ILO-RAS/NET/Vanuatu/R.2

Vanuatu

Report on the implementation of the Health Insurance Scheme in Vanuatu

International Labour Office, 2006

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1. Introduction

Over years the government of Vanuatu has been considering the implementation of social health insurance. International organizations, such as ILO and WHO[1], have provided technical assistance to develop policy for implementation of health insurance scheme.

At the Pacific Islands National Provident Fund and Allied Social Security Agencies CEO Forum in October 2005, the CEO of VNPF, Mr Kelip Sandy, stated that "The VNPF Board intends to diversify its benefits into housing, pension and medical insurance and that ILO has approved to assist in providing technical assistance for a feasibility study to be carried out."

In the framework of the ILO project 'Sub-regional initiative on social security for the Pacific island countries', a policy to implement a health insurance was developed[2]. It is recommended that Vanuatu introduce a health insurance scheme starting with the formal sector workers currently covered by the VNPF and their families, and gradually expand the coverage to all the population in Vanuatu.

To further advance our analysis, this report focuses on the issues related to the implementation of health insurance scheme. It aims to provide key information on the aspects that one faces in the implementation of the health insurance scheme. Despite the potential weaknesses in data, the report covers a number of areas.

The remainder of this report has been organised as follows. Chapter 2 looks into the key characteristics of the VNPF members, including their age-structure and income distribution. Chapter 3 provides the information on the estimated covered population, contribution rate and the estimated contribution income to the scheme. Chapter 4 will analyse how the health insurance scheme will affect the public financing on health. Chapter 5 concludes with the summary of the main findings and recommendation.

This report was prepared by Afsar Akal, ILO Expert on Social Health Insurance. Technical supervision was provided by Kenichi Hirose, Social Protection Specialist, ILO Subregional Office for South-East Asia and the Pacific.

[1] WHO, *"The WHO Strategy for Health Care Financing for Countries of the Western Pacific and South-East Asia Regions (2006-2010)"*, 2005.
[2] ILO, *"Social Security for All Men and Women - A source book for extending social security coverage in Vanuatu: options and plans"*, 2006.

2. Background: Health expenditure in Vanuatu and the financial capacity of the VNPF

2.1 Trend of health expenditure in Vanuatu

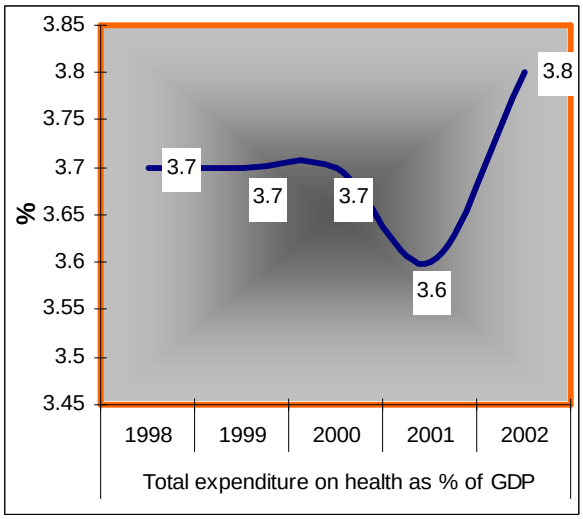
As shown in Figure 1, the health spending in Vanuatu has been at slightly below 4% of gross domestic product for the last five years. Government's share of health spending has shown a gradual increase from 70.4% in 1998 to 73.6% in 2002. Health spending accounts about 12-13 per cent of the total government expenditure.

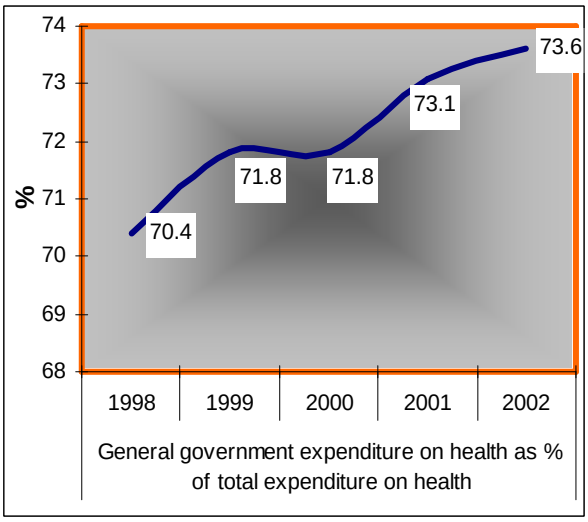
The population in Vanuatu grew rapidly at around 2.7% per annum for the period 1993-2003. The total fertility rate for this period was 4.1 children per women. While the country receives substantial external funding for health, the share of external sources fell from 26% to 19.5% in 2002.

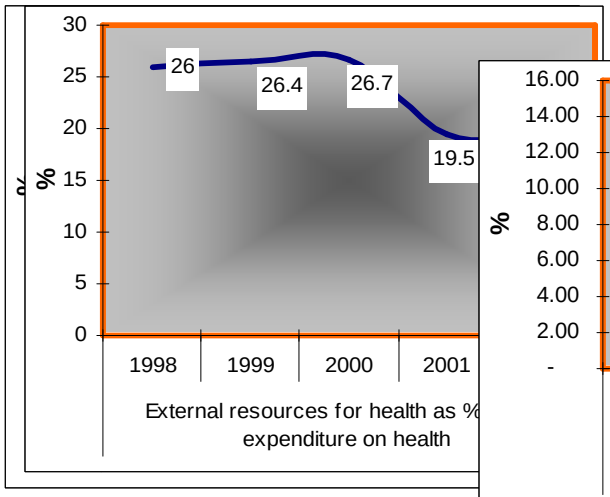
Although the health expenditure of Vanuatu is at a low-level in terms of percent of GDP, the per capita health spending stood at the level of US$120, which makes it a medium-level spender in per capita terms.

Per capita health expenditure has barely withstood its historical average and has fallen recently. In terms of purchasing power parity, health expenditure per capita has gone up slightly in 2002. While out of pocket funding for health care is much higher in comparison with other Pacific Island Countries its share of total health expenditure has fallen from more than 15% in 1998 to about 12% in 2002.

Figure 1: Health financing profile, 1998-2002







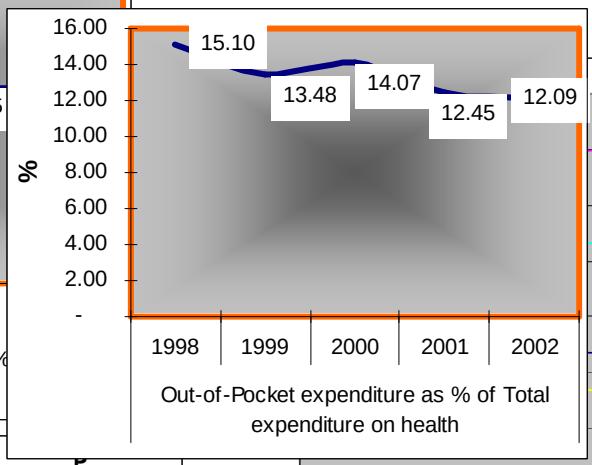


Figure 2: Per capita health expenditure, 1998-2002

2.2 VNPF membership and contributions

Table 1 shows VNPF membership and funds from 1999 to 2005. The 2005 data is estimated from the preliminary data. In 2001, there was a 31% decrease in the number of members from 26,976 to 18,607, followed by a further 7% decrease in membership next year. For the last four years, the number of contributors has remained at the level of 17,000. The average contribution per member has also been in a declining trend. This could be attributed to either wage stabilisation (nominal wages not growing much recently) or drop out of high income contributors.

Table 1: VNPF membership, funds and contributions, 1999-2005

Growth of VNPF membership, Funds and Average Contributions							
Year	*Annual contribution*	*Total members' credit*	*Number of contributing members*	*Annual Change in Membership*	*Average Contributiion per member*	*Average Contribution Per Month Vt*	*Annual change in average contribution per member*
	Vt'000	*Vt'000*	*persons*	*%*	*Vt*	*Vt*	*%*
1999	436,825	1,433,904	22,865		19,105	1,592	
2000	725,986	2,114,368	26,976	18.0%	26,912	2,243	40.87%
2001	1,023,903	3,052,221	18,607	-31.0%	55,028	4,586	104.47%
2002	1,085,521	3,991,012	17,297	-7.0%	62,758	5,230	14.05%
2003	1,005,210	4,832,151	17,222	-0.4%	58,368	4,864	-7.00%
2004	918,843	5,511,106	17,702	2.8%	51,906	4,326	-11.07%
2005 (est.)	865,777	6,484,629	16,681	-5.8%	51,902	4,325	-0.01%

2.3 Profile of the VNPF members

(1) Age structure and health needs

Figures 3 and 4 present the age structure of the VNPF members in 2005.

Figure 3: Active VNPF members by age, 2005

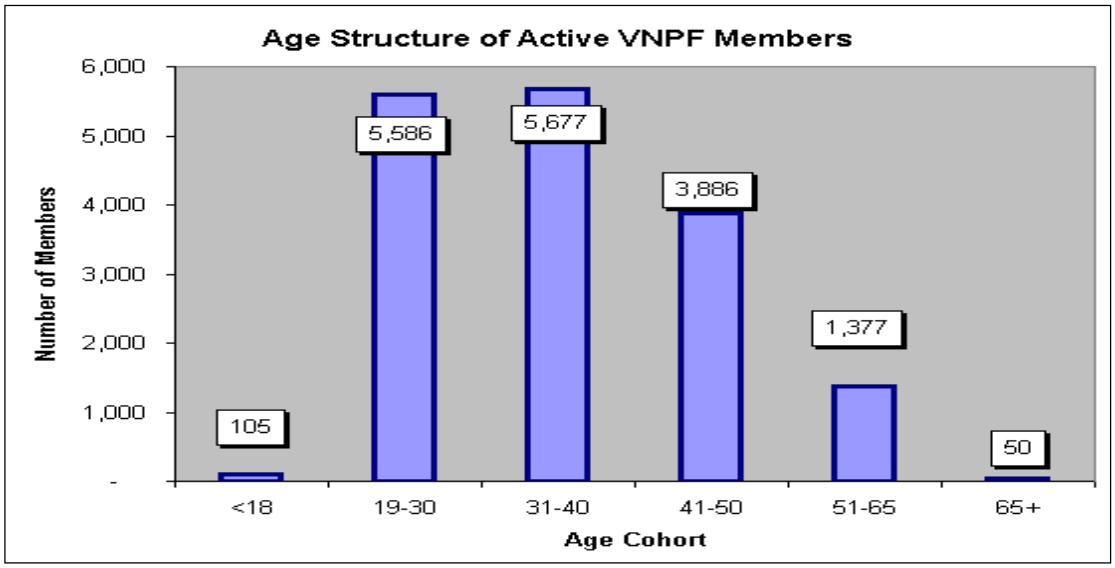
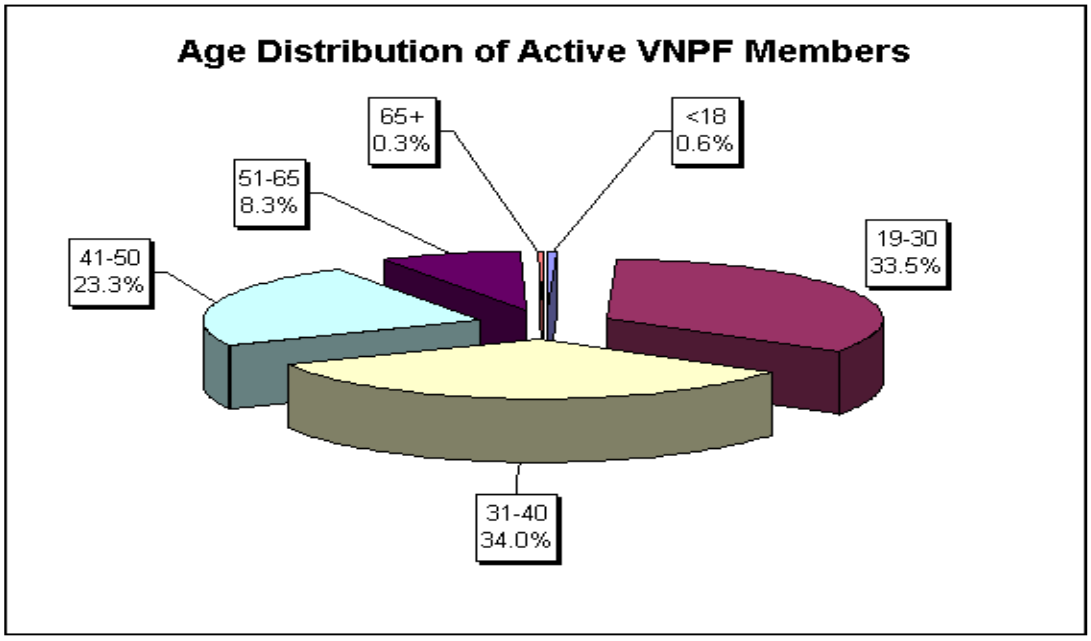


Figure 4: Percent shares of active VNPF members by age, 2005



As seen from the two graphs, the VNPF has a young age structure of its members. More than two-thirds (68%) of active VNPF members are below 40 years of age. The number of members who are above 50 years of age is 8.6%. Some 23.3% of the active members are age-group of 41-50 years.

In general, the health needs of old members would be higher and thus require more resources. On the other hand, young members would face the need for maternity care and child health benefits as the dependents of active contributors are also covered.

(2) Income profile

As shown in Figure 5, the VNPF members can be roughly divided into three income groups. About half (49%) of the VNPF members earn between VT 250,000 and VT 750,000, one quarter (23%) of the members earn more than VT 750,000, and another quarter (28%) of members earn less than VT 250,000.

Figure 5: Percent shares of active VNPF members by income level, 2005

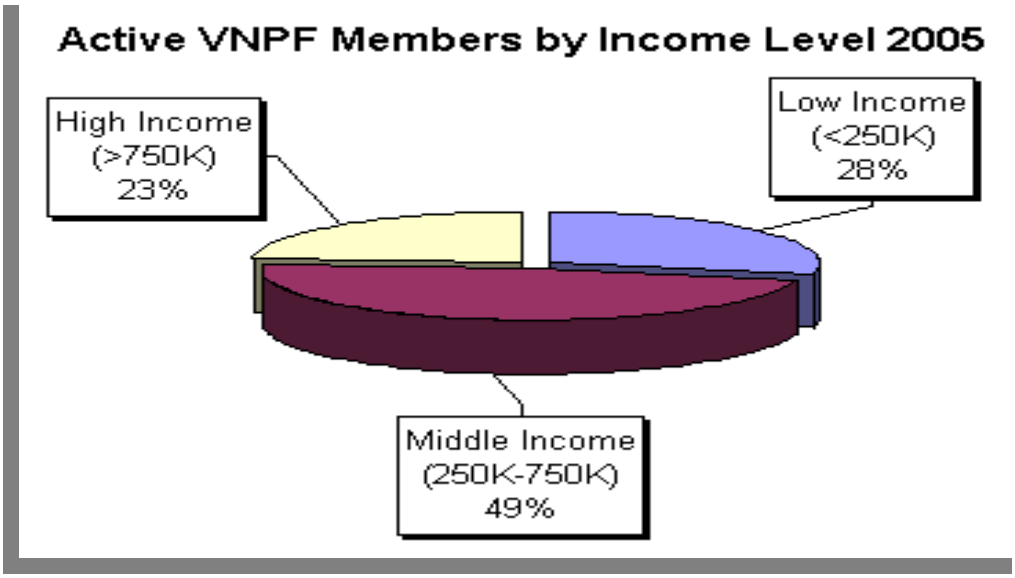


Figure 6: Salary distribution of active VNPF members, 2005

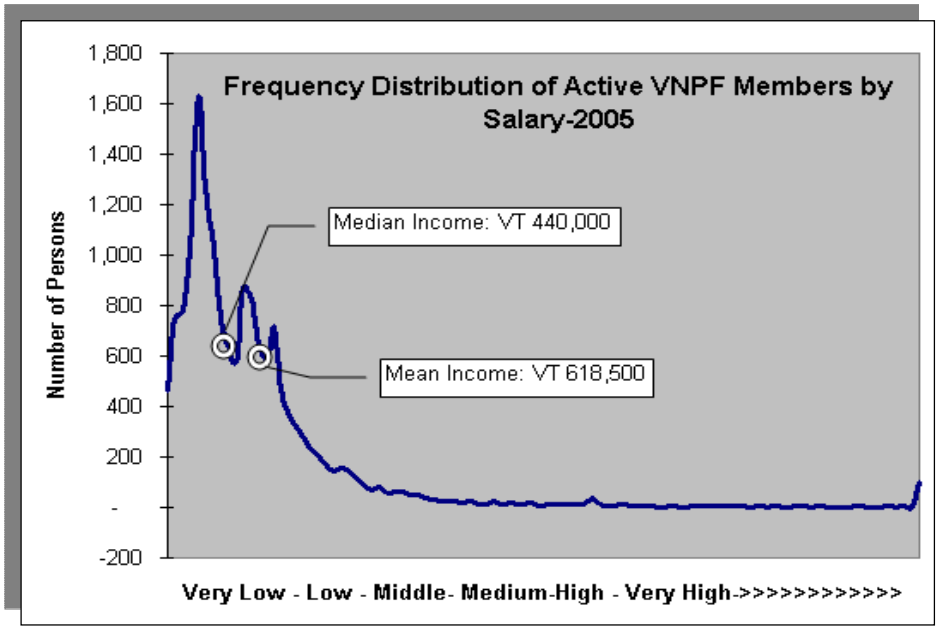


Figure 6 shows the salary distribution of active VNPF members based on the data of 16,393[3] individuals who reported their salary in 2005. The salary distribution is skewed to the lower end. More than two-thirds of active members earn less than the mean income, which is estimated at VT 618,500. The median income is estimated at VT 440,000. To measure the earnings gap between the high and low income groups, the following Table 2 calculates the average incomes for members above and below the median income. As a result, the higher income group on average earns 4.34 times more than the lower income group. For a member with a non-working spouse, this income would be equivalent to GDP per capita (around US$1,254[4]). For a household with dependent spouse and children, this level of earnings is regarded as low-income.

Table 2: Analysis of income of active VNPF members, 2005

Key Salary Earnings Indicators			In USD/per	
	VT/per year	VT/per month	year	USD/per month
Median Income	439,834	36,653	$ 3,792	$ 316
Mean Income	618,460	51,538	$ 5,332	$ 444
Mean Income-Below Median	231,434	19,286	$ 1,995	$ 166
Mean Income-Above Median	1,005,414	83,785	$ 8,667	$ 722
Number of members earning below mean income	10,863	persons		
As percent of total active members	66.3%			
Earnings Multiple	4.34	(Mean Income of Above Median/Below Median)		

[3] 288 members appear to be Active Contributor as per the flag yet their salary or wage earnings are reportedly nil. Also there are some members who have made retirement contributions without a reported salary or earnings. In the analysis we have ignored these anomalies. For earnings analysis, we have included all members with a reported salary (active or not) as a member and for demographic summaries by age cohort and gender, we included all active members with a "flag".
[4] Data refers to 2002.

Figure 7: Number of active VNPF members by salary range, 2005

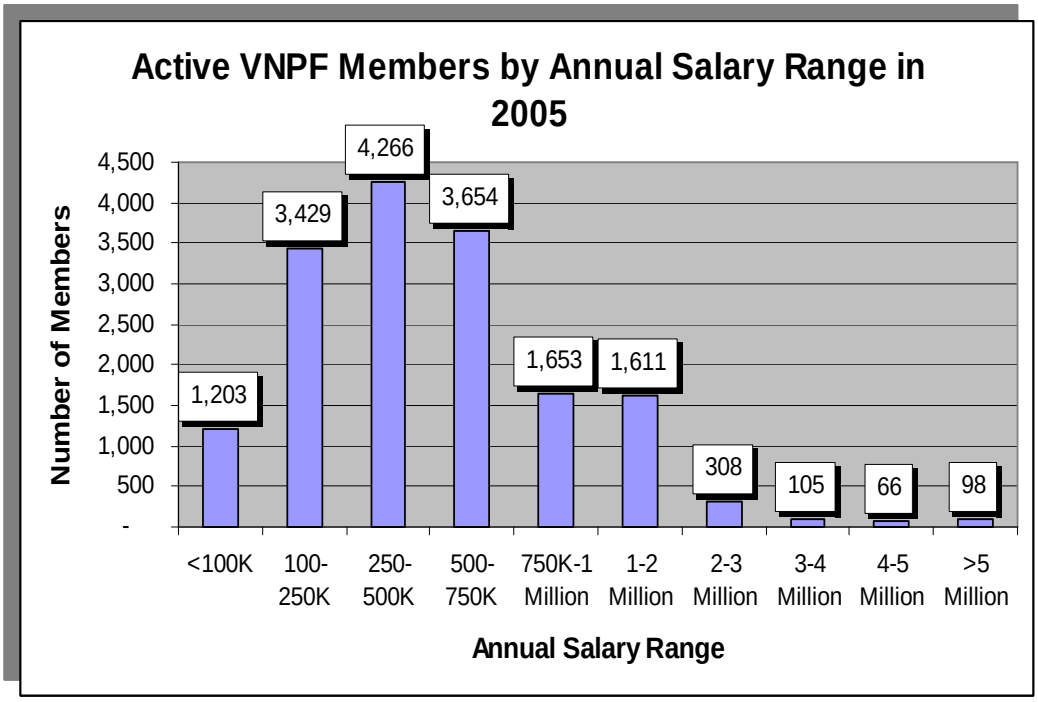
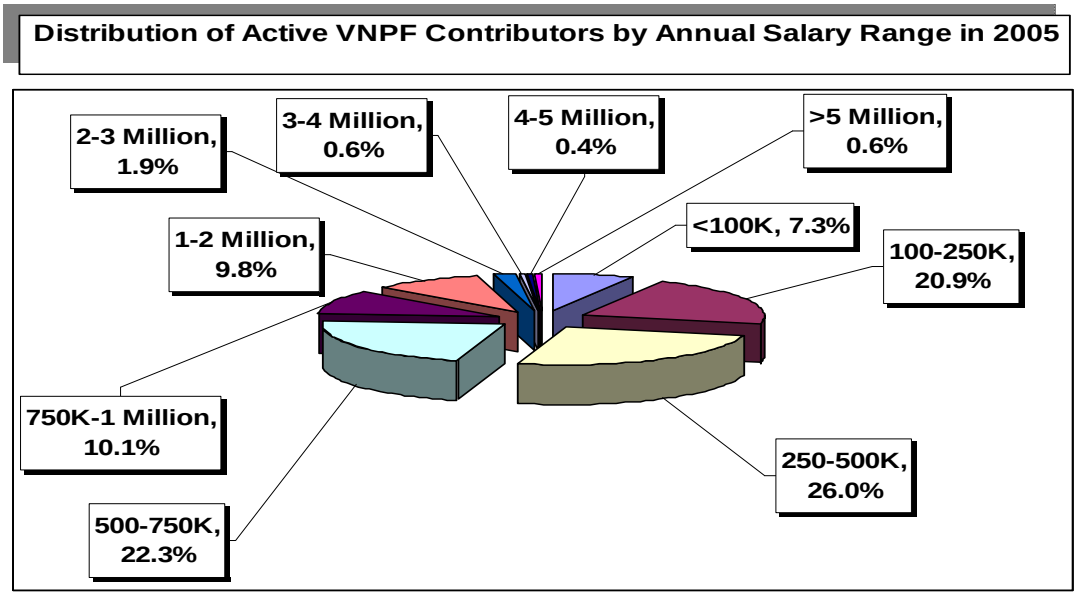


Figure 8: Percent share of active VNPF members by salary range, 2005



Figures 7 and 8 above show the number of persons in each salary bracket based on the salary distribution in Figure 6. About 7.3% of members earn below a living wage of less than VT 100,000 a year. On the other hand, some 20% of the members earn VT 750,000 to VT 2 million. Social health insurance entails a cross subsidisation from high income members to low income members. There is no ceiling on individual earnings on which the VNPF contributions are calculated. However, a ceiling on earnings could be taken into account for to limit excessive burden on contributions.

In the following sections we evaluate the impact of the policy option of capping the health insurance contributions by imposing a contribution ceiling.

Table 3: Active VNPF members by age group and salary range

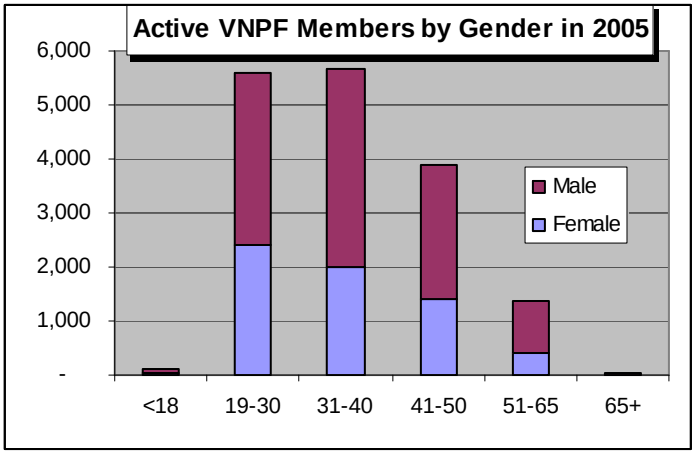
Percent Shares of Age Cohort within Income Groups in 2005				
	Salary Range			
Age Cohort	<250K	250K-750K	>750K	**Share of Total Members**
<18	1.95%	0.25%	0.06%	0.63%
19-30	47.17%	33.92%	11.56%	33.54%
31-40	28.22%	36.23%	32.24%	33.95%
41-50	15.41%	21.92%	39.76%	23.27%
51-65	6.74%	7.51%	16.09%	8.31%
65+	0.50%	0.17%	0.28%	0.31%
Total	100.00%	100.00%	100.00%	100.00%
Salary Range Shares	28.26%	48.31%	23.43%	100.00%

Table 3 above analyses the relation between age and income level. As shown in the table, there is a positive correlation between income level and age. For instance, members aged 19-30 years account one third of total active members yet they represent nearly half of the low income earners. This share of high income earners in this age group is about 11.6% whereas more than 56% of high income earners are older than 40 years of age. It should be noted that more than 70% of middle income earners are below the age of 40 which means that this group with low health needs and a higher earning capacity can cross subsidise the low income young and old members.

(3) Gender analysis

Table 4 and Figure 9: Active VNPF members in 2005 by age group and sex

Age Cohort	*Female*	*Male*	***Female %***
<18	47	58	44.76%
19-30	2,414	3,172	43.22%
31-40	2,015	3,662	35.49%
41-50	1,393	2,493	35.85%
51-65	421	956	30.57%
65+	7	43	14.00%
	6,297	10,384	37.75%



Ratio of females in the total VNPF members is 38%. For the 19-40 cohort (reproductive ages), the ratio of females is 39%. From a point of view of health insurance, this age group would require adequate maternity and child care benefits.

3. Key information for the implementation of the VNPF health insurance scheme

3.1 Estimated health insurance coverage

It is recommended that the VNPF health insurance scheme cover both contributing members and their legal dependents. Table 5 estimates the population covered by the proposed health insurance scheme based on the assumed number of dependents per main contributor. Consequently, upon inception, the health insurance scheme can cover 62,700 persons, or 28% of the total population in Vanuatu on a compulsory basis. This coverage is considered reasonably broad given the fact that less than half of total VNPF members are currently active.

The estimated covered population depends on the assumption on the average number of dependents. While the resulting 2.76 average dependents per contributor appears to be lower than the national average (based on the average household sizes of 4 to 5 family members), this is because there are cases where both couple are VNPF members and that household sizes are smaller in urban areas.

Table 5: Estimated health insurance population coverage for formal sector

Estimated VNPF Formal Sector Health Insurance Coverage

Age Cohort	Main Members	Dependents	Total Estimated Coverage	Avg Number of Dependents
<18	105	21	126	0.20
19-30	5,586	11,471	17,057	2.05
31-40	5,677	17,461	23,138	3.08
41-50	3,886	13,899	17,785	3.58
51-65	1,377	3,089	4,466	2.24
65+	50	37	87	0.74
Grand Total	***16,681***	***45,978***	***62,659***	***2.76***
Total Population (2005 Est.)			**221,419**	
Estimated Health Insurance Coverage			**28%**	

No estimate has been made for voluntarily insured members from 19,616 non-active VNPF members. However, once the health insurance scheme is successfully implemented, non-active VNPF members would recognize the value of the health insurance and could possibly take up voluntary coverage. Thus, there is further prospect for additional covered persons in the formal sector.

Table 6 looks into the potential impact of retired members on average contributions to the VNPF.

Table 6: Impact of retiring members on average contributions

Estimated Impact of Retiring Members on Average Contributions						
	Total Salary	*Total Members*	*Average Earnings in 2005*	*Total Contributions*	*Average Contribution per member*	*Average Contribution rate*
	Vt	*persons*	*Vt*	*Vt*	*Vt*	*%*
All members	10,138,422,031	16681	607,783	865,777,212	51,902	8.54%
55+ members	464,508,742	659	704,869	39,952,625	60,626	8.60%
<55 members	9,673,913,290	16,022	603,789	825,824,587	51,543	8.54%

Key Indicators

Members becoming Inactive since 2004 (through retirement or drop out)	1021
Estimated number of inelible members dropping out	362
Earnings differential of Eligible Retiring Members vis-à-vis not retiring	16.74%
Estimated decline in average earnings under the assumption that all eligible retire	-0.66%
Estimated decline in average contributions under the assumption that all eligible retire	-0.69%

In 2005, a total of 1,021 members left the fund. It is estimated that out of 660 members above the age of 55, around 360 people left the fund or became inactive for other reasons. This number could be higher if we take into account the new members have joined the workforce and not all eligible members retired. In 2006, further 167 members will become eligible to retire. Assuming the same trend, some 500 to 700 people could leave the fund in 2006 due to retirement reasons and a further 200 to 300 for other reasons.

The members eligible for retirement on average earn 16.7% more than those below the age of retirement and they contribute VT 9,000 more per year on average. If all eligible persons retire and there is no new entrant to the fund, contribution per member could decline by 0.7%.

3.2 Setting the contribution rate of health insurance

Historically the statutory contribution rate of VNPF was set at 8% before 2001, increased to 12% from 2001-2003 and back to 8% from 2004 and after.

Table 7 shows the VNPF contributors by average contribution level. It is seen that 19% of members pay at a rate lower than the current statutory rate; 36% of members contribute at the statutory level; and 41% contribute above the statutory level (the majority are paying at 12%, which was the former statutory level). It should be noted that 4% of members contribute at even higher than 12% which could be related to payments in arrears.

It is recommended that at the outset the health insurance scheme collect a contribution of 2%, shared equally by employers and employees. As a result, the total statutory minimum contribution rate for the VNPF will increase from the current 8% (4% each for employers and workers) to 10% (5% each).

Table 7: VNPF contributors by average level of contributions, 2005

Distribution of Contributors by Level of Contribution	Number of Contributors	% Share
Lower than Statutory Minimum	3,180	19%
8% (Statutory Level)	5,864	36%
9% to 12%	6,686	41%
Above 12%	662	4%
Total	16,392	100%

The 2% contribution rate for health insurance is considered affordable and sufficient in the short term. As the health insurance scheme becomes fully operational after two to three years, an actuarial review should be conducted to evaluate the contribution rate that ensures the sustainability of the scheme. In the long-term, one may consider a gradual increase in the contribution, for instance, up to 6% provided that other prerequisites for health insurance are satisfactorily implemented. A key issue is whether the members are convinced to pay more for the financial protection of health care that the scheme provides.

3.3 Benefit package

Logically, the level of contribution rate is determined by the health insurance benefits package and its prices. However, in the context of the Pacific island countries, it is suggested that the contribution rate be set in the first place and then the benefit package be tailored within the available resources. A feasible health insurance benefit package has been presented in earlier report[5]. As direct taxes are almost zero in Vanuatu, the VNPF health insurance contributions could serve as an additional funding to the public health system.

Table 8: Household expenditure on health services by area, 1998 (in Vatu)

	Hospital	Hospital Dentist	Other Medical	Private Doctor	Private Dentist	Total	% Expenditure	% Population
Port Vila	10.0	0.4	11.4	104.2	24.7	150.6	47.7	16
Luganville	1.4	0.1	1.4	2.4	0.0	5.3	1.7	6
Rural	42.9	5.1	42.0	51.9	18.0	159.9	50.6	78
Vanuatu	54.3	5.6	54.7	158.5	42.7	315.8	100.0	100
	17.2%	1.8%	17.3%	50.2%	13.5%	100.0%		

Source: Vanuatu Household Income and Expenditure Survey 1998.

One approach is to include in the benefit package the items which user fees are charged. The level of out-of-pocket funding for health care is between 12% and 15% of the total health expenditure (see Figure 1), which appears relatively low among the developing countries. However, a detailed study[6] indicates that some private doctor fees are less affordable. Also ambulatory medical drug prices with the value added tax is known to have priced out many low income people among the population. As Table 8 shows, more than half the out-of-pocket

[5] ILO, *"Social Security for All Men and Women - A source book for extending social security coverage in Vanuatu: options and plans"* (2006), Chapter 9: *Expanding Social Health Insurance in the Pacific Island Countries*.

[6] See for instance *"Human Development In The Pacific Islands Country Study – Health And Health Services In Vanuatu"* by D. Roy Harvey, December 2004.

payments are paid for private doctors' fees. By area, almost half the out-of-pocket payments are made by households in Port Vila area where majority of VNPF members reside.

Therefore, out-of-hospital ambulatory care and drugs could be a potential priority area for health insurance benefits. On the other hand, it is important to retain the quality of public hospital services at an adequate level as the VNPF does not cover all the population. Vanuatu has a limited number of specialised health professionals[7] and the insurance payments should not be directed to private health care providers but to public health care facilities.

3.4 Estimated contributions of the health insurance

Table 9 shows the estimation of the health insurance contributions at 2% of workers' payroll in 2005 prices. For the purpose of this estimates, the ceiling for the contributory earnings was set at VT 3 million, which is equivalent to 4.9 times the average earnings or 6.8 times the median earnings. In other words, the members above this income are supposed to contribute VT 60,000 (US$ 517 at average exchange rate) for the whole household. From Figure 7, it follows that 269 members or 1% of the total VNPF members are estimated to reach the ceiling of VT 3 million.

The policy of imposing a contribution ceiling is mainly for not penalising members with a substantial amount of foregone savings which they may otherwise have added to their retirement account. Unlike retirement savings, health insurance premiums are not placed in a member account but pooled separately for the benefit of all members. Without the *contribution ceiling* policy, the whole scheme may be grossly unwelcome by a small group of members that may otherwise block the passage of policy or lobby against any such initiative that may elevate VNPF from a fraternity type agency to a social security organization that caters for the whole of Vanuatu population in the future.

With the assumption of full collection, the contributions of the health insurance from the formal sector workers is estimated VT 191.6 million in 2005 prices. The step-by-step estimation in Table 9 is given as follows:

- The first column shows the health insurance revenue for each earnings bracket without taking into account the contribution ceilings. The gross contributions income is estimated VT 202.8 million.
- The second column calculates the health insurance contribution subject to the contribution ceilings. As a result of the imposition of the ceiling, the contribution income will be VT 191.6 million, which is 5.5% less than the gross contributions.
- The last three columns summarise average contributions per member at full collection subject to the ceilings.
- The last column shows that due to the ceilings the effective contribution rate members who earn more than VT 3 million is 0.8% of the actual earnings. The effective contribution rate for the total VNPF members is 1.9%.

[7] Vanuatu has fewer than 40 doctors in total.

Table 9: Estimate of the VNPF health insurance contributions, 2005
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Medicare Levy Policy Assumptions		*Shared by*	
Exemption Threshold (Salary per year)-Vt	-	Employer	Employee
Contribution Rate	2%	1%	1%
Income Threshold for Contribution Ceiling-Vt	3,000,000		

PREMIUM ESTIMATES

Salary Range	*Medicare Levy Annual Revenue (at Full Participation without Ceiling)*	*Medicare Levy Annual Revenue with Ceiling*	*Number of Members*	*Share of Medical Insurance Revenue (at Full Participation without Ceiling)*	*Shares of Total Medicare Revenue with Contribution Ceiling*	*Average Annual Medical Insurance Contribution (at Full Participation without Ceiling)*	*Average Annual Medical Contribution per member (with Contribution Ceilings)*	*Effective Health Insurance Contribution*
	Vt	Vt	persons	%	%	Vt	Vt	%
<100K	1,454,156	1,454,156	1,203	0.7%	0.8%	1,209	1,209	2.0%
100-250K	12,940,727	12,940,727	3,429	6.4%	6.8%	3,774	3,774	2.0%
250-500K	30,145,636	30,145,636	4,266	14.9%	15.7%	7,066	7,066	2.0%
500-750K	45,110,028	45,110,028	3,654	22.2%	23.5%	12,345	12,345	2.0%
750K-1 Million	28,307,068	28,307,068	1,653	14.0%	14.8%	17,125	17,125	2.0%
1-3 Million	57,516,923	57,516,923	1,919	28.4%	30.0%	29,972	29,972	2.0%
>3 Million	27,293,903	16,140,000	269	13.5%	8.4%	101,464	60,000	0.8%
Total/Average	202,768,441	191,614,538	16,393	100.0%	100.0%	12,369	11,689	1.9%

Key Summary and Indicators

Reduction in revenue through exemptions and ceilings		-5.50%
Average contribution in USD per household per year	$	101
Average contribution in USD per beneficiary per year	$	26
Estimated Revenue as percent of:		
Total Health Expenditure		15% (2005 estimate)
General Government Expenditure on Health		20% (2005 estimate)

The average annual contribution per contributor (including dependents) is about US$100 at the average exchange rates in 2005. The total health insurance contributions cover 15% of the total health expenditure, or 20% of the total government expenditure on health. If a large portion of these resources are channelled to the public health sector, the difference in the earnings between public and private health care providers is expected to be smaller.

One key objective of health insurance is to improve service quality and adequacy of health care services. In view of the declining trends of resources allocated for health care, the health insurance scheme can generate additional resources for the government to commit in more active investment in specialist personnel and in additional health services and facilities.

4. Analysis of impact of the health insurance scheme

This chapter will undertake economic analysis of the VNPF health insurance contributions.

4.1 Health insurance contributions by income groups

Table 10 estimates the effects of the health insurance contribution for low and middle income groups who earn less than VT 750,000 and high income groups who earn more than VT 750,000.

Table 10: Distributional impact of compulsory health insurance contributions

Low Income Earners			
(Those earning below 750.000 VT per year)			
Total Wage and Salary Payments (Annual)	4,482,527,359	Total Health Insurance Contributions	89,650,547
As % of Total Salary and Wage Earnings	44%	As % of Total Medicare Levy Revenue	47%
Total Number of Members	12,552		
As % of total VNPF Active members	77%		
Mean Salary per month	29,760	Mean Contribution per year	***7,142***

Middle and High Income Earners			
(Those earning more than 750.000 VT per year)			
Total Wage and Salary Payments (Annual)	5,655,894,679	Total Health Insurance Contributions	101,963,990
As % of Total Salary and Wage Earnings	56%	As % of Total Medicare Levy Revenue	53%
Total Number of Members	3,841		
As % of total VNPF Active members	23%		
Mean Salary per month	$ 122,709	Mean Contribution per year	***26,546***

Income multiple	4.1	Mean Contribution Multiple (High/Low)	3.7

As seen in Figure 5, the low and middle income groups represent 77% of the members but earn 44% of the total payrolls. On the other hand, the high income group represents 23% of the total VNPF members but earn 56% of the total payrolls. On average, a member in the high income group earns 4 times more than the low and middle income group. Because of the contribution ceiling, the average health insurance contributions of high income earners are 3.7 times more than those of the low income members.

4.2 Impact of health insurance scheme on the public financing

When the VNPF health insurance scheme is implemented, the government of Vanuatu is also required to pay the contributions as an employer of the government employees. Table 11 presents the estimate of the health insurance contributions from the government. In fact, the government is the largest employer in Vanuatu. Government employees account 36% of the active VNPF members. Assuming that the earnings of the government employees are the same as the average income of all VNPF members, the government's share of health care contributions (1% of the payroll) is estimated about VT 36.9 million in 2005 prices[8], which is roughly 20% of the total health insurance contributions.

[8] Some government employees earn more than the contribution ceiling (VT 2 million). Therefore, this amount is slightly overestimated.

Table 11: Estimated health insurance contributions from the government

Estimated Impact of Medicare Levy on Government Budget-2005		
Civil Servants	4,668	persons
Teachers	1,300	persons
Total Public Sector	5,968	persons
Total Active VNPF members	16,393	persons
Public Sector as % of total VNPF members	36%	
Average Salary Per Contributor/year	618,460	Vatu
Medicare Levy Employer Contribution Rate	1%	
Medicare Levy Employer Contribution from Government	36.9	Million Vt
Total Estimated Medicare Levy Revenue	191.6	Million Vt
Public Sector Share as % of Total	19.26%	
Estimated GDP (current prices) in 2003	34,020	Million Vt
Central Government Revenue in 2003	6,416	Million Vt
Central Government Exp're in 2003	6,711	Million Vt
As Percent of GDP-2003		
Central Government Revenue	18.86%	
Central Government Exp're	19.73%	
2005 Macro Estimates		
GDP at current prices	35,263	Million Vt
Central Government Revenue	6,650	Million Vt
Central Government Exp're	6,956	Million Vt
Medicare Levy from Public Sector (as percent of)		
Central Government Revenue	0.55%	
Central Government Exp're	0.53%	

Assuming that the share of central government revenue and expenditure as percent of GDP remain at the 2003 levels, the health insurance contributions from the government would account for 0.53% to 0.55% of the total central government expenditure and revenue.

Table 12 presents the preliminary analysis of the impact of health insurance scheme on the government budget.

Although the government has to pay VT 36.9 million contributions, the public health care providers will in turn receive payment from the VNPF health insurance scheme. Assuming that 8% of the health insurance contributions are retained for reserves and 3% for administrative costs, 89% of the total contributions, or VT 170.5 million, can be allocated for the health care benefits.

To allocate this amount by sector, in view of international experiences, we assume that 65% is allocated to public health care providers, 20% private health care providers and the remaining 15% for the purchase of drugs. Under these assumptions, the public health care providers would receive VT 110.9 million as payment from VNPF health insurance scheme.

Table 12: : Impact of health insurance scheme on the government budget

Estimated Impact of Medicare Levy on Public Health Sector Revenue		
Government Exp're on Health-2005 Est	948	Million Vt
As Percent of Central Gov't Revenue	14.2%	
As Percent of Central Gov't Exp're	13.6%	
Total VNPF Medicare Levy Revenue	191.61	Million Vt
Budgetary Assumptions for VNPF		
Reserve Ratio	8%	
Administration Ratio	3%	
Available for Health Benefits	89%	
Health Insurance Budget		
Allocation for Reserves	15.33	Million Vt
Insurance Administration	5.75	Million Vt
Health Benefits Budget	170.54	Million Vt
Allocation of Health Benefits Budget		
Share of Public Sector Providers	65%	
Share of Private Sector Providers	20%	
Allocation of Ambulatory Medical Drugs	15%	
Health Benefits Budget		
Public Providers	110.85	Million Vt
Private Providers	34.11	Million Vt
Drug Benefits	25.58	Million Vt
Government Budget for Health Care (ex ante)	948	Million Vt
Less Cost of Medicare Levy to Government	- 36.9	Million Vt
Net Government Budget	910.65	Million Vt
Plus VNPF Public Provider Financing	110.85	Million Vt
Total Budgetary Resources available for Public Sector Providers	1,021.50	Million Vt
Per cent increase (ex-post)	7.80%	

Based on these estimates, the following analysis is made regarding the impact of health insurance scheme on the government budget.

- Before the introduction of the health insurance scheme, the government budget for health is estimated VT 948 million, equal to 14% of the total government budget.

- With the implementation of the health insurance scheme, the government has to pay VT 36.9 million to the health insurance scheme as employer's contributions for the government employees.

- On the other hand, under certain assumptions, public health care providers are expected to receive VT 110.9 million as providers' payment from the health insurance scheme.

- As a result of these two factors, the government will receive a net amount of VT 74 million from the health insurance scheme. The resulting government budget is thus increased to VT 1,021.5 million, which is 7.8% more than the original government health budget.

Therefore, the introduction of the health insurance scheme will result in a substantial increase in the allocation of resource to the public health sector.

5. Summary and conclusion

This report has addressed and analysed the key issues regarding the implementation of the health insurance scheme in Vanuatu. The main findings in the report can be summarised as follows:

- The age structure of the VNPF members is young. Although, a young insured population is generally healthier than an old population, the specific health care need of the covered population, in particular needs of maternity and child care benefits, should be taken into account.

- The salary distribution of the VNPF members is skewed to the lower end. While the average annual salary of the VNPF members is estimated VT 618,500, the median income is estimated at VT 440,000. The ratio of the average salaries of the higher half and the lower half is 4.34 times.

- It is recommended that the health insurance scheme initially cover the VNPF members and their legal dependents. It is estimated that the health insurance scheme would cover 62,700 persons, or 28% of the total population in Vanuatu in the first year of implementation. There is also a scope of additional voluntary membership. In the long-term, the VNPF should consider steps to extend the health cover gradually to all the population.

- It is recommended that the contribution for the health insurance scheme is set initially at 2%, shared equally by employers and workers. This will increase the statutory minimum contribution to VNPF from 8% to 10%. An actuarial review should be conducted within three years to evaluate the validity of the contribution rate. As the scheme becomes fully operational, one may consider a gradual increase in the contribution in the long-term.

- The ceiling for the contributory income should be set at VT 3 million. The ceiling will reduce health insurance contribution by 5.5% compared to the case where no ceiling is applied. The effective contribution rate is 1.9% of the total earnings which do not take into account the ceiling.

- Assuming the full collection of contributions, the total contribution to the health insurance scheme is estimated VT 191.61 million in 2005 prices, which covers 15% of the total health expenditure, or 20% of the total government expenditure on health. The per capita contribution is VT 11,690 per year, which is around US$100.

- By income groups, the members earning more than VT 750,000 would contribute 3.7 times more than those earning less than this threshold.

- The implementation of the health insurance scheme affects the government financing on health. On the one hand, the government has to pay VT 36.9 million as the health insurance contributions (1%) for the nearly 6,000 government employees. On the other hand, the public health care providers will receive the payment from the health insurance scheme. Under certain assumptions, this amount is estimated at around VT 110.9 million. Consequently, the public sector will receive a net amount of VT 74 million from the health insurance scheme. This amount will increase the allocation of health resources to the public sector by 7.8%. Therefore, the introduction of the VNPF health insurance scheme will generate additional funding to improve the quality of public health care services.

In view of these findings in support of the introduction of the VNPF health insurance scheme, it is recommended that the Government of Vanuatu and the Board of Vanuatu National Provident Fund consider the implementation of the scheme in 2006.

Implementation of the scheme would require strong commitment and continuous efforts of the key stakeholders. Subject to the availability of the funding, the ILO stands ready to provide the Government, VNPF and social partners with further technical assistance in the implementation of the health insurance scheme in Vanuatu.