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Knowledge Brief

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CAN SOCIAL HEALTH INSURANCE BE SUCCESSFULLY INTRODUCED AND EXPANDED IN PAPUA NEW GUINEA?

KEY MESSAGES

- In the current context, the introduction of comprehensive Social Health Insurance is not feasible or sustainable in Papua New Guinea (PNG).
- Social Health Insurance (SHI) is likely to be a further drain on government revenues and human resources because of the initial start-up costs and the additional government spending required for the formal sector coverage.
- The introduction of SHI should only be revisited when the technical enabling conditions more favoured to this scheme are developed.

Cross-country comparisons have identified several enabling conditions required to ensure the sustainability of payroll tax-based systems[1]. These are: (i) a large formal labour market; (ii) a growing economy; (iii) an administrative capacity for collection; and (iv) good regulatory and oversight structures. Political willingness is another important factor. The brief below discusses in detail the technical enabling conditions in the context to introduce and expand social health insurance in PNG.

Is the country's labour market supportive?

Successful introduction of SHI financing in PNG will, in part, depend on the feasibility of expanding coverage to the entire population, including the informal sector. A second important factor is how an increase in contribution rates will affect labour and capital markets. Expanding SHI coverage to the informal sector will be challenging in almost all contexts. The population in the formal sector is relatively easy to enrol and collect contributions from due to the availability of employment earnings records. The population in the informal sector is typically not affiliated with any organisation from which to enrol and collect premiums. They are also poorer and less able to afford premiums.

According to the 2000 Census, PNG's population is predominantly in the informal sector; 67.5 percent of economically active citizens aged 10 years or over were in subsistence and self-employment, while 10.4 percent were in formal wage employment.

[1] Carrin, G., and C. James. 2004. *Reaching Universal Coverage via Social Health Insurance: Key Design Features in the Transition Period.* Discussion Paper Number 2. Geneva: WHO.

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In contrast, countries that have chosen payroll taxes as the primary source of funding in Europe, Central Asia and Latin America benefitted from having a large percentage of the working-age population employed in the formal sector[2].

Moreover, Eastern and Central European countries where payroll taxes are the predominant source of financing have a tradition of large state enterprises and civil service institutions with a large pool of formal sector employers that enables a reliable source of payroll contributions.

Are the country's macroeconomic conditions supportive?

The most effective way to scale up SHI coverage is for the government to use general revenues to subsidise premium payments for the population in the informal sector. The macroeconomic conditions are important to consider because they determine whether it is fiscally realistic to finance the expansion of coverage to the informal sector using general revenues. The few countries that have followed this model have employed substantial general tax revenues to fund the social insurance schemes and extended insurance coverage on a mostly non-contributory basis. In addition to the need to increase taxation to extend insurance coverage, it should also be noted that a significant length of time is required to extend insurance coverage to the informal sector population. For instance, it took Costa Rica 29 years from the enactment of SHI legislation to effective coverage of 85 percent of the population.

In PNG, significant additional health spending would be needed to expand SHI to the 80 percent or more of the population that is in the informal sector. Moreover, the establishment of SHI involves relatively high start-up costs, which will also have to be financed through general revenues.

Payroll taxes can also have a negative effect on future economic growth, which in turn is critical for expanding the revenue base. A review of labour markets in OECD countries found that adopting SHI in preference to revenue financing led to a reduction in the formal sector share of employment by 8-10 percent and a reduction in total employment by as much as 6 percent[3].

Is there adequate administrative and technical capacity?

Effective collection and pooling of SHI revenue requires a high degree of administrative and technical capacity within the country. Administrative capacity refers to the organisational infrastructure needed to register members, distribute membership cards and collect contributions. Technical capacity refers to the skill-set needed to operate a health insurance program, including bookkeeping, banking and actuarial skills, as well as information systems for monitoring performance[4] . The capacity needed to design and implement SHI is limited at present. It is recommended that the necessary educational qualifications and other skills–for example actuaries–are introduced first and SHI implementation postponed until such skilled personnel exist.

Is there adequate regulatory capacity?

Regulatory capacity to pass and enforce SHI laws is important to ensure the long-term financial sustainability of SHI programs. Mandatory enrolment is desirable in order to have a broad funding base, however, in settings where regulatory capacity is weak and the government is unable to enforce mandatory enrolment, adverse selection becomes a problem. Individuals with low expected health care costs do not enrol, while those with higher expected health care costs do. Costs rise relative to the SHI funding base, threatening the long-term financial sustainability of SHI. Non-enrolment of formal sector workers in insurance schemes and evasion of payments among those who are enrolled also means that SHI is no more efficient than the collection of tax revenue. In PNG, the necessary regulatory capacity has not yet been developed and sufficient suspicion around the allocation of resources already exists amongst the general population. The presence of a significant private insurance market often provides the basis for developing such regulatory capacity. The small size of the private insurance market in PNG precludes this.

[2] Ensor T., and R. Thompson. 1998. "Health Insurance as a Catalyst to Change in Former Communist Countries?" *Health Policy* 43(3): 203-18.

[3] Wagstaff. 2009. *Social health insurance vs. Tax-financed health systems: evidence from the OECD*. Washington DC: World Bank.

[4] Carrin and James, 2004.

Conclusion

In the current context, the introduction of comprehensive social health insurance is not feasible or sustainable in PNG. The feasibility and sustainability of SHI as a health financing mechanism depends on how quickly it can be scaled up to cover the entire population. The formal sector is very small and in this context, SHI is likely to be a further drain on GoPNG revenues and human resources because of the initial high start-up costs and the additional government spending required for the informal sector coverage. It is not likely to bring in significant new funding for health. Moreover, many of the prerequisites needed for effective implementation are also not in place. Administrative and technical capacity to run a comprehensive SHI scheme is currently limited. The introduction of SHI should only be revisited when the technical enabling conditions more favoured to this scheme are developed.

References

Carrin, G., and C. James. 2004. *Reaching Universal Coverage via Social Health Insurance: Key Design Features in the Transition Period.* Discussion Paper Number 2. Geneva: WHO.

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