Rethinking Social Health Insurance’s Role in Universal Health Coverage

9th Annual Caribbean Health Financing Conference

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World Bank
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Outline

- Background
  - Health financing functions and modalities
  - Health insurance categories

- Social Insurance - features, experiences, lessons learned

- Role of the World Bank in supporting UHC and Health financing
Health Financing: Main Functions & Objectives

- **Revenue Collection**
  - Obtain sufficient resources efficiently, equitably, and in a sustainable manner

- **Risk Pooling**
  - Manage resources equitably and efficiently

- **Purchasing**
  - Ensure allocative and technical efficiency in purchasing of services *(value-for-money)*
Diferentes modalidades to finance a health system

Revenue | Risk Pooling | Purchasing | Service Provision
--- | --- | --- | ---
Taxes | Government Agency | Social Insurance or “sickness funds” | Public Providers
Public Charges/resource Sales | Public Providers | Private Insurance or Community organizations | Private Providers
Mandates | Private Insurance or Community organizations | Employers | 
Grants | Private Insurance or Community organizations | 
Loan | Private Insurance or Community organizations | 
Private Insurance | Employers | 
Communities | Individuals or households | 
Out of pocket | 

Source: World Bank
OOP is highest in LICs and lowest in HICs, while SHI increases with income level.
Among regions, Europe has lowest OOP (16%) and highest combined contribution of SHI & Government (75%).

Stacked bar chart by financing agents, 2012

- Other Private
- Territorial government
- Out-of-pocket
- Private prepaid plans
- Social health insurance

Source: WHOSIS
Revenue-collection: Lessons/Main Points

- Countries use various funding mechanisms, most of the time simultaneously.
- Diversification of financing depends on country context; generally desirable to have tax revenue for UHC.
- Need explicit policies to avoid regressive (e.g. taxes on goods consumed by the poor) & distortionary revenue collection schemes (e.g. incentives for informality).
## Health Insurance: Main Categories

<table>
<thead>
<tr>
<th>National Health Service</th>
<th>Social Health Insurance</th>
<th>Private Insurance</th>
<th>Community – based health Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Main Funding Source:</strong></td>
<td>Payroll tax, employee contributions</td>
<td>Risk adjusted premiums</td>
<td>Flat rate (in general)</td>
</tr>
<tr>
<td>National (citizens)</td>
<td>Mandatory: (formal sector) and their beneficiaries</td>
<td>Voluntary (insured individual and dependents)</td>
<td>Voluntary (members and families)</td>
</tr>
<tr>
<td><strong>Examples:</strong> Canadá, Italy, UK, New Zealand, Brazil, Barbados</td>
<td>Germany, France, Japan, common in LAC: Chile, Colombia, Costa Rica, Dominican Republic, etc.</td>
<td>USA, South Africa</td>
<td>Schemes in India, Philippines, and Rwanda</td>
</tr>
</tbody>
</table>

Sources: adapted from Scheil-Adlung, X. and Gottrett, P. & G. Schieber
In practice, contributory SHI usually needs to be complemented by other insurance mechanisms to expand coverage

- National health services or public provider networks that provide services for uninsured
- Subsidized noncontributory social health insurance schemes for the poor & partially subsidized for informal sector workers unable to fully contribute - could have specific benefit package

  e.g. Dominican Republic - specific benefit package for the Subsidized Regime

Colombia (before 2012) - different benefit packages between Contributory & Subsidized SHI

✓ Chile - same minimum package of benefits for all citizens with quality standards
Many countries have SHI systems with multiple contributory schemes

- While some countries such as Costa Rica have a single large pool, several SHIs in LAC tend to be horizontally segmented with schemes linked with different employers:
  - Mexico: IMSS for private & ITSS for public employees;
  - El Salvador: several public schemes based on employer with different benefit packages
Segmented programs/schemes have certain disadvantages

- **Inequities**
  - Different benefit packages for specific target groups

- **Inefficiencies**
  - Use of infrastructure and scarce health personnel
  - Administration of various insurance schemes generating large costs

- **Potential barrier to continuity of care**
  - Prevents smooth integration & continuity of care for patients who change affiliation due to change in labor market status
Risk Pooling: essential for equity & for financial risk protection

- Cross subsidies and mechanisms for redistribution are important (e.g. between rich and poor, old and young, healthy and ill)

- Fewer, larger risk pools are desirable & ideally integrated into one program
  - More difficult to administer various programs with different contributions and benefits
Countries have tried to integrate fragmented systems to national social insurance systems with a single health plan

France consolidated multiples schemes (20) into single scheme and payer model, with general scheme covering > 85% of the population, including the poor.

Turkey’s Social Security Insurance is the single purchaser of health services which integrated all five of the previously fragmented health insurance programs

- Other countries have followed this path including Costa Rica, South Korea, and Indonesia.
Countries have tried to integrate fragmented social insurance systems into a national social insurance system with multiple health plans

- Despite having multiple health plans, these systems provide similar entitlements to all
- Adjust for risk their resource allocation to health plans to reduce risk selection of affiliates
  - Netherlands, Belgium, Israel, Germany, Japan, Czech Republic, Slovakia, and Colombia
Strategic Purchasing: also essential to achieve and sustain UHC

- Core public health services, a universal priority in prioritizing resource allocation

- Strong, evidence-informed purchasing institutions required to negotiate prices and incentives with providers/suppliers

- In most regions, SHI system contracts out services with outside providers but in LAC, many SHI systems operate their own provider networks
  - Financing and provision not separate

- Budget allocation usually not linked to productivity or quality indicators but this is changing.
  - Examples of results-based financing in Argentina, Panama, DR (primary care), Belize
LAC SHI experiences (examples of 4 countries with high coverage rates)
# High Coverage Rate Countries with Integrated SHI and Public System

<table>
<thead>
<tr>
<th>Chile</th>
<th>Costa Rica</th>
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</thead>
<tbody>
<tr>
<td><strong>Total Health Exp./GDP:</strong> 8.1% (2011)</td>
<td><strong>Total Health Exp./GDP:</strong> 10.9% (2011)</td>
</tr>
<tr>
<td><strong>Dual System:</strong> Integrated Social Security and Public funds under one public payer: National Health Fund (FONASA) Private insurers (ISAPRES)</td>
<td><strong>Dual System:</strong> Social health insurance and private (small) Integrated Social security and public (MOH) under the CR Social Security System (CCSS)- one public payer</td>
</tr>
<tr>
<td>Public health services provided by National Health Services</td>
<td>*integrated funding sources with one coverage scheme. Mandatory enrollment</td>
</tr>
<tr>
<td>*Universal Access with Explicit Guarantees- guaranteed package of services for everyone (at least 80 conditions)</td>
<td><strong>SHI</strong> (sector formal): ~88% of population – contributions from employers &amp; employees</td>
</tr>
<tr>
<td>Mandatory health insurance enrollment but people can select insurer</td>
<td><strong>Informal sector/independent workers:</strong> Government pays 50% of contributions</td>
</tr>
<tr>
<td>Coverage: 73.5% (FONASA), 16.3% (ISAPRES), 6.7% (Army), 3.5% uninsured</td>
<td><strong>Poor, disabled, and elderly:</strong> general taxes</td>
</tr>
</tbody>
</table>

Coverage: universal (public)

Sources: Cotlear et al (2014) and Mesa-Lago (2008)
## High Coverage Rate Countries with Segmented SHI and Public Systems

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<th><strong>Colombia</strong></th>
<th><strong>Mexico</strong></th>
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<tbody>
<tr>
<td><strong>Total health exp./GDP: 6.1% (2011)</strong></td>
<td></td>
<td>Total Health Exp./GDP: 6.2% (2011)</td>
</tr>
<tr>
<td><strong>Tripartite System:</strong></td>
<td>Public or subsidized SHI, contributory SHI, and private</td>
<td><strong>Tripartite System:</strong> Public, SHI, and private</td>
</tr>
<tr>
<td><strong>Contributory SHI</strong></td>
<td>(formal sector and self-employed) : employee and employer contributions</td>
<td><strong>IMSS/Mexican Social Security Institute</strong> (formal sector private and their families): employee and employer contributions</td>
</tr>
<tr>
<td><strong>Subsidized Regime</strong></td>
<td>(poor and those without insurance access): general and sin taxes; subsidy from Contributory SHI</td>
<td><strong>Social Insurance / Seguro Popular</strong> (for informal sector and indigent): financed by taxes</td>
</tr>
<tr>
<td>✓ By 2014, almost entire population insured.</td>
<td></td>
<td><strong>ITSS/Institute of Social Security and Services for State Workers</strong> (civil servants and their families): employee &amp; employer contributions</td>
</tr>
<tr>
<td>✓ Equalization of benefits between Contributory and Subsidized Regimes based on 2008 Court Ruling</td>
<td></td>
<td><strong>Private; other</strong></td>
</tr>
<tr>
<td>✓ Moving toward integration of SHI and public (MOH)</td>
<td></td>
<td><strong>Sources:</strong> Cotlear et al( 2014) and Mesa-Lago (2008).</td>
</tr>
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</table>

*Segmented systems
Enabling Conditions for Coverage Expansion in LAC

- Economic-stable economic policies with social program investments aimed at reducing poverty

**Per Capita GDP Growth and Poverty**

*LAC Countries*

Source: Chief Economist Office, World Bank/LAC. “LAC Decade: Ending or Beginning?”
Enabling Conditions for Coverage Expansion in LAC

- Political - democratization & the right to health
  - Changes in government (e.g. end of dictatorship in Chile, 1st change in ruling party since 1929 in Mexico); constitutional rulings on right to health in Colombia & Costa Rica
  - Economic growth helps but reducing inequities requires explicit legal reforms, policies & programs to redistribute resources

- Demographic and epidemiological - aging population & increasing NCD burden
MOVING TOWARD UHC: MAIN CHALLENGES TO BE TACKLED

- Improve quality and reduce differences across subsystems/regimes
  - Contributions, benefits (scope & quality), provider payment
  - Structured system for determining expansion of benefits & new technology adoption
- Integrate levels of care
- Enhance sustainability in financing & organization of health care
  - Needs of aging population
  - Effectiveness of revenue collection for health
    - Improve progressivity in financing
    - Avoid creating incentives for informality
    - Enhance capacity to capture non-labor income
- Improve governance & extend to entire sector to include private
## WB Activities related to UHC & health financing

<table>
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<th>Financing</th>
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<tr>
<td>• Health Systems Strengthening/Health Sector Reform Projects (RBF oriented projects) in the region</td>
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<td>• Introduction of innovative financing instruments</td>
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<tr>
<td>• Conferences /webinars on selected topics</td>
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<td>• Facilitate dialogue &amp; cooperation between MoF, MoH, other local stakeholders (e.g. sub-nationals)</td>
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<td>• development partners</td>
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<tr>
<td>▪ Collection and analysis of country-level data</td>
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<td>▪ Curation of implementation-relevant know-how</td>
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<td>▪ Expansion of knowledge base on emerging challenges</td>
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<tr>
<td>▪ Recent outputs: Universal Health Coverage Studies</td>
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<td>▪ 25 country case studies in all regions in 2013</td>
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<tr>
<td>▪ 11 country case studies in 2014 (political economy, health financing, HRH)</td>
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<tr>
<td>▪ LAC Regional Study- 10 countries (forthcoming)</td>
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<tr>
<td>▪ Updating health financing profiles</td>
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<td>▪ Health financing training workshops with Government teams</td>
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Thank you!

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