



Technical Brief Series - Brief No 5

FRAGMENTATION IN POOLING ARRANGEMENTS

WHAT IS FRAGMENTATION IN POOLING?

Pre-paid revenues for health services come through various sources, such as taxes, compulsory insurance contributions (payroll taxes), voluntary insurance premiums, and foreign assistance. After collection, such funds are accumulated or *pooled* on behalf of some or all of the population in one of several organizations such as health insurance funds, national health ministries, local governments, etc. The purpose of pooling is to spread risk so that no individual carries the full burden of paying for care; effectively the healthy subsidize the sick, which also often means that the young subsidize the old, and the rich the poor. Pools are fragmented when barriers to the redistribution and efficient use of prepaid funds exist.

WHY ARE WE TALKING ABOUT FRAGMENTATION?

Because fragmentation limits the scope for redistribution possible from a given level of prepaid funds, it is an obstacle to progress towards the key objectives of universal coverage – removing the financial barriers to services for all who need them, and protecting the entire population against the financial risk of using health care. In addition, fragmented pooling is a source of system-wide inefficiency which can lead to the duplication of administrative costs and limitations on the capacity of the financing system to use strategic purchasing to support changes at the provider level.

While financing policy dialog at national and international levels often focuses on options to increase the level of prepaid funding - for example by introducing a new source of funds - implementing such measures without paying proper attention to changes in pooling can result in increased fragmentation and compromise equity and efficiency objectives. Conversely, several countries have made important strides towards universal coverage by de-fragmenting pooling (sometimes in combination with the introduction of a new financing source). It is hence time to raise the profile of this relatively neglected financing policy instrument and make reduction in fragmentation an explicit target for policy reforms on the path towards universal coverage.

WHAT FORMS DOES IT TAKE?

Fragmentation in health financing systems can manifest in different ways. Some important forms are described here:

- **Population segmentation** occurs where revenues for the care of different population groups are held in separate pools, with no potential for cross-subsidy between them. This occurs in many countries that have a compulsory insurance fund managing a “financing system” for contributors (typically formal sector workers), and the government (e.g. Ministry of Health, decentralized local authorities) managing a financing system for the rest of the population. This type of fragmentation tends to have severe equity consequences because the levels of per capita funding tend to be much higher in the pool serving the richer part of

the population. It also impacts efficiency because the pools cover populations in the same geographic territory, leading to duplication of effort.

- Geographic fragmentation occurs where funds collected in a distinct administrative region (e.g. state or district) can only be used for services within that region, with no (or very limited) scope for redistribution of funds between regions. Without measures for cross-regional equalization of funding levels, this can result in poorer regions losing out. Efficiency problems also arise when decentralized regional pools serve a relatively small population, resulting in higher than necessary administrative costs for the system as a whole.
- Some countries rely on multiple competing insurers. In such systems, equity is a concern because insurers have an incentive to select young and healthy persons for coverage, excluding those with greater health needs. It therefore becomes necessary to use some form of financial equalization across pools to minimize the potentially harmful effects of this form of fragmentation. It is worth noting that several middle- and upper-income countries that use competing insurers to manage their compulsory insurance systems have created a “virtual single pool” through the use of sophisticated mechanisms to redistribute revenues across insurers in relation to the relative risk of the populations they cover. Needless to say getting such mechanisms to work is administratively demanding.
- Fragmentation in funds flow for disease control programs occurs where funds for specific health programs and services – from both domestic and international sources – are managed in separate pools and fund “their” interventions through different mechanisms than the rest of the system. For example, if the funds for a national HIV program are managed separately from those for a national drug abuse programme, it is more difficult to organize efficient HIV prevention packages for some high risk groups, such as injecting drug users, served by both programs.

WHAT DO POLICY MAKERS NEED TO THINK ABOUT?

Fragmentation in funds pooling contributes to systemic inefficiency and inequity, and needs to be a target for policy action. The existence of fragmentation means that for a given level of prepaid revenues, systems can redistribute less than they could if the funds were managed in larger pools.

Fragmentation is pervasive. Fragmentation exists to some extent in all countries. Typically, it is a product of the historical or political development of a country’s health financing system. As a result, there is no “one-size-fits-all” strategy to address it, and possible political obstacles to progress must be considered. Nevertheless, policy makers should incorporate de-fragmentation of existing pooling arrangements as an explicit part of their universal coverage strategy.

When introducing a new health financing source or agency, consider changes to the flow of revenues from existing sources to minimize fragmentation. In those countries with a relatively large share of the population not engaged in the formal part of the economy, the introduction of a compulsory social health insurance scheme poses a high risk of excluding people if it only (or largely) serves contributors. In recent years, several countries have redirected general budget revenues into the same pool as the Social Health Insurance contributions enabling the rapid scale-up of

coverage because non-contributors form the majority of the population in these countries. Even in richer countries with Social Health Insurance, the amount of general budget revenues provided may be relatively small (e.g. Czech Republic, Germany) or large (e.g. Hungary, where general budget revenues comprise about half of prepaid revenues). But in all these countries, ensuring universal coverage would be impossible without these transfers and pooling of contributory and budgetary revenues.

Don't wait; design universality into health financing strategies from the beginning. By recognizing the limits of contributory approaches, countries should in turn create an explicit role for general budget revenues in the financing system. This can occur by pooling general budget with contributory revenues as already stated, or by consolidating previously separate pools and creating a universal, budget-funded, non-contributory entitlement, as is the case with Thailand's Universal Coverage scheme. This approach offers much greater potential for progress than does the idea of "starting insurance" with the formal sector and then hoping that economic growth will lead to growing formality of the economy and progressive increases in contributory insurance coverage. There is no reason to wait; if they have not done so already, countries can proceed now to create a unified national health financing policy framework. Minimizing fragmentation has a key role to play on the path to Universal Coverage.