurance schemes in the near term. The main challenges are legal barriers, lack of understanding and awareness of health insurance at the community and governmental levels, lack of technical capacity, current quality of care, a large informal work sector, and low ability to pay among members of the population. Based on the challenges identified and the changes needed to lay the groundwork for a system, it is unlikely that the Afghan government will be able to establish health insurance schemes in the short term. The country should take immediate action to address these barriers and begin laying the groundwork for future implementation.

**Preparation for health insurance and road map:** Addressing such challenges requires strong political commitment. In Afghanistan, this is particularly critical because one of the major barriers identified by stakeholders was a lack of a clear and universal interpretation of Article 52 of the Constitution. Experiences from Thailand and Rwanda demonstrate that strong political commitment from the highest authorities is essential to the successful implementation of healthcare reform.

The interpretation of constitutional Article 52 should be clarified and institutionalized among policymakers to pave the way for health insurance. A new law/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, utilization of health insurance funds to pay providers, and any associated liabilities and responsibilities of a new health insurance agency.

Equally important to addressing the legal barriers is ensuring that the MoPH is equipped with sufficient technical capacity to provide evidence to inform decision making during the design and establishment of a health insurance mechanism. This phase one study lays the foundation for further in-depth examination of the feasibility of establishing health insurance in Afghanistan, but additional evidence is needed to assess the feasibility of such a system. Further studies and next steps may include: designing benefits packages, estimating costs of a benefit package, examining the target populations' willingness and ability to pay, conducting actuarial analysis to assess the financial affordability of health insurance and determine premiums, establishing regulations and laws on health insurance, and establishing a 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 general population. Thus, actions to improve healthcare infrastructure and stimulate demand for healthcare should take place concurrently with technical efforts to design a system.

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

When implementing a health insurance scheme, Afghanistan should consider taking a step-by-step approach and design schemes that target specific portions of the population. Given that there is a large informal work sector in Afghanistan, multiple health insurance schemes should be considered to reach different segments of the population. To begin, Afghanistan can roll out health insurance within the formal sector, as premiums are easier to collect and participants' income is stable. Health insurance could be gradually expanded to cover populations in the informal work sector.

Health insurance and health financing constitute only one of the six pillars of the healthcare system as defined by the World Health Organization (WHO) (WHO, 2007). To have a well-functioning health system, efforts must also focus on improving other parts of the system, such as leadership and governance, human resources, information systems, service delivery, and medical products and technologies. When designing a health insurance scheme, Afghanistan should take an integrated approach that considers the other five pillars of the health system. Introducing health insurance to improve health financing and increase funds for health can also lead to improvements in other areas of the health system and increase synergies among the six pillars.

Figure 1 presents a preliminary road map for preparing Afghanistan for health insurance, outlining the sequence of key activities that must occur in order to establish a sound and equitable system. The most imperative tasks are to address the legal regulation barriers and to improve the quality of healthcare.

**Figure 1. Preliminary Road Map and Timeline for Health Insurance in Afghanistan**



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