Rethinking Social Health Insurance's Role in Universal Health Coverage

9th Annual Caribbean Health Financing Conference

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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

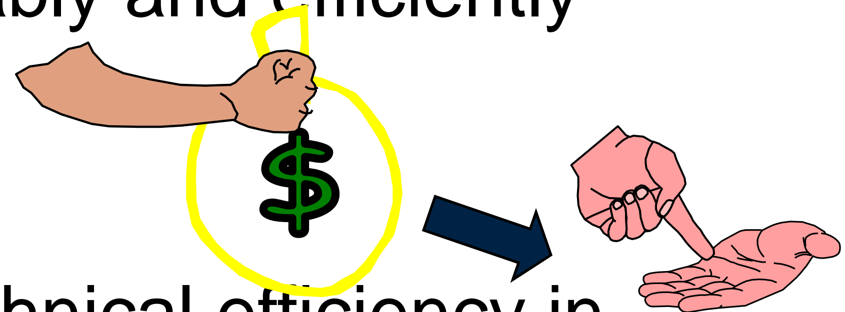
Health Financing: Main Functions & Objetives

- Revenue Collection

  - Obtain sufficient resources efficiently, equitably, and in sustainable manner

- Risk Pooling

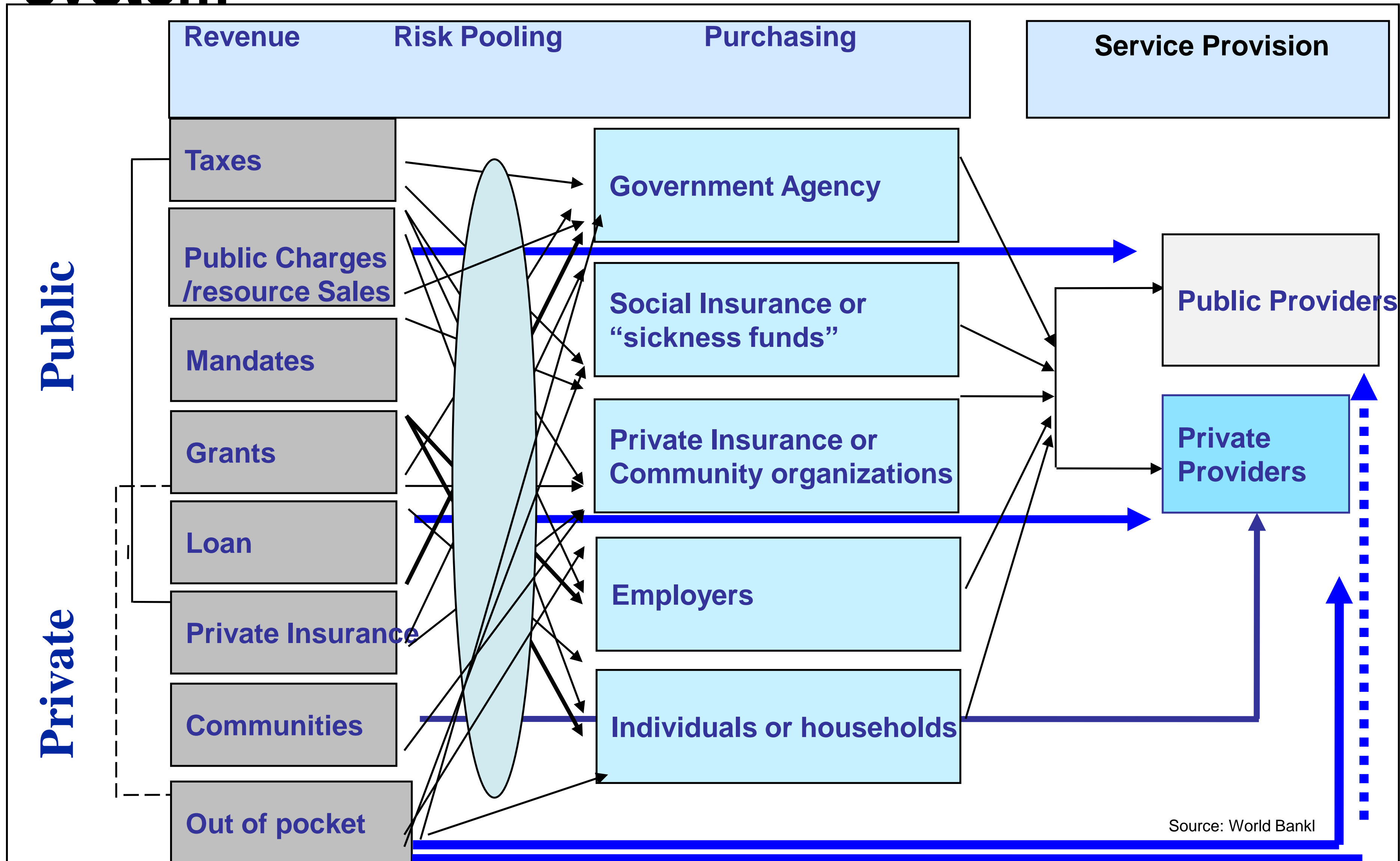
  -Manage resources equitably and efficiently



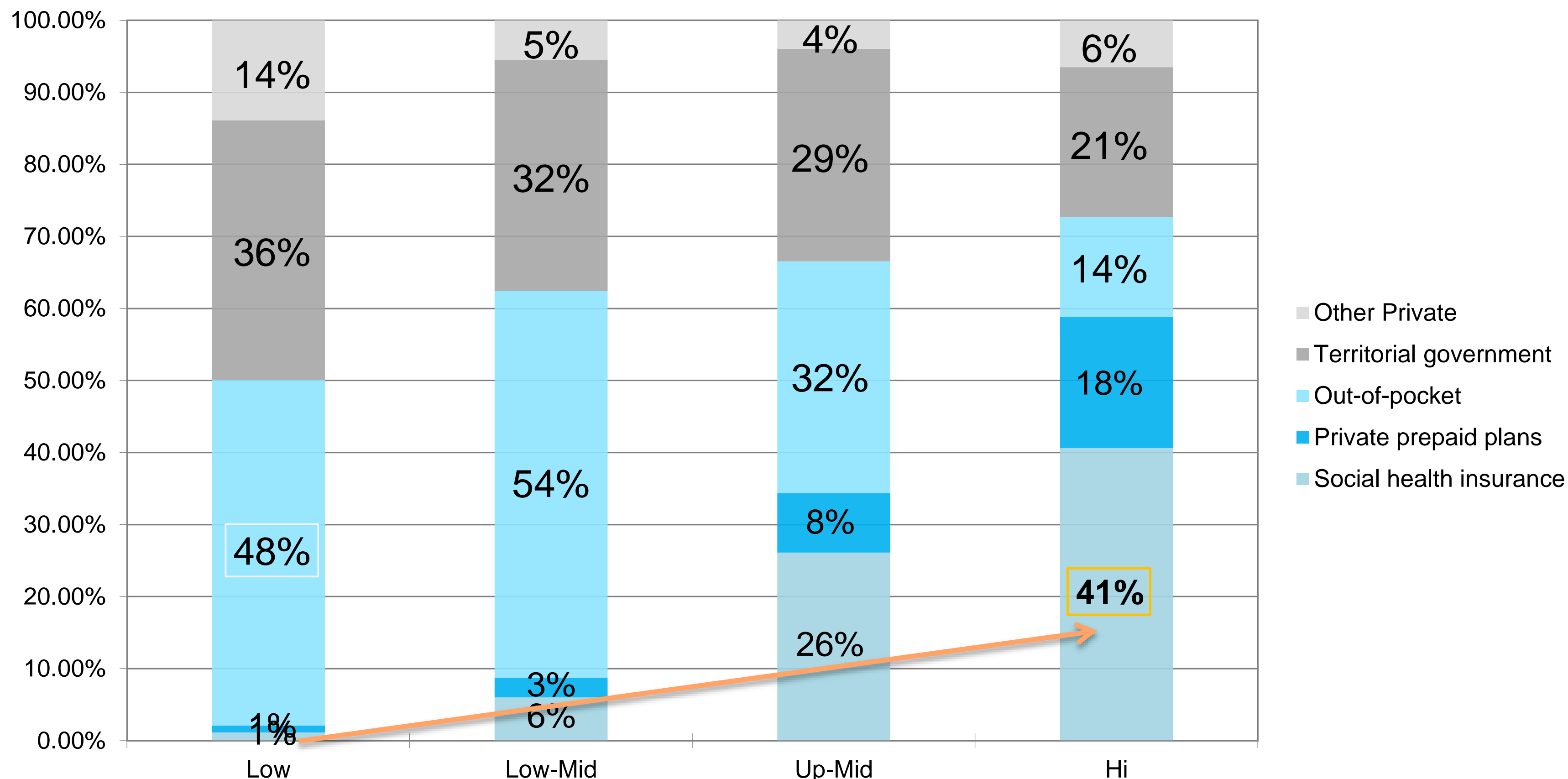
- Purchasing

  -Ensure allocative and technical efficiency in purchasing of services **(value-for- money)**

Diferentes modalities to finance a health system

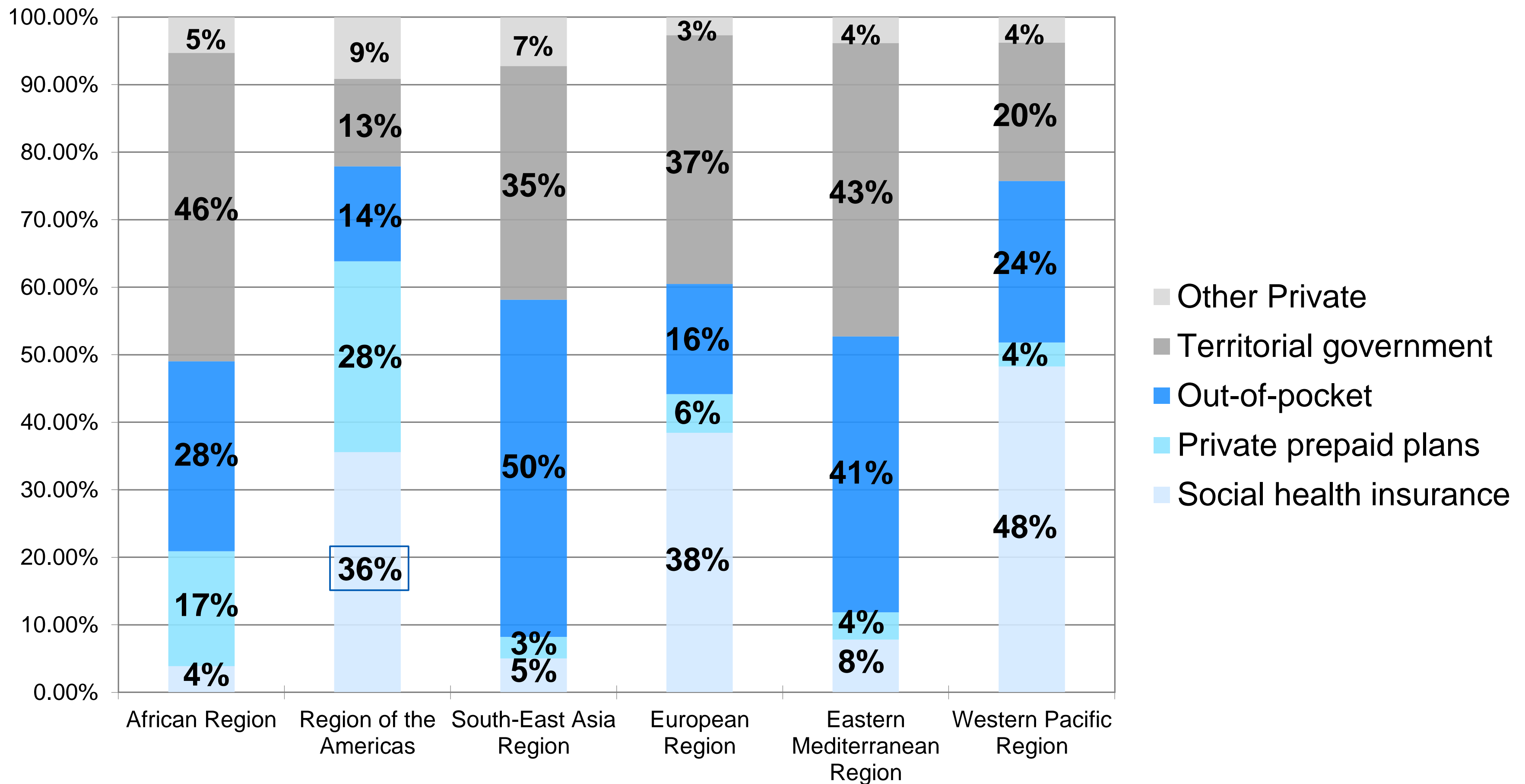


OOP is highest in LICs and lowest in HICs, while SHI increases with income level



Source: WHOSIS

Among regions, Europe has lowest OOP (16%) and highest combined contribution of SHI & Government (75%)



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

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

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

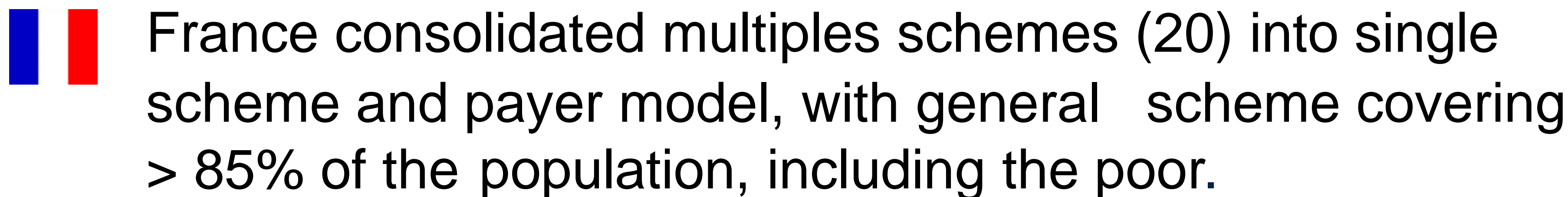
- Inequities
  - Different benefit packages for specific target groups
- Inefficiencies
  - use of infrastructure and scarce health personnel
  - administration of various insurance schemes generating large costs
- Potential barrier to continuity of care
  - Prevents smooth integration & continuity of 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

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

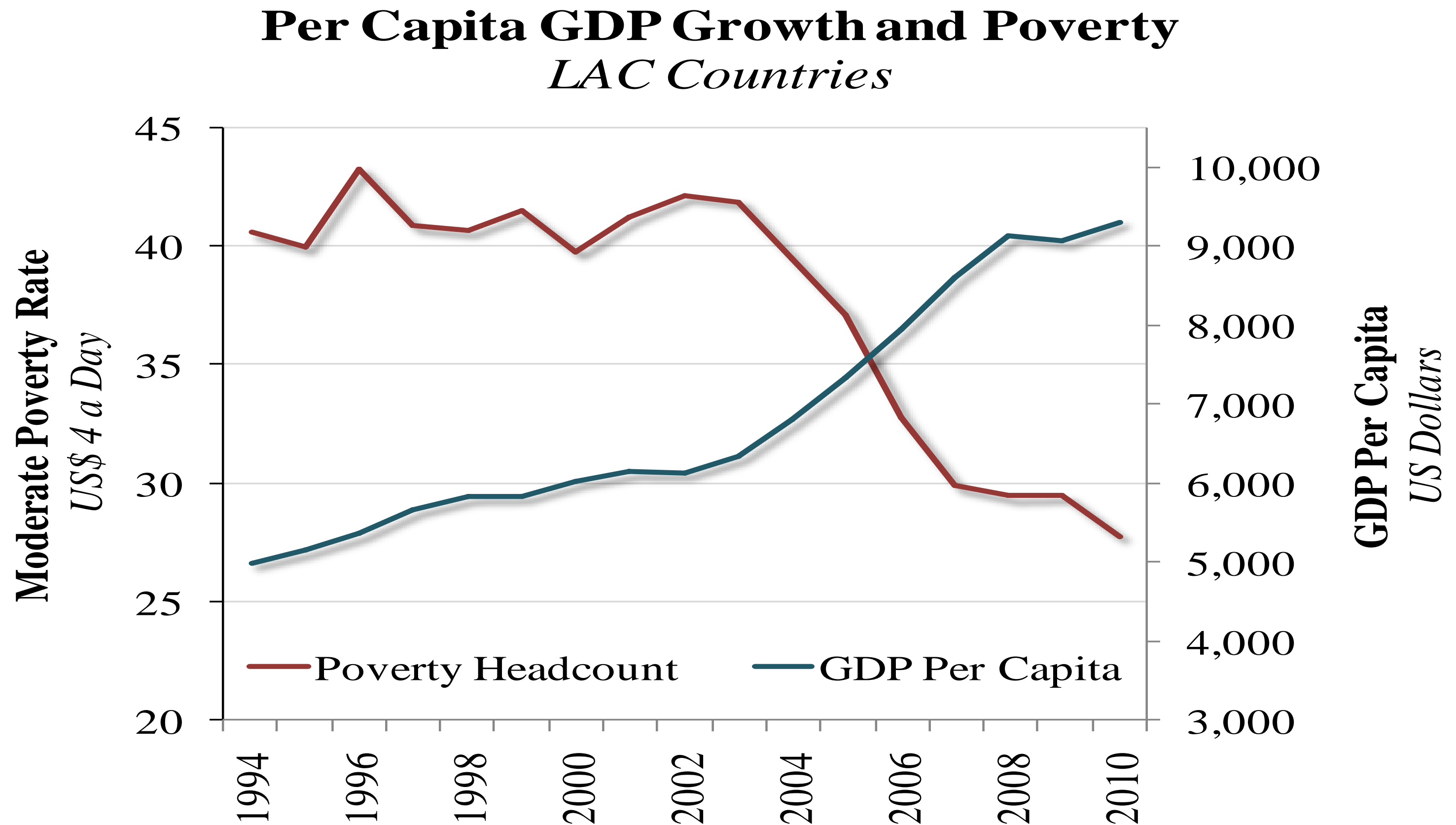
Sources: Cotlear et al (2014) and Mesa-Lago (2008)

High Coverage Rate Countries with Segmented SHI and Public Systems

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

Enabling Conditions for Coverage Expansion in LAC

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



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

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

Thank you!

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