1.0 Introduction

The Ministry of Gender, Child and Social Welfare [MGC&SW] in collaboration with the Ministry of Health, proposed to establish an innovative system of Health Care Service Provision [HCSP] through NHIF to cover the ten States of South Sudan.

1.1 Brief Background on Health Care System in the Sudan

After independence of Sudan from Anglo-Egyptian rule in 1956 and subsequent formation of national governments including the Regional Government of Southern Sudan established in 1972, the government was responsible for funding health care.

In the late seventies patients payment was introduced to assist government but did not work because most patients could not afford. In 1994 Health Insurance Act was enacted.

In 2001 the Government of Sudan extended National Health Insurance Fund Services to five States in the South; Eastern Equatoria, Central Equatoria, Western Bahr El Ghazal and Upper Nile. The other five states Unity, Jonglei, Warrap, and Northern Bahr El Ghazal did not benefit from the National Health Insurance Fund.

In 2003 the Health Insurance Act was amended to ensure stability in funding the system to be equitable to cover all the communities regardless of their financial position, be they low paid or unemployed. During the civil war the healthcare services deteriorated.

1.2 Challenges

The changing demography, economy and increasing expectations and needs of the population for improved healthcare and introduction of new technologies to health sector, the cost of health care started to rise dramatically. Government found itself-unable to meet the burden of financing health care alone, and user fees system were suggested to solve this problem. An attempt to introduce out-of-pocket payment had also failed as a result of inability of both the population and the Government to finance health care. However, both Government and population failed to finance health care, causing chronic under funding that led to:

a) **Deteriorating health care services.**
b) **Dissatisfaction with quality and quantity of services.**
c) **Inequality in access to health services (financial barriers).**

As a result, the prepayment system or National Health Insurance Fund (NHIF) was introduced as an option to reduce inequality and to improve health services situation of the people.

1.3 National Health Insurance Fund Establishment in South Sudan

To have healthy population, the Council of Ministers resolved on 28/2/2007 to establish NHIF. The process to adopt and establish an innovative system of healthcare is expected to have far reaching benefits on the health of the population. The National Health Insurance [NHI] will ensure that everyone has appropriate, efficient and quality health services. It is intended to bring about reform that will improve service provision. It will promote equity and efficiency so as to ensure that all South Sudanese have access to affordable, quality healthcare services regardless of their socio-economic status.

Regrettably the NHIF could not be established since 2007 due to many constraints. Now is the time to do it for the Republic of South Sudan. Prior to successful implementation of healthcare system, three key interventions are required:

a) **Political commitment to adopt the Health Insurance Scheme.**
b) **Management of the scheme should be semi-autonomous with financial, administrative and legal status.**
c) **The provision of a comprehensive package of medical services.**
d) **Regular and timely collection and payment of premium.**

1.3.1 Vision:

To have a model National Health Insurance Fund that is affordable, sustainable, effective, progressive and equitable.

1.3.2 Mission:

To encourage public private partnership within the Umbrella of Health Insurance for a total Health coverage in South Sudan to minimize the cost of the medical treatment, and to maximize the values of Social protection and Solidarity among all citizens.

1.3.3 Objective:

To provide quality Social Health Care System through efficient use of NHIF by polling funds into single unit, administer financial resources; procure Health Services, where

all citizens are accorded protection from hardships of medical consultations and treatment to satisfaction of vulnerable, the pensioned, children and the elderly.

1.3.4 Universal Coverage:

The universal coverage is defined by WHO ***"as the progressive development of a Health System including its financing mechanisms into one which ensures that everyone has access to quality, needed Health Services and where everyone is accorded protection from financial hardships linked to accessing these Health Services".***

A number of countries have adopted the Health Insurance Systems to achieve the above goals. This has brought about equity in access to services, administrative efficiency, increased revenue and quality improvements.

2.0 Brief Description of National Health Insurance:

a) To provide access to quality Health Services for all South Sudanese Irrespective of whether they are employed or not
b) To reduce the expenses of treatment and the financial burden on the insured person.
c) To lay down strategies of the Health Insurance for the promotion of the Medical services and minimized cost of medical treatment abroad.
d) To pool risks and funds so that equity and social solidarity will be achieved through the creation of a single fund (National system).
e) To procure services on behalf of the entire population and efficiently mobilize and control key financial resources. This will prevent the weak purchasing power that is demonstrated to have been a major limitation of some of the medical schemes resulting in spiralling cost of medical treatment.
f) To strengthen the under-resourced and strained public sector so as to improve Health Systems performance.
g) To manage Health Insurance to formulate policies, plans and programmes for the sound administration of the Fund.

3.0 Principles of National Health Insurance Fund:

The National Health Insurance will be guided by the following principles:

i. The Right to Access Health Services:

The Transitional Constitution of Republic of South Sudan article 31, "*All levels of Governments shall promote Public Health, establish, rehabilitate and develop basic Medical and Diagnostic institutions and provide free Primary Health Care and emergency service for all citizens."*

ii. **Social Protection and Solidarity:** This refers to the creation of financial risk protection for the entire population that ensures sufficient cross-subsidisation between the rich and the poor, the Healthy and sick. Such a system allows the spreading of Health costs over a person's life cycle.

iii. Equity: This refers to the Health System which ensures that those with the greatest Health needs are provided with timely access to Health Services. It should be free from any barriers and any inequalities in the system. Equity in the Health System should lead to expansion of access to quality Health Services to vulnerable groups and any under served areas.

iv. **Affordability:** This means that services will be procured at reasonable costs that recognise Health as not just an ordinary commodity of trade but as a Public Good and Human Right.

v. Sustainability: This means the Health Care Services and drug supplies, to be cost contained. This will be ensured through regular and timely collection of premium, pooling of resources and administrative stability.

vi. **Efficiency:** This will be through creating administrative structures that minimize or eliminate duplication across the National, States and local Governments. The key will be to ensure that minimal resources are spent on the administrative structures of the National Health Insurance and that value for-money is achieved through transformation of resources into actual Health Service delivery.

viii. Effectiveness: This will be achieved through evidence based interventions, strengthened management systems and better performance of the Health Care System that will contribute to positive Health outcomes and overall improved life expectancy for the entire population.

ix. Appropriateness: This refers to the adoption of new and innovative Health Service Delivery Models that take into account the local context and acceptability tailored to respond to local needs. The Health Services Delivery Model will be based on a properly structured referral system rendered via a re-engineering Primary Health Care Model.

4.0 National Health Insurance Fund Policy Statement:

National Health Insurance Fund should be a Governmental Institution (semi Autonomous) concerned with the provision of Medical Services to the insured people, through a National Health Insurance card, with equity and sustainability, at an affordable cost, conforms with quality standards, inspiring the values of social

solidarity and social co-operation and adopting the theory of large numbers taking into account community participation and clients satisfaction.

The rationale for introducing National Health Insurance is to eliminate the current tiered system where those with the greatest need have the least access and have poor Health outcomes. National Health Insurance will improve access to quality Health Care Services and provide financial risk protection against Health-Related catastrophic expenditures for the whole population. Such a system will provide a mechanism for improving cross-subsidization in the overall Health System, whereby funding contributions would be linked to an individual's ability-to-pay and benefits from Health Services would be in line with an individual's need for care. It also significantly reduces direct costs for Health Care; households under National Health Insurance are less likely to face impoverishing Health Care costs.

The National Health Insurance will ensure that everyone has access to a defined comprehensive package of Health Care Services. The covered Health Care Services will be provided through appropriately accredited and contracted *Public and Private Provide*r (Indirect Method); however, it may apply the direct and the Joint methods according to a particular situation.

4.1 How to subscribe or to be insured:

Health Insurance is a form of financial protection against the risks of paying for Health Care. It is the pooling of funds to spread the financial burden across population, through Cost Sharing System. The Health Insurance shall be compulsory to include:

I. **All employees in the Public and Private sectors.**
II. **Pensioners.**
III. **Poor families.**
IV. **Self- employed.**
V. **Farmers, Nomads, Students. etc.**

4.2 Compulsory Health Care Insurance:

It is made compulsory in order to obtain the following:

a) Achieve the rule of large numbers (actuarial reserve).
b) Sustainability of Medical and Drug Supplies with minimum cost (efficiency).
c) Unified standards of Medical Services (equitable).
d) Pre-existing conditions, children, elderly, disable, do not influence the level of contributions and must not lead to exclusion from protection.
e) Avoid favouritism.

4.3 Contribution from Employees (Premium):

The current contribution rate is 10% of total wages (6% by the employer and 4% by the employee). Another flat rate contribution is paid on behalf of certain categories through different sources as follows (third partner):

a) **Pensioners shall be covered by Social Insurance and Pension Funds.**
b) **Martyrs families shall be covered by the concerned institutions.**
c) **Vulnerable groups, e. g elderly, persons with disabilities shall be covered by the Government and other Institutions.**
d) **Poor families shall be covered by the Government and Religious Organizations.**
e) **The Higher Education Students shall be covered by the National Students Fund or their families.**
f) **Informal Sectors through their Councils, Unions, local Development Committees and others.**

The premium whether fixed or flat rate is specified by the actuarial studies. Once a person is insured, the following members of his or her family can get the same package of services, (but, any one of them should have his or her own National Health Insurance Card):

I. **Parents.**
II. **Children aged less than 18 years (Birth Certificates required) plus unmarried daughters.**
III. **Wife (Husband is included only in cases of disability).**
IV. **National Health Insurance Fund card gives a person a right to have access to the package of Health Services in any National Health Insurance centre inside South Sudan.**
V. **The number of the dependence to be covered shall be (8) members of nuclear family.**

5.0 Socio-economic Benefits of National Health Insurance:

Development and prosperity of a Nation depends on the Healthy State of its citizens. Therefore, Good Health, promotes Social Development and Economic productivity in many ways, just to name a few:

a) **Healthy Person works more effectively, efficiently and devotes more hours to productive activities and promotes Growth Domestic Product of the Country.**
b) **A broader knowledge in Health Insurance increase life expectancy.**
c) **Increased working life and long life expectancy will result in high earning and more saving for retirement.**
d) **Strengthen Social Solidarity among the citizens.**

These benefits promote Healthier population which in turn translates into productive and an effective work force that grows local business, attracts foreign investors and boost Domestic Economy·

An investment in Health Care is important safety net against poverty traps in times of economic crisis. Lack of Health Insurance for instance, in India over 37 million Indians fall below the poverty line each year due to catastrophic Health spending families often sell assets like livestock, gold chains, etc in order to meet medical expenses.

6.0 Population Coverage under National Health Insurance:

National Health Insurance will be mandatory to cover all South Sudanese working in both Public and Private sectors, Pensioners and all the citizens.

The Coverage will be extended to the population and the priority will be given to those with greatest need (People with pre-existing conditions) and those experiencing greatest difficulties in obtaining care (vulnerable groups). The identification of this population will be based on objective criteria and the family will be the unit of coverage.

6.1 Health Care Benefits under Health Insurance:

The provision of a comprehensive benefit package of care under National Health Insurance will be fair and rational. The term 'benefit package' describes how different types of services are organized into different levels of care in the Public and Private sectors. It also defines the types of services that are considered as achievable for the Country in line with its resources.

6.2 Health Care Services Package:

1. Medical consultation.
   - Clinical officers.
   - General practitioner consultation.
   - Specialists and consultants.
2. Routine and Chemical Laboratory Investigations.
3. Maternal and Child Health Care.
4. Diagnostic and Radiographic Investigations.
5. Dental care:
   - Root Canal Treatment.
   - Tooth Extraction
   - Tooth Filling.
   - Dental X-Ray

All the above packages should be provided free of charge for insured People except Medical prescription, Health Insurance pays three quarters of the drug price and patients pay only one quarter.

6.2.1 Temporary Exempted Services:

- Open Heart Surgeries.
- Plastic Surgery (Non Therapeutic Reasons).
- Prosthesis.
- Artificial Reproductive Technology (ART).
- Some Dental Procedures e.g. Dentures.
- Cosmetics.
- Organ Transplantation.

6.3.0 Health Care Services Delivery:

The Health Insurance Medical Care Services in South Sudan will be rendered at different level of Health Care Services, with specific core packages at every level. The insured patient should be able to access the services needed at the time of need. This should be part of the system designed and operates with appropriate grantee of patient's safety. These levels of Health Care Services will be the Primary, Secondary and the Tertiary level.

6.3.1 Primary Level:

This is the first point of entry into the Health Insurance Medical Services. The Health facilities may include the Rural Hospitals and Health Centres, Urban Health Centres. The package may include Trauma and Emergency Care, In-patient care, Out-patient visits, Rehabilitation Services, Laboratory and Diagnostic Services, Paediatric; Obstetric and Gynaecological Care, General Surgery and Dental Services.

6.3.2 Secondary Level:

This level will consist of the General or Urban Hospitals and will offer a range of General Specialist Services. Hospitals at this level render services at a General Specialist Level, receive referrals from the Primary Level Hospitals and provide specialist services to a number of Rural Hospitals. The General Specialist Services that will be provided are General Surgery, Orthopaedics, General Medicine, Paediatrics, Obstetrics and Gynaecology, and Radiology.

6.3.3 Tertiary Level:

Tertiary level Hospitals include Teaching and Specialized Hospitals that render super specialist and sub speciality care. They also serve as a main platform for training of Health workers and research. Most Health Care provided in these Hospitals, requires the expertise of teams led by experienced specialists. This includes Cardiology, Cardiothoracic Surgery, Craniofacial Surgery, Diagnostic Radiology, Maxillofacial Surgery, Endocrinology, Haematology, Human Genetics, Infectious Diseases, General Surgery, Orthopaedic, General Medicine, Paediatrics, Obstetrics & Gynaecology, and Radiology. These services may be included in more developed tertiary service, Cardiothoracic Surgery, Renal Transplant, Neurosurgery, Oncology, Nuclear Medicine, and a range of Paediatric sub-specialties.

6.4.0 Method of Health Services Delivery:

The Health Insurance Scheme may adopt the indirect method of services delivery by purchasing services from a third party Medical Services Provider; this may either be Public or Private sectors. However it may apply the direct and the Joint methods according to a particular situation especially in areas where Health facilities are not available.

Direct: The Health Insurance Scheme operates the facilities for the provision of Health Care Services by themselves; mostly this is at the Primary level.

Indirect: This is where the scheme purchases the services from other Health Providers, by paying directly for the Health Care Services expenditure base on the volume and the type of services given.
Mixed or Joint: This is where both the Direct and the Indirect methods are applied.

6.5.0 Accreditation of Health Care Services Providers:

AII Health facilities (Public and Private) that wish to be considered for rendering Health Services to the insured population will have to meet standards and quality of the Medical Services set up by the National Ministry of Health and the National Health Insurance Fund regulations.

The accreditation standards will specify the minimum range of services to be provided at different levels of care. The main purpose of the accreditation is the provision of Primary Health Care Services that can demonstrate performance linked to Health outcomes. This will entail involvement of competent Health and Medical staff with appropriate skills. In addition, providers at all levels of care must adhere to the referral procedures as defined by the National Ministry of Health. The referral system will be clearly stated; for services within or outside of the country when necessary. This will assure continuity of care and effective cost containment.

7.0 Payment of Providers under National Health Insurance:

In order to ensure effective cost-containment and future sustainability of the accountability processes of National Health Insurance, the provider payment mechanisms and associated accountability processes will be established.

At the Primary Care level accredited providers will be reimbursed using a risk-adjusted capitation system linked to a performance-based mechanism. The annual capitation amount will be linked to the size of the registered population, Epidemiological profile, target utilization and cost level.

At the Hospitals level, accredited and contracted facilities will be reimbursed using the general budget of the Hospitals in the initial phases of implementation with a gradual shifting towards Diagnosis Related Groups (DRGs) with a strong emphasis on performance management.

In preparation for contracting to private providers, mechanisms for achieving cost-efficiency will be investigated including International benchmarking from countries of similar Economic Development that have successfully implemented such processes.

Public Emergency: Medical Services will be reimbursed through the Public Hospital global budget initially and a case-based mechanism as the system matures. Contracted private emergency services will be reimbursed using a case-based approach.

The Provider Payment Mechanisms must ensure incentives for the Health workers, professionals in the Public sector and it is also important to consider the implementation of performance-based Payment Mechanisms.

Capitation shall be maintained as one of the basic forms of provider reimbursement, adjustment should be made in its application with the following principles:

a. **The capitation amount will be a uniform amount for the defined levels of providers;**
b. **The capitation amount should be linked to an appropriate index;**
c. **The Public and Private Health Providers contracted by the National Health Insurance will be assisted in controlling the expenditure through recommended formula, and adherence to treatment protocols for all conditions covered under the defined package of care. This will be necessary to ensure the appropriate level of service provision and avoid under servicing which is a common characteristic of many capitation-based system.**
d. **The budgets will be calculated on the basis of a risk-adjusted capitation formula taking into account key factors such as population size, age, Gender and Disease Epidemiological profile.**

8.0 Financing Mechanisms for National Health Insurance:

Universal coverage to affordable Health Care Services is best achieved through a Prepayment Health Financing Mechanism. To achieve universal coverage, pooling of funds requires that payments for Health Care are made in advance of an illness and these payments are pooled and used to fund Health Services for the population. The funds can be from a combination of sources (contributory).

An important consideration is that the revenue base should be as broad as possible in order to achieve the lowest contribution rates and still generate sufficient funds to supplement the general tax allocation to the National Health Insurance. As the National Health Insurance matures; consideration will be given to the alignment and consolidation of Health benefits offered by other relevant statutory entities.

8.1 Funding Flows:

The premium collection should be from the National Ministry of Finance and Economic Planning to the account of National Health Insurance Fund, and then the National Health Insurance Fund should transfer the money to the States Health Insurance's account.

9.0 The Establishment of National Health Insurance Fund Structure:

The National Health Insurance Fund will be a Semi-autonomous Public entity reporting to the Ministry of Gender, Child and Social Welfare. It will be governed by the Board of Directors. The Fund will be established through the passing of enabling legislation and supporting regulations. The National Health Insurance Fund Headquarter shall be at the National Capital and shall establish States Executive Administrations.

At the National level, the National Health Insurance Fund will be managed by a General Manager who will report directly to the Minister of Gender, Child and Social Welfare. The General Manager will be supported by competent Management Team and Specific Technical Departments. The Board of Directors shall be composed of:

a) Minister of Gender, Child and Social Welfare-chair.
b) Minister of Health, Member.
c) Minister of Finance and Economic Planning, Member.
d) Minister of Labour, Public Service and Human Resource Development, Member.
e) Chair of Chamber of Commerce, Member.
f) National Health Insurance General Manager, (Secretary).
g) Chair of Labour Unions, Member.

At the State level, the National Health Insurance Fund will establish State Executive Administrations that will be responsible for managing Health Insurance scheme in the States. The Board of Directors shall be composed of:

a) Minister of Social Development, Chair.
b) Minister of Health, Member.
c) Minister of Finance, Member.
d) Minister of Labour and Public Service, Member.
e) Minister of Local Government and Law Enforcement Agency, Member.
f) Chair of Labour Unions, Member.
g) Chair of Chambers of Commerce, Member.
h) Executive Director, (Secretary).
i) Chair of Women Association, Member.
j) Chair of Association of Persons with Disability, Member.
k) Chair of Martyrs Association, Member.

In order to implement effective National Health Insurance, there will be a formation of any institutions and organisations involved in the pooling, purchasing and provision of Health Care Services to the insured South Sudanese.

The covered services will be defined as a comprehensive package of services. The main responsibility of the National Health Insurance Fund will be to pool funds and use these funds to purchase Health Services on behalf of the insured population from contracted Public and Private Health Care Providers. The Health Insurance may deliver Direct Services when there is no accredited Health Care Provider.

The Ministry of Health will continue to play its overall stewardship role of the Health System, such as development of overall Health Policy and remain a major Health Services Provider through its National, State and County level structures and facilities. The National Health Insurance Fund will purchase services and equipments in accordance with the regulations approved by the Board of Directors of the Fund.

10.0 Registration of Population:

The Board of Directors will proposed specific date for application of mandatory insurance to any class for approval by the Council of Ministers. Every employer shall present the names of their employees to the State Executive Administrations for registration.

A National Health Insurance card will be issued for the registered population and their family members. It will allow easy access to package of services by the patient. The card will be uniform for the insured population, regardless of their contribution

or other status, in order to avoid the stigma that is associated with subsidised households and individuals.

11.0 Information System of National Health Insurance Fund:

There shall be a National Integrated Health Information System within National Health Insurance Fund. The National Health Information system will contribute towards the determination of the population's Health Needs and outcomes. The information system will be essential for portability of Services for the population and also help in management planning.

12.0 Action Plan for Establishment of National Health Insurance Fund:

A short-Term Strategy (2012-2014) is to provide a coherent framework aims at promoting the existing Health Insurance Services and establishment of Health Insurance Scheme, to cover the ten States.

Long- Term Strategy (2015-2020) will include, consolidating Health Insurance Services and capacity building of staff in collaboration with concerned Ministries in the ten States.

Chart No. 1

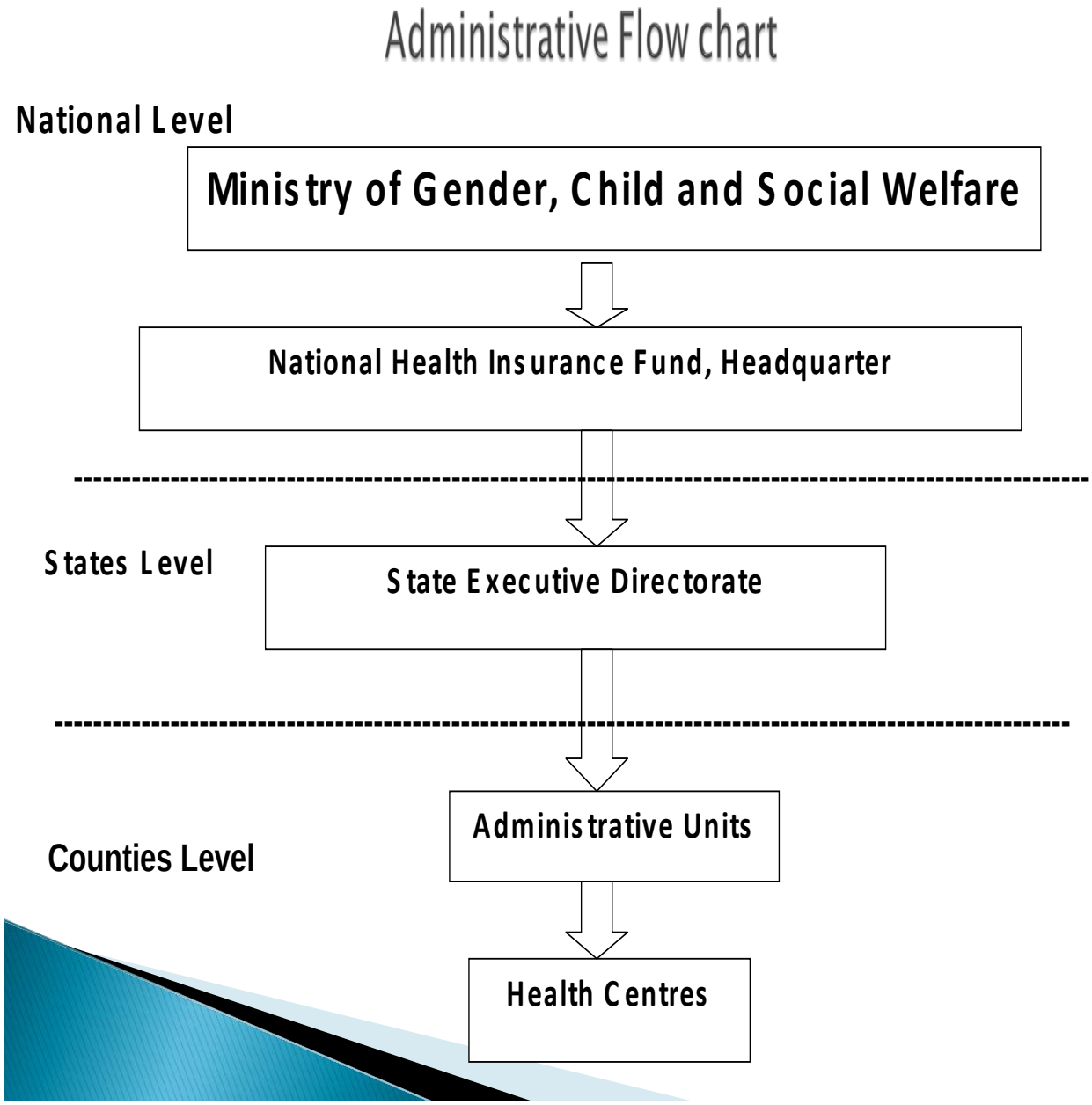
Administrative Flow chart
National Level
Ministry of Gender, Child and Social Welfare
National Health Insurance Fund, Headquarter
States Level
State Executive Directorate
Counties Level
Administrative Units
Health Centres

Chart No. 2

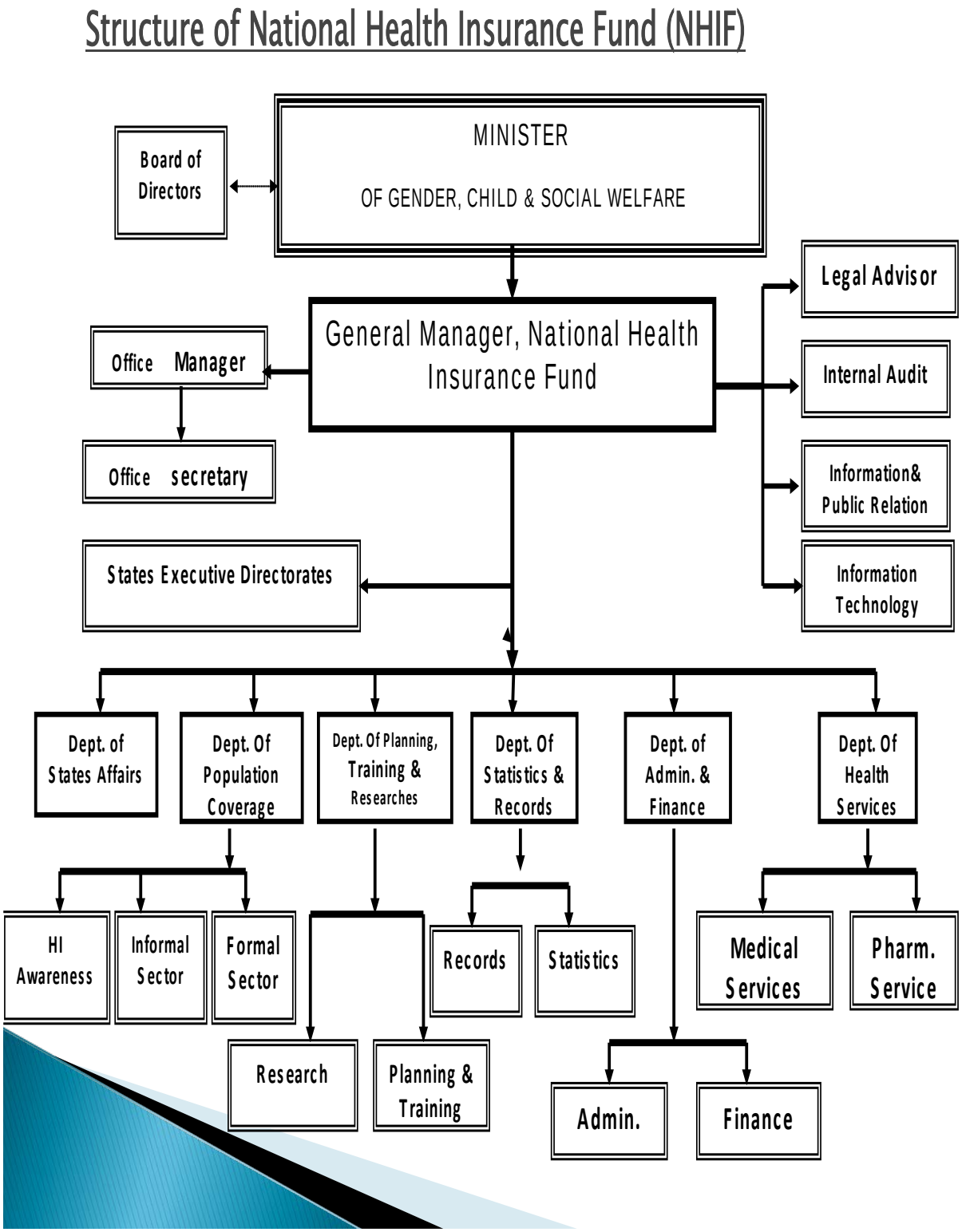
Structure of National Health Insurance Fund (NHIF)
Board of Directors
MINISTER
OF GENDER, CHILD & SOCIAL WELFARE
Legal Advisor
General Manager, National Health Insurance Fund
Office Manager
Internal Audit
Office secretary
Information& Public Relation
States Executive Directorates
Information Technology
Dept. of States Affairs
Dept. Of Population Coverage
Dept. Of Planning, Training & Researches
Dept. Of Statistics & Records
Dept. of Admin. & Finance
Dept. Of Health Services
HI Awareness
Informal Sector
Formal Sector
Records
Statistics
Medical Services
Pharm. Service
Research
Planning & Training
Admin.
Finance

Chart No. 3

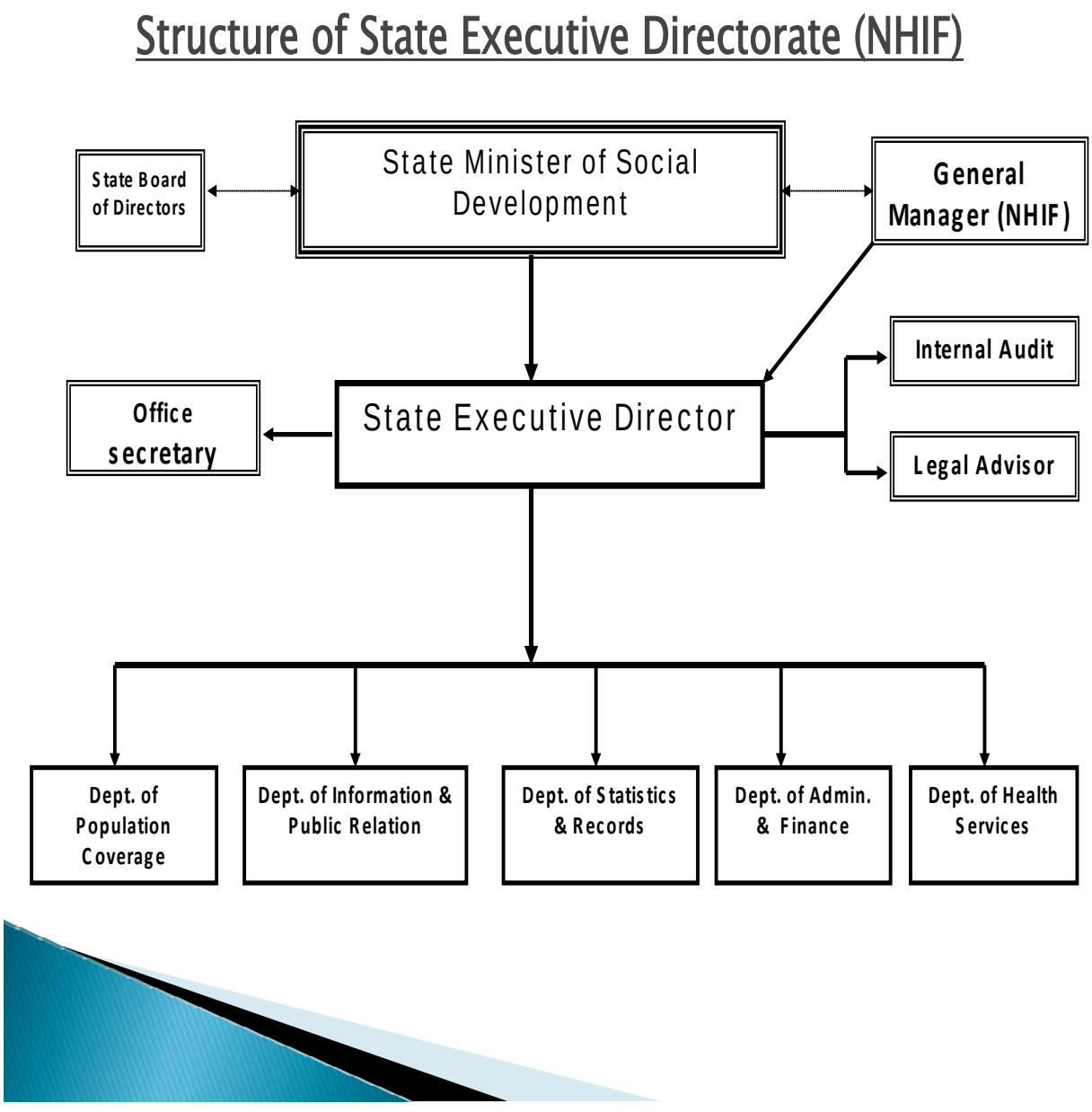
Structure of State Executive Directorate (NHIF)
State Board of Directors
State Minister of Social Development
General Manager (NHIF)
Internal Audit
Office secretary
State Executive Director
Legal Advisor
Dept. of Population Coverage
Dept. of Information & Public Relation
Dept. of Statistics & Records
Dept. of Admin. & Finance
Dept. of Health Services

Chart No. 4

Proposed Structure of Executive Administrative Units-NHIF (Counties Level)