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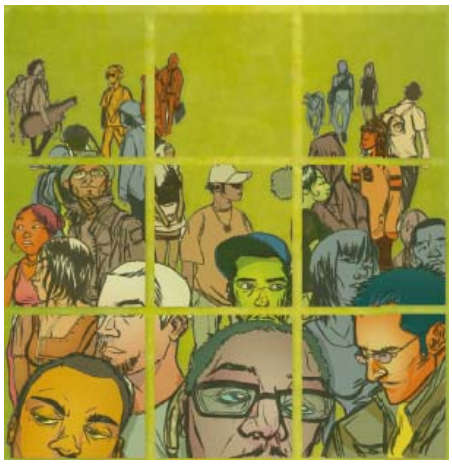
World Health Report (2010)
Background Paper, 26

HEALTH SYSTEMS FINANCING
The path to universal coverage

World Health Organization



Thinking of introducing social health insurance? Ten questions

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1. What do you mean by social health insurance?

Social health insurance (SHI) is one of the possible organisational mechanisms for raising and pooling funds to finance health services, along with tax-financing, private health insurance, community insurance, and others.[i] Typically in the more mature European SHI systems, working people and their employers, as well as the self-employed, pay contributions that cover a package of services available to the insurees and their dependents. In most cases they are obliged to make these contributions by law. Many governments also pay subsidies into these systems in order to ensure or improve their financial sustainability.

Within this context, there has been considerable variation in how SHI systems have developed across countries. Contributions are sometimes held in a single fund, or there might be several funds that compete for membership. These funds may be run by government or by nongovernmental or parastatal organizations. Contributions have generally, but not always, ensured that the rich contribute more than the poor but contributions do not typically vary with health status. The sick do not pay more than the healthy, to allow the financial risks of paying for care to be shared across the healthy and the sick, or across the life cycle for individuals. A multitude of ways of paying providers can be observed, from unrestricted fee for service, to selective contracting at negotiated rates.

As SHI systems developed, they have evolved further. For example, governments have extended coverage to people who cannot pay, such as the poor and the unemployed, meeting or subsidizing their contributions from government tax or non-tax revenues. No SHI system these days is financed entirely by payroll deductions anymore. The so-called informal sector has also been included, sometimes at flat rates (each contributor or family pays the same contribution regardless of wealth) to account for the fact that it is difficult to identify their incomes precisely. These days, the variations between systems that people call SHI are very great, so that even systems that rely on voluntary enrolment are sometimes called SHI. The underlying objective in using the term seems to be that all people are, or will be over time, offered the right to enrolment in at least one type of mechanism allowing financial risks to be shared. This might involve a mix of various forms of insurance funding for some types of health services with others being funded directly from government revenues. Accordingly, the feasibility and sustainability of any SHI system - broadly defined - will depend crucially on the combination of characteristics it will have.

2. How will SHI contribute to your health system objectives?

No health financing mechanism is an end to itself – it contributes to the objectives of the health system. The objectives specified in the WHO health systems framework after extensive consultation with countries are (a) improving health and reducing health inequalities (b) being responsive to people's expectations, and (c) ensuring fairness of financing.[ii] More recently, WHO has also committed to renewing Primary Health Care, of which the search for universal coverage is one of the core principles.[iii] WHR2008 In designing or modifying a health financing system, it is important to be explicit about the reasons for introducing SHI and how it will contribute to achieving one or more of these objectives, or others you value. Most commonly, policy makers consider the introduction of SHI for one or more of the following reasons:

SHI is thought to:

(a) be a way of mobilizing additional domestic resources for health;
(b) allow organizational change for improved health system quality and efficiency which is easier to introduce through SHI (e.g. purchaser-provider splits, new provider payment mechanisms);
(c) extend financial risk protection to more people, or provide greater levels of protection to those already with coverage (e.g. replacing out-of-pocket spending with some form of prepayment, switching from private health insurance to SHI, at least for a basic package of health services). This additional financial protection is seen as a way of allowing more people to use needed services without incurring high out-of-pocket payments, effectively moving closer to **universal coverage**.

When determining how to finance health services for some people, it is important to also consider the remainder of the population. One or more of the health systems' objectives will not be achieved *for all* unless there is universal coverage.[iv] This does not necessarily mean enrolment in SHI for everybody, but it does mean that coverage by SHI for some must not reduce access, risk protection or equity for others. And if parts of the population are not included in the first wave, a clear, realistic timetable is established for including them or other forms of coverage are established for them.

Related questions then are: How fast can coverage be extended to all? And how will populations be ensured access to needed health services until SHI coverage reaches them? What health

financing mechanism will cover the others? And will risk pooling be extended beyond SHI, i.e. will there be cross-subsidies from SHI to the financing of health of non-SHI covered populations?

In prioritizing and developing a plan for achieving the desired objectives, it is important to assess whether SHI is indeed the best option and what features will get closer to the desired outcomes.

3. Will SHI raise additional funding for health?

***Not necessarily*.** It depends on how contribution systems are designed. If people who normally pay providers directly out of their own pockets at the time they receive care are offered health insurance, the overall financial contributions by this group of people as a whole may fall, rise, or stay the same depending on the levels at which the contributions are set. The purpose of replacing direct out of pocket payments by prepayment (health insurance contributions) is generally to ensure that the people who are unlucky enough to fall sick can readily access services without the fear of financial hardship or catastrophic health care costs. It changes the timing of people's payments rather than necessarily raising more funds.

A second issue is how the Ministry of Finance (or equivalent) reacts to an increase in pooled funds available through health insurance contributions. It may well be tempted to reduce allocations from other sources to the Ministry of Health because additional funds from insurance are available. In practice, many countries choose to use health insurance contributions to supplement existing funds, at least partially, e.g. they may continue to meet the costs of public health and many preventive interventions from Ministry of Health budgets while moving payments for curative care to SHI funds. Mature SHI systems tend to have moved gradually to having most health financing operated through SHI although the majority of countries establish hybrid systems that combine a number of health financing mechanisms. *In transition*, countries might allow a health insurance system for formal sector employees to coexist with systems of community insurance for the informal sector, supplemented by government provision and even some private health insurance. In the end, however, the total availability of funds is determined by people's willingness and ability to meet contributions and how the Ministry of Finance reacts to additional funds being available through a health insurance pool. SHI should not be seen as a way of automatically ensuring an increase in funding for health.

4. Are all stakeholders in support of SHI?

Implementing SHI is a major undertaking and requires sustained support from the government and other important stakeholders and interest groups in society. In particular, in industrialized countries or countries with an important or emerging formal sector, employers and employees play a crucial role as they negotiate wages and working conditions, of which SHI would be an important component. Some countries have also found it difficult to incorporate existing health insurance schemes for civil servants or formal sector employees into a broader insurance pool covering other segments of the population because the more affluent people in the formal sector fear losing some of their benefits. It is clear, however, that considerable effort needs to be put into building consensus and support of all stakeholders as well as the general public if SHI is to be established successfully.[v]

In this respect, countries reliant on donor support may face an additional hurdle with the sometimes very divergent views of external development partners such as the international financial institutions, the various bilateral aid agencies and international health NGOs. While some of these partners have not been strong supporters of the introduction of SHI in low income countries in the past, others have recently been willing to channel external funds through nascent SHI-type institutions.

5. Is there a legal framework for SHI to operate within?

The Ministry of Health will generally remain responsible for setting health policy goals and directions even if a SHI pool is established outside the Ministry. It will also be responsible, in collaboration with the parts of government dealing with legislative issues (e.g. an Attorney General's Department), for creating the legal framework for the operations of health insurance agencies and their interactions with contributors/beneficiaries and service providers. This must answer questions on how SHI is governed, how independently it can manage its resources, and how much it is involved in determining benefit packages and in accrediting providers. This takes considerable advanced planning although there is growing experience across the world from countries who have taken these steps, and which can be used to aid mutual learning.

6. Are revenue collection procedures technically feasible?

SHI revenue typically comes from membership contributions, employer contributions, government subsidies and interest payments on any accumulated funds. As contributions rely on

coverage, the policy-makers must consider whether their coverage expansion targets are realistic. Is the necessary administrative organisation in place to register members, to distribute membership cards if necessary, to collect contributions? This includes considering dependants as well as poor people who may have to be exempted from paying contributions.

7. Are the physical and intellectual resources available to setup a SHI organization?

To receive, pool and pay-out its funds, the health insurance must have a functioning administration. This includes personnel and office buildings as well as procedures for handling health insurance funds, overseeing its own operations, investigating fraud and complaints, negotiating and sometimes contracting providers, computer systems and more. People with the appropriate skills to plan, implement and run these must be available.[vi] The necessary educational qualifications may have to be introduced first and SHI implementation may have to be postponed until such skilled personnel exist. For speedier progress, and especially for very specific skills (e.g. management of a data information and computer system), recruitment abroad may be necessary on a temporary basis, though salaries might then have to be at a higher level than is sustainable in the longer run.

8. What benefits will SHI members be entitled to?

A big part in determining whether a SHI is technically feasible, financially viable and supported by all stakeholders depends on the depth and height of coverage. Depth refers to the range of services available while height refers to the proportion of the total cost covered by insurance.[vii] As an aside, the breadth of coverage is used to describe the proportion of the population that is covered. Many countries have established what is often referred to as the "essential package", which should be covered. Costing this package will help in determining the requirements for financial equilibrium (see question 10 below), but it will also enhance the discussion about what can and cannot be covered, and for what reasons. The funds available are never unlimited so choices have to be made and priorities have to be set. This includes striking a balance between what is most cost-effective (i.e. provides the biggest health benefit to the population for the least cost) and what is desired by the stakeholders involved. The latest health technologies and certain medical services that save i*ndividua*l lives may not represent the best value for money on a population basis. However, excluding these may provoke a public outcry. All stakeholders (patients, providers, politicians, workers, farmers etc.) typically need to be involved in the discussions of costs versus effectiveness, and scope versus depth, and make the trade-offs and

options as clear as possible. WHO has determined the cost-effectiveness of a large number of specific interventions.[viii] This information may assist you in establishing an essential package.

9. How should the SHI purchase or provide health services?

To ensure the desired health services are available, different methods can be used. The SHI could simply employ providers and establish hospitals and pay for them using the accumulated funds. Alternatively, and most commonly, it could purchase from existing or new providers. Typically this includes a mix of government and non-government providers. Various provider payment mechanisms may be adopted. Options here include fee for service payments, capitation payments (where providers are paid a set amount for each person in their catchment area or who enrols with them), diagnosis-related groups or types of performance related payments. Some health insurance systems contract with preferred providers while others are required to work with all legally registered providers. Purchasing services clearly requires an additional set of skills, particularly skills in the area of contracting. There is an extensive literature on the most effective and efficient payment mechanisms, but as a generalization, fee for service payment paid through health insurance is a recipe for rapidly rising costs that will eventually require many types of controls over provider (and even patient) behaviour.

10. Can SHI operate at a financial equilibrium?

In principle, SHI revenues from contributions and perhaps subsidies must balance with its expenditures on the health services of its members plus administration costs and potential other payments (e.g. risk equalization, cross-subsidies to non-SHI covered populations). Given the contribution rate that is politically and economically feasible and the costs to pay for the agreed health care benefits, is it possible to break even financially? And is it likely to stay financially feasible in the future? Since the establishment of SHI will require relatively high start-up costs, funds to cover these must be available. There are a number of tools that can be used to help undertake this analysis, including one provided by WHO.[ix]

[i] cf. http://www.who.int/health_financing/mechanisms
[ii] World Health Organization. The World Health Report 2000. Health systems: improving performance. Geneva: WHO, 2000.
[iii] World Health Organization. The World Health Report 2008. Primary health care: now more than ever. Geneva: WHO, 2008.
[iv] cf. World Health Organization. Social health insurance – Sustainable health financing, universal coverage and social health insurance: Report by the Secretariat A58/20. Geneva: WHO, 2005.
[v] Doetinchem O, Schramm B, Schmidt JO. The Benefits and Challenges of Social Health Insurance for Developing and Transitional Countries. In Laaser U, Radermacher R (eds) Financing Health Care: A Dialogue between South Eastern Europe and Germany. Series International Public Health, Vol. 18, 2006.
[vi] Carrin G, James C. Reaching universal coverage via social health insurance: key design features in the transition period. Discussion Paper 2, 2004. Geneva: WHO, 2004.
[vii] Beware of confusion. Much of the literature talks about breadth, scope and depth of coverage. In that terminology, scope is the equivalent the term "depth" above and depth is the equivalent of "height" above.
[viii] cf. http://www.who.int/choice
[ix] http://www.who.int/health_financing/tools/simins