When doctors and nurses are not enough: The need for more qualified social health protection staff for developing Universal Health Coverage

By Martina Pellny, Bart Jacobs, Franziska Fürst, Rajani Pokharel*

Introduction

Universal Health Coverage (UHC) has become an internationally widely accepted concept to improve the health status of countries’ populations (1). It is also discussed as one of the sub-goals for the post-2015 agenda on sustainable development. Consequently, many governments around the world have drafted strategies to achieve this goal.

The reason and challenge behind universal health coverage can be described as follows: Around 100 million people are pushed into poverty each year paying for health care out of pocket at the time of need. Many more are too poor to consider going to a doctor in the first place or do not have access to care at all (2).

Universal health coverage has therefore been labeled as the “single most powerful tool in public health”(3). It was for this reason that WHO devoted its World Health Report “Health Systems Financing – the path to universal coverage” to this topic in 2010 (4). Other international bodies and organizations such as the United Nations General Assembly and the African Development Bank have equally emphasized the need to focus on universal health coverage in the recent past (5; 6; 7). In 2007, during the G8 summit in Germany, Germany and France launched together with Switzerland, Spain, the USA and the International Labor Organization (ILO), the World Health Organization (WHO), the World Bank and the African Development Bank the network P4H (Providing for Health) to jointly support countries in their endeavor to establish sound plans for universal health coverage.

While the UHC-debate so far has been revolving predominantly around topics such as access to care and financial risk protection, with the obligatory technical debates on funding, pooling, purchasing, and the provision of medical staff to deliver quality care, one aspect has received little attention so far: the need for non-clinical skills and competencies to formulate and implement comprehensive health system reforms for UHC in low and middle income countries.

The topic of this paper has emerged from discussions within the P4H network during country work and aims to raise awareness for the need of more qualified social health protection staff in countries that wish to implement UHC. It outlines a number of competencies related to health system functions, gives a snapshot into the situation of countries such as Cambodia and Nepal, and finally describes the case of Germany where the profession and training of “social insurance clerk” was established under public law to guarantee the availability of qualified staff tailored to the system.

Understanding educational bottlenecks to health system reforms

Health system reforms aiming for universal health coverage are a complex undertaking – there is no one-size-fits all solution. Most health system elements in countries are historically pre-defined and interdependent: for example, investing in the education of the clinical health workforce requires information on the epidemiological health needs of the population as well as the organizational set-up of how health services are delivered. The way how health services are delivered depends often on the existing payment schemes, thus how health professionals or health facilities are remunerated and incentivized. The level of remuneration as well as the breadth of the benefit package offered to

---

*This discussion paper is based on an unpublished earlier draft written by Heiner Solomon, Kai Straehler-Pohl, Viktoria Rabovskaja, Jean-Olivier Schmidt, Nina Siegert
the population free of charge on the other hand is dependent on the ability of a country to raise funding for health. This is indirectly linked to the funding model a country has subscribed to – either tax based, contribution based or mixed, mandatory or voluntary. And here we enter into the field of governance with policy formulation and implementation. The ability to translate health policy goals into legal regulations and to ultimately integrate them into the overall legal and fiscal system of the respective country is crucial for smooth and successful reforms. And since health reforms in most countries are a continuous undertaking, the links between resource generation, service delivery, financing and governance need to be well understood for policy formulation and implementation.

This is a challenging task and requires skills that are not always common in low and middle income countries for staff working in the health sector. Traditionally medical doctors have dominated the policy level, along with other allied health professionals. The needed skill mix is often not available and only few are trained in economics and financing, or in legal affairs. Each choice for example on the expansion of a benefit package, or the merging of two existing schemes for different population groups has implications on access to care, financial risk protection or affordability. This demands econometric studies, fiscal gap analysis or legal feasibility studies – research and evidence that requires training in economics, law and related fields.

Policy formulation

Translating evidence into policy formulation does not require that ministries or other public agencies carry out studies and analysis in-house. In many countries, this is done either in cooperation with universities or academia, or in executive agencies that work under the respective ministry. Ideally, here we find professionals that are trained in medical science, working in teams with policy analysts, economists, epidemiologists, IT specialists, mathematicians, actuarial scientists, financial managers, auditors and lawyers.

The advantage of having a separate entity responsible for evidence generation such as executive agencies has allowed – especially in many Western European Countries – the clear delineation between functions of policy formulation and policy implementation.

Many ministries have shifted over the past 25 years from operating and managing health care directly towards regulating, monitoring and incentivizing the health care system and all actors involved. This change in responsibilities from a process based towards a results-based approach implies at the same time the focus on regulatory and political functions that demands a skill mix that many low and middle income countries are struggling to install. While ministries’ officials do not require the depth of specialist training found in academia or executive agencies, but they still need to be sufficiently trained in a variety of skills in order to understand the implication of technical studies for policy implementation, and in a first instance, to understand what kind of studies needs commissioning.

In addition, it also needs inter-sectoral thinking: Health sector reforms often touch on sector boundaries that go beyond the technical remit of health ministries: the introduction of universal health coverage with its consequences on the state budget and/or a separate funds is hardly manageable without the joint action of the Ministry of Health and the Ministry of Finance. With regard to legal aspects of the formal labor market such as remuneration packages, employment conditions, private sector regulations, and the share of employers towards (possible) health insurance contributions, the Ministry of Labor needs to be involved. In many countries where the informal sector is large, the Ministry of Social Affairs is important to liaise with, as well as possibly with the Ministry of Planning, the Ministry of Decentralization, and the Ministry of Welfare etc. – depending on how government responsibilities are set-up. Lastly, for education policies such as the introduction of certified courses for qualified social health protection staff, the Ministry of Education plays a key role. Working across sectors therefore demands consensus-building capacities as well as coordination and negotiating skills. Other needed skills relate to being able to appreciate the contextual, historical, cultural and socioeconomic context.

Policy implementation

For policy implementation, skill-mix is even more evident: the more technical the task, the more important is specialization and the ability to learn and apply from a wide range of competencies and professions.

Many countries face the challenge of raising funding for health. Depending on their funding system, countries have either tax-based, contribution based or mixed systems. The challenges in low and middle income countries to collect revenue are however similar, especially with regard to the informal sector. Thus, needed skills do not differ much. Informal sector workers are highly mobile and usually have undeclared irregular incomes – automatic payroll or income tax deductions cannot be applied. In addition, these countries usually have large populations of poor people who have few resources to contribute. Collecting contributions for health insurance/ taxes is therefore difficult; creative incentives are needed, for example in combination with low-cost technologies for enrolment and claims processing as applied in the RSBY scheme in India. Raising revenue from the formal sector is therefore easier, although

2 RSBY (Rashtriya Swasthya Bima Yojna) uses smartcard technology which enables immediate enrolment and cashless provider reimbursement as well as addresses administrative challenges related to patient verification and processing of claims, and thus makes it easier to include informal sector workers.
employers often try to evade payments by manipulating payroll taxes. Thus a good monitoring system with excellent database technology and enforceable sanctions is indispensable for collecting from both the formal and informal sector – and demands a qualified team of lawyers, economists, claim and compliance officers, accountants, IT specialists and others.

Resource generation also touches upon policy questions such as: what are the long term trends in the proportion of total health expenditures to GDP? What is the ratio of public expenditures versus private expenditures/ out-of-pocket payments - numbers that are available from the routine implementation of National Health Accounts (NHA) that allows guidance for the bigger picture in terms of: Is there sufficient funding for the sector – and is it equitable? Or, what is the role of public funding and what are options for future funding? The following examples in the table outline potential competencies and skills needed to guide the implementation of resource generation and revenue collection for health

### Table 1: Competencies and Skills in Resource generation/Revenue collection

<table>
<thead>
<tr>
<th>Function</th>
<th>Areas</th>
<th>Examples: Competencies and skills needed in…</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tax-based</td>
<td>- Tax types and options for earmarking for health (potential revenue versus cost of administration)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Capacity to tax the informal sector</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- State budget formulation procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- National health accounts (NHA)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Percentage of public spending on health in line with health needs</td>
</tr>
<tr>
<td></td>
<td>Contribution-based</td>
<td>- Enrolment of population groups (individual or family membership/ mandatory or voluntary/ exempted groups), database management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Calculation of contributions in line with entitlements (flat rate/ proportional on income/ risk based/ share of employer/ ceilings)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Collection method (formal and informal sector)</td>
</tr>
<tr>
<td></td>
<td>Co-payments/ user fees</td>
<td>- List of services and prices</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Collection method (potential revenue versus cost of administration)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Exemption/ waiver criteria and procedures</td>
</tr>
</tbody>
</table>

Source: (table based on 12 and own)

Most countries seek to manage funding for health through risk-pooling mechanisms in order to better spread the financial risk of health care across a large and diverse membership. The logic behind this is solidarity between members who are more at risk of ill-health and those who only need little care. Pooled pre-paid funds reduce the likelihood of ill people facing financial hardship vis a vis for example countries which rely more heavily on out-of-pocket payments. Tax-based national health services have ideally one pool for health costs, the part that is allocated from the national budget to the health sector. However, in reality, most countries have a decentralized administrative system, where several pools exist (for example per region/ district). The same is true for countries with social health insurance and often multiple insurance funds. In both institutional set-ups, resource allocation formulas are often applied to guarantee similar resources for similar health needs regardless of age, gender or geographical location and contain therefore adjustment factors that require skills in epidemiology and mathematics. Pooling also requires managing possible short-term investments, transfer and cash-flow procedures - skills that are typically taught in banking and financial management. And finally, the supervision and regulation of pools is an important topic that again requires mixed and highly specialized skills. In some Western European countries, this has led to the establishment of executive agencies. For example in Germany, the Federal Insurance Authority (BVA) supervises and audits not only all health insurance funds in Germany, but also develops and revises the resource allocation formula on a regular basis to guarantee allocative and administrative efficiency in funding decisions (13). The following examples in the table outline potential knowledge areas and skills needed to guide the pooling of funding in the health sector.

### Table 2: Competencies and Skills in Pooling

<table>
<thead>
<tr>
<th>Function</th>
<th>Examples: Competencies and skills needed in…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pooling</td>
<td>- Defining pools (part of central budget/ separate insurance pools centralized or decentralized/ pooling of donor funding)</td>
</tr>
<tr>
<td></td>
<td>- Allocating resources to pools/ risk equalization/ resource allocation formula in countries with decentralized administration (adjusted to age/ gender and geographical factors)</td>
</tr>
<tr>
<td></td>
<td>- Managing pools (investment procedures, transfer procedures)</td>
</tr>
<tr>
<td></td>
<td>- Supervision and regulation of pools</td>
</tr>
<tr>
<td></td>
<td>- Merging pools/ schemes</td>
</tr>
</tbody>
</table>

Source: (table based on 12 and own)

Many countries decide to move towards active purchasing for a number of reasons: one advantage is that money follows the patient, which enhances responsiveness. Active purchasing usually allows including public and private providers under the same framework which is important in countries with a large private sector. Some also argue (14) that contracting and the establishment of specific provider payment mechanisms can help to mitigate fraud, contain costs and create incentives for better quality services. High administrative costs are often reported as a downside, since the implementation of contracting mechanisms coupled with complex provider payment schemes needs a high degree of specialization and qualified staff, able to design, operate and monitor a complex system based on big data: millions of medical data need to be coded and translated into financial data. This again demands the investment into skills and competencies as outlined in the following table.
Table 3: Competencies and Skills in Purchasing/ Provision of services

<table>
<thead>
<tr>
<th>Function</th>
<th>Areas</th>
<th>Examples: Competencies and skills needed in…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchasing/ Provision of services</td>
<td>Provider relation and payment</td>
<td>- Single/ multiple purchaser; competing/ non-competing/ public/ private</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Active purchasing; contracting (selective/ collective)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Provider payment mechanisms (capitation, fee for service, performance-based, mixed etc.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Retrospective/prospecting price setting/ payment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Claims management and review</td>
</tr>
<tr>
<td></td>
<td>Benefit package</td>
<td>- Definition of benefit package (services included, eligible groups, maximum duration/ lengths, role of preventive actions, referral system applied etc.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Costing of benefit package (including reimbursement ceilings and deductibles)</td>
</tr>
<tr>
<td></td>
<td>Quality of health services</td>
<td>- Accreditation of providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Medical audits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Rewards for good performance and sanctions for non-compliance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Health Technology Assessment (HTA)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient appeal mechanisms</td>
</tr>
</tbody>
</table>

Source: (table based on 12 and own)

Active purchasing is usually associated with a health insurance system, where we have a natural, institutional split between purchasers and providers. But also tax-based national health services can establish a so called “internal market” where budgets are allocated according to the performance of providers and the quality they deliver, and thus the same payment schemes for providers can be applied. One famous example is the installation of the Quality and Outcome Framework (QOF) in the UK in 2004. The QOF is a voluntary program that provides financial incentives for general practices to meet performance criteria in four domains: clinical (80 indicators), organizational (43 indicators), patient experience (four indicators) and additional services (eight indicators). Alone the number of indicators applied gives an idea of the huge administrative investment that was needed to implement the program and included the employment of numerous IT specialists, data entry clerks, medical auditors and accountants as well as the installation of a sophisticated clinical information systems (15).

A snapshot into the need for more qualified social health protection staff in Cambodia and Nepal

Both countries that we want to look at are at different stages on the path towards universal health coverage.

Nepal still has a way to go: At roughly $9 per capita in 2009, public spending on health in Nepal is low (16). Although access to health care officially is free of charge, 49% of total health expenditure is paid directly by households in the form of out-of-pocket payments at the point of service (17). In 2013, the government decided to implement a national health insurance scheme that is now in the preparation of being set up.

Cambodia is also on its way towards UHC. With a government per capita health expenditure of $13 (18), it spends a bit more compared to Nepal - but with a higher out-of-pocket rate: 57% of health expenditure is spent directly by the population. Cambodia has a fragmented landscape of social protection with at the moment two main schemes: the National Social Security Fund (NSSF) for the private formal sector, and the Health Equity Funds for the poorest population.

Despite the different set ups, both countries have one similarity: They need well trained social health protection staff in order to be able to implement UHC in the long-run. There is another similarity as well: the remarkably little evidence on the educational background of staff already working in the social health protection administration as well as on skills and knowledge needed for the further development of the systems.

Cambodia

The social security scheme for the private formal sector, known as the National Social Security Fund (NSSF), started in 2008 with three branches - employment injury, social health insurance and pension fund - of which only the first one is fully operational so far. The health insurance part is piloted in 10 garment factories by a non-governmental organization (NGO). The current NSSF operates under the Ministry of Labour and Vocational Training. There is a second fund for civil servants that is under the Ministry of Social Affairs, Veterans and Youth Rehabilitation which is non-operational at the moment.

There are plans to turn the NSSF mandatory for all formally employed including the civil servants, and to cover the informal sector population under the Ministry of Health with the so called National Social Health Protection Fund (NSHPF). The NSHPF would be based on the existing scheme for the poor, the Health Equity Funds (HEFs). The reforms and the respective health financing policy drafted in 2013 are still under discussion.

The NSSF currently operates with around 300 social health protection staff although its services are geographically limited to concentrations of (garment) factories and plantations. The planned new National Social Health Protection Fund, the social health insurance scheme for the informal sector population, would require around 73 additional staff members according to conservative estimates (19). This already assumes that services such as monitoring and evaluation will be contracted out. A similar number of social health protection staff may be required for the fund for civil
servants. It is envisaged that the three schemes will use the same health insurance purchasers at district level. These purchasers will be most likely local NGOs, similar to the approach currently applied for the operating Health Equity Funds (HEFs), the scheme for the poor.

Against this background, it can be expected that if reforms for the National Social Health Protection Fund are implemented in the near future, Cambodia will need at least 150 additional social health protection staff to be able to run the two additional schemes for civil servants and the informal workers. Most of the additional staff will fulfill implementation tasks related to the revenue collection and pooling function. The estimate for needed staff does not include staff that will be required for the registration and enrollment of the population, a task that for the informal sector workers is quite human resources intense and also needs training. It also excludes all staff working on the purchasing side of the health system because this level is planned to be run by local NGOs (which in turn would also need to employ additional social health protection staff).

The now existing scheme for targeting the poorest population was initiated in 2000 by various NGOs with the establishment of so called Health Equity Funds (HEFs) on a pilot basis. HEFs are third party payers (purchasers) that reimburse selected health providers for services rendered to eligible poor. The HEFs were institutionalized in 2005 and today cover 2.7 million beneficiaries. During 2015, the HEFs will be extended to all public health facilities in all 81 operational health districts of the country.

Currently most activities related to the HEFs are performed by local NGOs independently from the Ministry of Health. As such NGOs are responsible to ensure daily operations of the HEF, the so-called HEF operators. The HEF operators in turn are monitored by an international NGO with financial support provided by an international development agency. The international NGO mainly verifies claims made by the HEF operator and conducts financial audits while also contracts health providers. HEFs operate with money pooled by donors (60%) and the Cambodian government (40%) with procurement procedures in accordance with the regulations of the World Bank. These are carried out by a special secretariat paid by the pooled funding and apply to the regular tendering and contracting of HEFs operators.

At district level, a typical HEF operator has a variety of tasks, mainly providing meet-and-greet services for patients seeking care at the referral hospital and advocate on their behalf. They also ensure social and psychological support for HEF supported patients and reimburse patients and their caretakers for transport, food and other assistance costs needed to reach health facilities and during care periods. They further keep records and receipts of all disbursements in line with the HEF Standard Benefits introduced by the Ministry of Health, which for example includes the provision of drugs. And finally, HEFs on district level maintain complaint mechanisms and monitor the quality of services provided to HEF patients.

Skill requirements for staff working at HEFs district level are thus considerable. In one health district in Takeo province, for example, the HEF caters for 60,700 eligible poor people out of a population of about 220,000 with a total staff of 10. To deliver the required services, the HEF operator employs a) one project officer managing activities at the site with a master degree in management, b) two administration assistants and two accountants, c) two data entry clerks with background in IT and d) two community facilitators interacting with the poor people and authorities. This team is backed up by a director of operations with a degree in business management administration, a clinician responsible for medical audits and all questions related to medical issues and one accounting officer with a bachelor in finance.

On ministerial level, it is the department of planning within the Ministry of Health that is currently responsible for social health protection of the informal sector population, and more specifically for the HEF scheme. The department has around 35 staff members, of whom six are employed for social health protection, all but one with a background in medical science. Most of them have attended additional courses carried out by international organizations on health financing and social protection but may benefit from further training in areas such as: defining and measuring quality of care, cost-effectiveness of care, contract formulation for purchasing services, risk management, financial audits etc.

To date, none of the country’s 22 public and 86 private universities in Cambodia offer a course on social health protection or related subjects such as health financing or social law, obliging interested persons to study abroad in a foreign language and at elevated costs. All other trainings are sporadic, mostly on the job and offered by various international organizations and NGOs.

Nepal

The agenda of universal health coverage has received considerable attention in Nepal in the recent past. The latest commitment to universal health coverage is included in the upcoming Nepal Health Sector Programme (NHSP III) 2015–2020, which has set ‘universal health coverage’ as its overarching objective.

Nepal has introduced a number of tax-based health protection schemes to address the high level of out-of-pocket spending. These include the provision of free basic health care services and some listed drugs at village and district-level health facilities (since 2007), the free delivery of children (since 2009) and cash transfers for transportation (since 2005). While these initiatives give some level of health coverage to the population, they are fragmented and do not provide sufficient coverage in the event of severe accidents.
or illnesses of the family breadwinner and lead to catastrophic expenditures (21). Overall, also for minor events, out-of-pocket payments remain high and are mostly spent on drugs and for private sector services - which play an increasing role in Nepal. According to data collected in 2012 the private sector provides 19,580 hospital beds while there are only 5,644 beds available in the public sector. Expansion of the private sector has not only taken place on the supply side, but also some private schemes have been launched over the years that offer financial protection: A number of NGO-driven community-based health insurance (CBHI) schemes are scattered around the country. However, a review of CBHI schemes in Nepal undertaken in 2012 suggested that total coverage of these schemes in the catchment areas is only around 3%. None of these schemes manage funds themselves (22). In addition to CBHI schemes, a few private for-profit insurance schemes are offered in Nepal for specialized services and the well-off. They are mostly managed from abroad and have outsourced key business processes, e.g. claims management, to India.

Before this background, the Government of Nepal is planning to roll out a national social health insurance scheme. In 2014, a policy on National Health Insurance (NHI) drafted by the Ministry of Health and Population (MoHP) was endorsed by the cabinet. The vision is the establishment of a semi-autonomous agency under the MoHP that collects contributions (on a voluntary basis), pools these with government subsidies for the poor and purchases services from the public as well as the private sector. A committee is currently drafting an act to form the legal basis for this new entity.

In the interim, to overcome the lack of a legal basis for the implementation of the national health insurance, the cabinet has issued an ordinance to form a Social Health Security Development Board, which has the mandate to run the health insurance scheme with its own regulations. This board will have seven members with the Secretary of the MoHP as the chair. Other members of the board are the Director General of the department of health services, one representative from the Ministry of Finance, one other representative from the MoHP, one expert in medicine and one expert in health economics nominated by the MoHP and one executive director. The executive director will be responsible for hiring the necessary personnel to run the planned national health insurance agency (NHIA).

For the time being, a coordination unit for the health insurance scheme has been formed under the MoHP at the central level and with branches being established in the pilot districts. It is planned to implement the national health insurance in three districts first (in Kailali, Baglung and Ilam) and then to subsequently expand to other districts until nationwide coverage is reached.

The central coordination unit has six core staff, with the Joint Secretary of the MoHP as the coordinator. Out of the core staff, one has a clinical background and the remaining five have a background in public administration. None of them have worked on anything related to health financing or health insurance before. The unit is responsible for setting the framework for the future NHIA. At the moment they mainly work on policy documents and standard operating procedures for the setting up of the information system, for designing the awareness campaigns, and for the training of the contracted district personnel and the orientating of various stakeholders in the pilot districts. So far the unit relies in many technical areas on external development partners as well as on international and local consultants to deliver the expected outputs, e.g. the Nepali-German Health Sector Support Programme is supporting the set-up of the information system, while KOICA is providing inputs into the communication campaigns. Training in these areas for the unit has been provided by development partners through study tours, national and international workshop as well as in-house trainings with international and national consultants.

The district branches are established with four contracted staff in each of the three pilot districts. The positions in each district are one district manager, one accountant and two social mobilizers. For the enrolment process, enrolment assistants from the community will be hired and paid on performance basis. The total population in the three districts is 1.03 million with 142,413 households in Kailali, 61,482 households in Baglung and 64,477 households in Ilam. Each enrolment assistant will have a catchment area of 1000 households, thus roughly over 268 assistants need to be hired. The required educational background of district staff varies: District managers should have a master’s degree in public health or social sciences. Accountants are graduates with a bachelor in business administration and social mobilizers should have a bachelor in education, sociology or law. Enrolment assistants are required to provide a school leaving certificate.

Over the course of the next ten to fifteen years, Nepal is committed to roll-out the national health insurance scheme to all 75 districts with a total population of 26 million. On district level, this would require to employ an additional 288 staff based on the ratio of four staff per district - and in terms of the enrolment process probably another 6700 temporary assistants (depending on the timing of the roll-out schedule).

For the establishment of the NHIA, the central headquarters, a study (23) has tried to estimate required task profiles and numbers and came up with a total of around 2022 staff for a fully rolled-out nationwide NHIA (see table in Annex). This is of course a huge challenge – not only in terms of finding qualified staff but also in terms of the hiring process - since the existing core unit right now is based on only six staff members.

The proposed organizational setup requires social health protection staff with background in the following areas: public relations [2], internal auditing [5], legal affairs [26],
actuary and statistics [4], human resources and training [7], sales and marketing [234], registration and enrolment [260], purchasing/ health economics and administration [1120], accounting and treasury [196], IT [9], and internal logistics [159].

To date, there is no formal training in health economics or insurance and related subjects available in Nepal, nor is it an integral part of any of the masters courses in public health. While the central department of economics at Tribhuvan University is supposed to offer an elective in health economics, this has never happened due to lack of capacity within the faculty. The master of public health curricula of the Institute of Medicine (whose graduates are, to a large extent, absorbed by the government health system) only provide a glimpse of health economics and financing and does not equip students with the skills required. Furthermore, there is no formal actuarial or any other insurance related professional training available in Nepal [24].

**Something of interest? The training of social health protection staff in Germany**

From a development perspective, it is interesting to look how other countries have dealt with the need for building up capacities for universal health coverage. In Germany for example, where social health insurance dates back to 1884, there exists a special profession, the so called “social insurance clerks”.

Social insurance clerks are the backbone of implementing health insurance in Germany. Over 85% of all staff working for the 83 social health insurance funds has been trained as social insurance clerks, often including the top level management. This guarantees a homogeneous interpretation of the respective social laws and financial processes. According to rough estimates, there is one social insurance clerk per approximately 500 insurees, with regional variations (25).

The training for social insurance clerks is an integral part of the social security system of Germany operating under public law and applies to all branches of the system: trainees can choose at the beginning of their training between the following options - general health insurance, statutory accident insurance, statutory pension insurance or the special social insurance schemes for miners and farmers.

The training for social insurance clerks is based on a joint regulation issued by the Ministry of Labor and Social Affairs and the Ministry for Education, Research and Technology (from 1971) that stipulates the public recognition of the profession “social insurance clerk”, and therefore sets the framework for: the content of the training, the three year duration, the implementing institutions and the examination (26). Before 1971, training was regulated by the federal states (“Länder” in German) and carried out by social insurance funds, but there was no national framework or public recognition.

In general terms, all trainees have to be trained in the following areas: (a) publicly stipulated tasks of the social insurance funds and the overall social security system, (b) data management and data protection, (c) internal and external communication and cooperation, (d) administrative, economic and legal processes and regulations. For trainees in the area of health insurance, the regulation also includes training in (e) insurance status and contributions (which includes regulations concerning the collection and monitoring of contributions) and (f) contracting and benefits in the event of sickness, pregnancy and maternity and long-term care.

As is the tradition of many educational programs in Germany, the training for social insurance clerks is based on the dual principle of training on the job and academic education. Implementing and thus responsible institutions are the social health insurance funds in Germany - they also act as employer at the same time. The training on the job thus takes place within the social health insurance funds, the academic training can either be organized in-house (the large social health insurance funds in Germany have special training academies for this) or with a specialized school for occupational training or other academic institutions. The training content for all (implementing) options has to be the same and is regulated by a so called *framework training plan* issued by a joint commission on health and education of the respective ministries of all Länder of Germany. All trainees receive, as employees of social health insurance funds, the same remuneration during the training period. In addition to the salary, the social health insurance funds invest around 15,000 Euros per trainee and year for the training.

The examination takes place at mid-term and at the end of the 3 years and is organized and administered on central level by the German Federal Insurance Authority (BVA) which operates under the Ministry of Labor and Social Affairs and with regard to social health insurance under the Ministry of Health as an independent supervisory agency, monitoring the social security system in Germany. Social insurance clerks with specialization in social health insurance are examined in the areas of (a) insurance and financing, (b) benefits and (c) economics and legal regulations in social affairs.

The *framework training plan* (27) for social insurance clerks and with specialization in social health insurance aims to prepare trainees for the following fields of activities: Social insurance clerks take care that all insured person who are members of that specific insurance funds pay their contributions and they guarantee insured members’ claims for benefits. They calculate individual contributions and advise insured persons on all matters of health insurance. Customer acquisition is also of their business. Furthermore, they assist in the administration of the health insurance funds. Social insurance clerks might also present measures for health protection to companies or private persons. In this case, they work as field sales representatives. Social insur-
ance clerks enjoy relative autonomy in their work and are required to carry out their duties with a sense of responsibility.

Table 4: Specific training contents for social insurance clerks with specialization in health insurance in Germany:

<table>
<thead>
<tr>
<th>Specific training contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Applying legal regulations: Identifying insurance status, calculating contributions, investigating insurance claims (accuracy of claim for insurance benefits)</td>
</tr>
<tr>
<td>• Customer counselling on insurance issues (e.g. on nursing care)</td>
</tr>
<tr>
<td>• Administrative tasks</td>
</tr>
<tr>
<td>• Applying relevant information and communications technology</td>
</tr>
<tr>
<td>• Advising employers and employees on (new) legal regulations</td>
</tr>
<tr>
<td>• Knowledge of preconditions for taking out family insurance</td>
</tr>
<tr>
<td>• Knowledge of competition and marketing in the health insurance business</td>
</tr>
<tr>
<td>• Data protection and environmental protection regulations</td>
</tr>
<tr>
<td>• Keeping to regulations on occupational safety and health protection at work</td>
</tr>
<tr>
<td>• Basics in economics</td>
</tr>
<tr>
<td>• Basics in social and civil law</td>
</tr>
<tr>
<td>• Accounting including statistics, state budget regulations, cost-benefit calculations, coding and billing</td>
</tr>
</tbody>
</table>

Source: (table based on 27 and own)

Once in their job, social insurance clerks are required to stay up-to-date with all rules and regulations that govern third party payments for health services. This usually requires a great deal of continuing education and training to stay on top of these constantly changing guidelines. In many social insurance funds, experienced clerks take part in producing reports used to improve patient care quality, to revise the benefit package, to better control costs, and conduct survey on patient satisfaction.

In addition to social insurance clerks, 15% of the staff of social health insurance funds have a different educational background, for example office management, lawyers specialized in labor law, court appeals or contracting, medical doctors for medical audits, physiotherapists for preventative programs and specialists in marketing, IT or controlling.

Conclusion

We all know that political leadership for health reforms towards universal health coverage is key - but once strategies are translated into legal regulations, they need proper implementation. Here, first and foremost medical doctors, nurses and other health personal are essential. However, as our article has shown, well qualified social health protection staff with a mixed skill-set in management, financial and legal competencies coupled with knowledge in information technology and others is in dire need in countries such as Cambodia or Nepal – which are just setting up their respective health protection system.

So – what needs to be done?

The first step might be what this article tries to do: Raising awareness in countries for the institutionalization of educating non-clinical staff for social health protection. The second step then is related to it: learning from other countries that are or have been in the same situation. The solution of Germany to establish a profession and training under public law tailored to the system might be very advanced, but offers an option that other countries could be interested in. Other options are to establish standardized courses with available local universities or partnerships with occupational schools. More studies and research on how other countries have approached the challenge to train non-medical social health protection staff are needed too. Most of the publications on human resources for health focus so far only on the need for re-thinking the education of clinical staff (28, 29). And finally, when plans how to approach the challenge – within the system or in partnership with schools or universities – are getting more concrete, the question how to develop and finance such a training stream for professional education needs to be discussed with all national stakeholders, ministries, universities, professional bodies, non-governmental organizations and possibly the international development community that can contribute technical and financial assistance.

But first we need to work on the realization that investing into the education of a knowledge-driven system (that the health system ultimately is) - is smart. Good reforms that go wrong because of unqualified staff are paid for with the trust of the population.
Annex 1:

<table>
<thead>
<tr>
<th>Planned organisational units for the NHIA</th>
<th>Responsibilities</th>
<th>Average ratio for Nepal</th>
<th>Numbers for Nepal full roll-out</th>
</tr>
</thead>
</table>
| Executive director office: public relations | - Communicating with the public on the activities and performance of the NHIA  
- Responding to objections and comments from the public  
- Final preparation of annual reports of the NHIA | 2 public relations specialists | 2 public relations specialists |
| Executive director office: internal auditing | - Auditing of operations of all departments and branches  
- Proposing enhancements for internal operations  
- Gathering statistics on the most frequent encountered errors in internal operations | 1 auditing specialists per 25 branches and 1 administrative officer per 50 branches | 3 auditing experts  
2 admin officer |
| Executive director office: legal affairs | - Reviewing all NHIA supply contracts  
- Reviewing and final preparation of all model contracts with health care providers  
- Settlement of legal issues with insurers and health care providers | 2 lawyers per 5 million insures and 1 administrative officer per 1 million insures | 10 lawyers  
26 admin officers |
| Executive director office: actuary and statistics | - Gathering statistics on the use of health care;  
- Assessing the expected impact of cost-sharing schemes  
- Proposing setup of parameters for cost-sharing schemes to be used for the benefit package  
- Calculation of contribution rates  
- Elaboration of actuarial/statistical reports | 3 actuaries/ statisticians  
1 administrative officer | 3 actuaries/ statisticians  
1 admin officer |
| Executive director office: human resources and training | - Recruiting new staff  
- Maintaining personnel records  
- Creating training/ educational plans for internal staff  
- Organising internal training | 1 human resources specialist per 300 NHIA staff | 7 human resources specialists |
| Department for sales and marketing | - Preparation, running and evaluation of marketing campaigns  
- Preparation of information booklets for insures  
- Training of sales/ enrolment assistants  
- Supplying sales staff with material (forms) and equipment  
- Answering queries of insures (by phone and email)  
- Forwarding complicated queries to relevant departments  
- Gathering statistics on most frequent queries | 2 marketing specialists  
2 admin officer  
3 sales specialists per branch office  
1 information worker per 5 million insures | 2 marketing specialists  
2 admin officer  
225 sales specialists  
5 information worker |
| Department for registration | - Collecting forms on enrolment or renewals from sale staff  
- Recording all data on households/ members and sold policies in the NHIA information system  
- Issuing insurance cards | 1 registration officer per 100 000 insures | 260 registration officers |
| Department for purchasing | - Definition of the benefit package  
- Selection of remuneration mechanisms for health providers  
- Creation and maintenance of classifications  
- Pricing/costing of units of health care  
- Recording of the benefit package and all associated classifications into the information system  
- Preparation of model contracts for types of | 2 health economists  
1 admin officer | 2 health economists  
1 admin officer |
| Department for accounting and treasury | - Accounting for all financial operations, valuating claims  
- Producing basic accounting reports for the annual report  
- Depositing/investing available funds to maximise earnings  
- Direct debiting of insured households | 1 specialist  
1 accountant per branch plus an additional 1 accountant per 600,000 insurees  
1 economist with specialisation in treasury  
1 administrative officer  
1 cashier per a branch | 1 specialist  
118 accountants  
1 economist with specialisation in treasury  
1 administrative officer  
75 cashiers |
| Department for IT | - Specification of requirements for IT support  
- Design and maintenance of all forms for business processes  
- Communication with IT vendors  
- Managing user accounts in the NHIA information system  
- Running first level help desk for internal NHIA staff  
- Gathering data on all issues in IT support | 2–3 analysts  
2 administrators (depending on the level of centralisation of the IT solution)  
1 software worker per 500 internal IT users | 3 analysts  
2 administrators  
4 software workers |
| Department for internal logistics | - Preparation of all tenders  
- Purchasing of supplies for NHIA  
- Ensuring premises with all amenities and communal services  
- Transportation of the staff to fulfil their duties in the field  
- Management of the archive | 3–4 administrative workers  
1 premise manager per branch  
1 driver per branch  
1 archive worker per 5 million insurees | 4 administrative workers  
75 premise managers  
75 drivers  
5 archive workers |
| Total | | | 2022 |
Literature

(3) Chan, Margaret. Best days for public health are ahead of us - Address to the Sixty-fifth World Health Assembly. World Health Organization. [Online] 2012. [Cited: ]
http://www.who.int/dgho/speeches/2012/wha_20120521/en/

(9) Tanzhearoensathien V, Evans D: Beyond clinical skills: key capacities needed for universal health coverage. WHO Bulletin 2013; 91: 801-801A.
(13) For more information, see http://www.bundesversicherungsumt.de/en/english.html
(20) Interview Bart Jacobs, GIZ Cambodia, 16.3.2015.
(25) Interview with AOK Bayern, Education and Training Centre Hersbruck, 09.03.2015
(27) Rahmenchrplan für den Ausbildungsberuf Sozialversicherungsfachangestellter/e, Beschluss der Kultusministerkonferenz vom 26 September 1996.

Published by:
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH
Registered offices: Bonn and Eschborn
Dag-Hammarskjöld-Weg 1-5 65760 Eschborn/ Germany
T +49 61 96 79-1446 F +49 61 96 79-11 001446
E social-protection@giz.de I www.giz.de/social-protection-systems
March 2015 Issue No. 24