The World Health Report
HEALTH SYSTEMS FINANCING
The path to universal coverage

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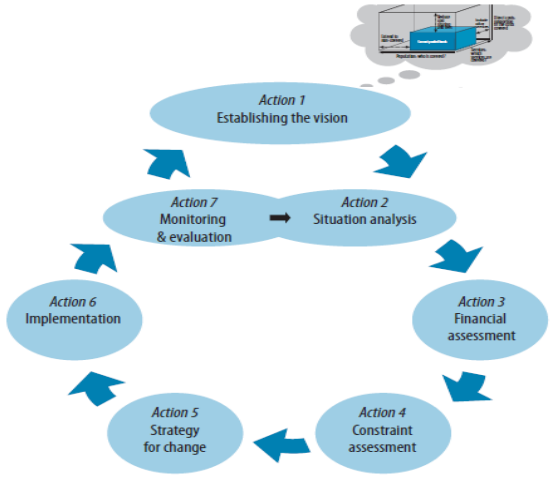
IMPROVING HEALTH FINANCING SYSTEMS: IMPROVING INSTITUTIONAL DESIGN AND ORGANIZATIONAL PRACTICE

THE IMPORTANCE OF INSTITUTIONS AND ORGANIZATIONS FOR HEALTH FINANCING PERFORMANCE AND UNIVERSAL COVERAGE

Health financing systems need to constantly adapt because there is always room for improvement and above all because country conditions and demands change. This is true for all countries across the income spectrum. Thus, accelerating progress towards universal coverage is not just a technical exercise but also a change-management and political process, as outlined in the WHR decision-making cycle.

Practical guidance on some of the steps that need to be taken can be found in the OASIS approach (Institutional and **O**rganizational **AS**sessment for **I**mproving and **S**trengthening Health Financing), developed by WHO. OASIS can help in systematically undertaking a health financing system review on the basis of which decisions can be made to improve the performance of a health financing system in order to move and accelerate progress towards universal coverage.



This brief puts particular emphasis on the role and importance of institutions and organizations in the decision-making cycle and in particular with regard to the situation analysis (Action 2), the development and formalization of strategies (Action 5) and implementation, including assessing organizational structures and rules (Action 6). This is because the achievement of universal coverage and the performance of a health financing system is contingent upon the institutional design and organizational practice relating to the health financing functions.

INSTITUTIONAL AND ORGANIZATIONAL BOTTLENECKS THAT AFFECT HEALTH FINANCING PERFORMANCE

Institutional design refers to the set of institutions, or rules, that prescribe the health financing system, including the resource collection rules, pooling rules and purchasing/provision rules. Such rules can be defined by health financing related policies, and more concretely are expressed in legislation and regulation. It goes without saying that the organizations involved in health financing are crucial for the performance of a health financing system and the degree to which they do or do not implement and comply with formal rules is critical.

Performance weaknesses in health financing systems can be caused by various bottlenecks in institutional design and/or organizational practice. As to the former, effective rules may not exist or be inadequately formulated, or else they may contradict other rules, or fail to align with country contextual factors. Organizational bottlenecks include weak organizational capacity or dysfunctional inter-organizational relationships that impede organizations in effectively undertaking their tasks within the health financing system.

IMPROVING INSTITUTIONAL DESIGN AND ORGANIZATIONAL PRACTICE TO ENHANCE HEALTH FINANCING PERFORMANCE

Once the causes of weak performance are identified/understood, appropriate changes and improvement measures in institutional design and organizational practice can be identified. The institutional design of a health financing system can be actively shaped and developed. Some countries will have to introduce new rules; others will simply need to adapt legal and regulatory provisions that already exist. Organizational capacity strengthening and better inter-organizational coordination and communication may also need to be improved. In many cases, substantial improvements and advances towards universal coverage can be achieved within the prevailing health financing system by effectively implementing and enforcing the existing legal and regulatory provisions, and/or by strengthening organizational capacity.

Vietnam, for example, has made tremendous efforts in enrolling the poorest 20% of the population in the social health insurance scheme by introducing a financing scheme, called "health care funds for the poor". However, SHI coverage could increase and double for the formal sector employees, if all eligible persons were enrolled. In Nicaragua, the government introduced a decree in 2007 that no longer allowed public hospitals to provide services to the insured. This aimed at preventing hospital managers to divert tax-financed MOH resources allocated for the uninsured to improve hospital services for the insured Separate hospital corporations were instead set up to cater for the insured. While there remain concerns about indirect cross-subsidization from tax-financed health service provision to the insurance scheme, the new legal provision constitutes an important step in the right direction. In Kenya, an important step towards reducing cost-sharing for national hospital insurance fund members was made by revising contracts with providers that limit the type of health services for which providers can charge user fees.

The choice of one improvement measure over another is ultimately guided by assumptions regarding outcomes. It is therefore important to anticipate the likely impacts of proposed changes on health financing performance as well as with respect to the overall health system and beyond. In Rwanda, for example, financial projections using 2006 data estimated that a differentiated premium amount based on income for the mutual health insurance schemes could raise 2-4 times more resources. In contrast to the current flat premium of 1000 RWF per person regardless of their ability to pay, such a differentiated premium would also improve health financing equity.

While identifying the most appropriate health financing options and strategies, including the changes and improvement measures relating to institutional design and organizational practice, the WHR decision-making cycle underlines the need to

consider both technical and political feasibility as well as assess financial implications of proposed improvements. In the Rwandan case, for example, it might be assumed that the government would be committed in principle to increasing health financing equity and to increasing resource mobilization whereas higher income groups might be reluctant to pay considerably more for the same benefit package. However, it could also be argued that better-off formal sector employees have to pay much more for the formal health insurance scheme anyway, namely 16% of their salary.

Lesotho's and Swaziland's reflections regarding the introduction of a social health insurance scheme, and in particular the possible speed in enrolling the informal sector workers, were largely determined by such feasibility considerations as well as financial projections.

FURTHER READING:

- Mathauer I, Carrin G (2010): The role of institutional design and organizational practice for health financing performance and universal coverage. Health Policy, doi 10.1016/ j.healthpol.2010.09.013.
- Ekam B et al. Health insurance reform in Vietnam: a review of recent developments and future challenges. Health Policy and Planning 2008; 23: 252-263.
- Fernandes Antunes A et al. Health financing system review of Rwanda. Options for universal coverage. Geneva: World Health Organization, Ministry of Health Rwanda; 2009.
- Mathauer I et al. Reaching universal coverage via Social Health Insurance in Lesotho? Results from a financial feasibility assessment and implications, International Social Security Review, forthcoming.