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Working paper

The value added of social health insurance in achieving health protection for all

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Summary

The goal of extending health protection is generally to reach universal coverage, to enable access to health care without financial barriers for all citizens or residents of a country. Universal coverage requires a mix of compulsory contributory social insurance schemes, with mechanisms to include the informal-economy population, and tax-based social assistance for those whose incomes preclude their own contributions. This paper deals with social health insurance as the major mechanism available to member organizations of the International Social Security Association (ISSA) for extending coverage, in line with the objectives of the ISSA's Dynamic Social Security conceptual framework.

The major reasons for the slow extension of coverage are reviewed, and the added value of health care as a benefit in formal-sector social security is stressed, as well as the importance of controlled and regulated growth of community-based or micro health insurance schemes to enable eventual linkages. The paper urges a reversal of the trend towards the separate development of social health insurance by separate health authorities; rather, it recommends its integration into existing formal-sector social security schemes, as these institutions have the political backing and the institutional structures to add health care and extend coverage to make universal coverage a reality. Finally, the paper stresses the role of the ISSA as a forum for discussion and information sharing on the extension of coverage, and provides the opportunities for formal and informal-economy schemes to interact and work together.

Introduction

The goal of extending health protection is generally to reach universal coverage, in terms of access to health care without financial barriers for all citizens or residents of a country. The use of the term "coverage" relates to financial access rather than the supply of health services, that is, coverage which refers to availability and geographic accessibility of health-care resources. Deficiencies in the supply and quality of health services may indeed hamper continued enrolment in contributory social health protection schemes. However, an integral component of the social health insurance concept is the commitment created between the fund, members and providers to provide timely and appropriate health care. Rather than wait for a significantly improved health-care system, we take the approach that the financing schemes, through the creation of additional pooled funds to pay for health care will in fact stimulate the overall supply and an improvement in the quality of services. Pre-payment creates this commitment to assure the quality of benefits and reduces the risk of non-compliance and even cessation of membership.

Universal coverage requires a combination of financing mechanisms, for different population sectors, and these include three basic forms:

- compulsory social insurance schemes with a regular contributory prepayment system, usually shared between employer and employees for both public and private sector salaried workers and affordable contributions for the non-salaried sector;
- social assistance for those whose incomes or lack of economic activity preclude their own contributions, with funding from tax-based or other government and non-government sources;
- government tax-based schemes for all citizens or specific groups of residents, financed through general or earmarked tax revenues, from income tax or other government revenues.

In reality, all social health protection systems are a hybrid of these basic forms. Most countries that have succeeded in reaching universal coverage spend tax revenues on the very low-income and vulnerable populations that require subsidies, while social health insurance systems have extended coverage to those who are able to contribute in the private and public sectors. This study deals with social health insurance as the major mechanism available to International Social Security Association (ISSA) members for extending coverage. The study discusses extension through the compulsory formal sector schemes as well as the voluntary community-based or micro health insurance for the non-salaried and informal economy. The paper will also deal with linkages with the social assistance and tax-based systems for specific population groups. The study focuses on the extension of coverage in low- and middle-income countries.

The inclusion of all these forms of protection for all population sectors follows the Dynamic Social Security approach of the International Social Security Association (McKinnon, 2007) and this paper will therefore focus on proactive and integrated measures which should contribute to universal coverage.

1. Issues in extending coverage

1.1 Impetus for the extension of coverage

At the beginning of the millennium, four out of five people worldwide lacked basic social security coverage (International Labour Organization (ILO), 2003). At regional level, a recent study on Latin American countries (Mesa-Lago, 2007) estimated that 53 per cent of the total population of the 20 countries was covered by social insurance, while in ten of these countries coverage was only between 7 and 26 per cent. A report prepared for the 11th African Regional Meeting of the ILO in Addis Ababa, in April 2007, noted that almost 90 per cent of the population of sub-Saharan Africa is not insured against the risk of illness or accident. It is more difficult to find estimates of coverage for Asia and the Pacific, but coverage in the largest countries, such as India, does not exceed 10 per cent. The full coverage reached in most European countries has largely been maintained (van Ginneken, 2009) although there has been loss of coverage in some Eastern European countries as a result of privatization and more unregistered self-employment.

Box 10.1***: Major factors behind extension of health-care coverage***

The interest in extending coverage is triggered by several factors operating in parallel, and without real linkage between them or collaboration between the stakeholders and agencies involved. Political and equity concerns are at the forefront, as it is now recognized that paying for health care is a major reason for poverty in populations which do not have health protection. Each year, an estimated 100 million people yearly fall into poverty due to health-care costs (World Health Organization (WHO), 2008) implying reduced opportunities for economic growth.

At the same time, existing social health insurance systems are constantly trying to reach maximal pooling as health-care costs rise, life expectancy increases and the burden of disease is increasingly due to chronic diseases, while communicable diseases continue to present challenges. To maximize pooling, several countries have shifted from a vastly pluralistic approach, with a very large number of social health insurance schemes, to merged schemes, as in Japan, or even a single national fund, as in the Republic of Korea (Ron et al., 2005) which has also taken a proactive approach to the prevention of chronic diseases.

Another impetus comes from governments which provide health services through public facilities and now look for stable financing mechanisms to assure steady revenue into these facilities. The social health insurance mechanism becomes particularly attractive when the introduction of user charges in public health facilities has had negative outcomes on the utilization of care, negative political reactions and failed to yield adequate revenues (Gilson and McIntyre, 2005).

In many of these countries, development partners have provided millions of dollars to prevent the spread of HIV/AIDS, malaria and tuberculosis – all communicable diseases which spread beyond borders through global activities – yet financial barriers at the family level hamper access to primary health care to enable timely diagnosis and thereby avoid the spread of these diseases to the immediate contacts. Prompt medical attention is a crucial factor in the effective control of communicable diseases which pose a national, regional and global public health threat if they are not controlled.

Poverty eradication, the changing burden of disease and lack of adequate funding in public health-care facilities therefore underscore the importance of enabling health care for all without financial barriers. All of these factors are now compounded by the current global economic situation, which could have profound implications for the health spending plans of national governments. Volatile exchange rates and shrinking industrial ouput are likely to have negative effects on getting health care to the people in need and reduce the amount of external aid for health to countries which still depend on this source for a large part of their health budget. Unless countries have safety nets in place, the poor and vulnerable will be the first to suffer and the expected shrinking of the salaried sector could disenfranchise a significant number of salaried workers who now have health-care coverage for themselves and their dependants (Parry and Humphreys, 2009).

1.2 Reasons for slow extension

All these interests do not explain why it is so difficult to reach substantial extension of coverage. Again, we find a wide range of reasons for slow and even arrested growth in health coverage. From the point of view of social security development, it would appear that there are three major reasons, stated here as "development failures". These may be described as:

- the failure of pension schemes and other social security schemes in developing countries to include health care as an integral benefit;
- the failure to cover a significant proportion of the informal economy population in countries where this sector constitutes the majority of the labour force;
- the failure of some compulsory social health insurance schemes to extend coverage to the legal dependants of active and retired workers.

Review of the first two failures: Statutory or compulsory formal sector social security schemes in many countries have been reluctant to expand coverage to include health care before resolving the problems in extending coverage of the existing benefits to the informal economy population (van Ginneken, 2009). Over the last two decades, labour force changes in countries going through shifts to market economies, such as China, Mongolia, many countries in the former Soviet Union and most countries of sub-Saharan Africa, led to streamlining of civil service and privatization of state-owned enterprises which created a new excluded population if these individuals lost salaried employment.

The political and economic shift in China had a tremendous impact on social protection coverage, as the move from collective to individual responsibility for production led to the collapse of their Rural Cooperative Medical Scheme, resulting in a drop from over 90 per cent

coverage of the rural population in the early 1990s to less than 10 per cent within two years (Carrin et al., 1999). Since the rural population comprises over 70 per cent of the total population, the drop in nationwide coverage was very significant and paying for health care became a major reason for poverty. It is only in the last two years that regulations have been put in place to again reach coverage of 90 per cent of this population by 2010, through committed subsidies by both central and local government (SSW, 2009). However, the health-care benefits of the scheme are limited to "serious health problems" and reimbursement is expected to be around 50 per cent of the health-care charges. Attractiveness of membership in such a voluntary scheme may well be problematic. Even if close to 100 per cent of this population will be covered, the true meaning of universal coverage will be comprised by the limitations.

Health care as a social security branch differs from an old-age pension, in which the actual amount paid during retirement is generally linked to the amount and duration of contributions. Health-care benefits are provided according to need, both in terms of volume and type of health services, and not according to the actual contribution or premium made by the individual or family. Contribution revenue during the qualifying period may be negligible compared to actual expenditure by the scheme if high-cost care is required within a short period. Another important difference is that use of the benefit by the insured person is usually unpredictable and an assessment of appropriateness of the benefits provided requires medical expertise which is quite different from the expertise needed for financial management and efficient operation of other social security branches. The social security schemes may well understand the importance of health care, but the complexity of dealing with this benefit and maintaining financial solvency may be beyond their capability.

Mature social security systems in industrialized nations have over time acquired the necessary inputs to deal with these challenges. Some of these systems actually started with health care from the very beginning. The social security systems in developing countries, however, generally started with work injury programmes and then long-term benefits, such as retirement and disability pensions, and now hesitate to take on health care as a new benefit. On the other hand, they already have the essential institutional capacity to provide this new benefit to their current membership.

These new social security schemes, and their governments, face at least four challenges in the extension of coverage. These four are described below not in order of priority, but suggested in order of preoccupation of the schemes, with emphasis on countries still in economic transition and/or with a majority of workers in the informal economy.

- First is how to improve compliance with the current legislation, which usually applies to salaried workers in the private sector.
- Second is how to expand coverage to the public sector workers, when the introduction of a contributory mechanism for typically low wage earners is difficult to justify and government is in no hurry to pay its part as employer. This applies to countries in which civil servants receive free health care in public health facilities; sometimes considered as compensation for their low wages. Particularly in countries with a high proportion of workers in the public sector, the inclusion of health care in the social security package could increase total contributions and may be opposed on economic grounds.
- Third is how to extend coverage to the self-employed and informal economy workers and their dependants, when registration and contribution collection systems are not well developed. Unless a compulsory legislative mechanism is put in place, covering this last population also means dealing with voluntary membership, which has its own problems in terms of adverse selection and continued compliance in timely contribution payments.

- Fourth is the question of whether or not to add health care as a benefit, for those who are currently covered as well as for new target populations. For the latter, an additional question will arise as to whether the developing social security scheme will allow the new population, that is, the self-employed and informal workers, to buy in only for health care, and not the full range of social security benefits.

The reluctance to deal with the fourth challenge, that is, the addition of health care, is to a large extent understandable on grounds of technical capacity. However, the basic rationale for a social security system to add health care is appreciation of the added value of this benefit. Health care is a short-term benefit, and most of the members and their dependants will use that benefit at least once each year: about 85 per cent of them are likely to visit a doctor or nurse as out-patients, and about 5–8 per cent may need hospital in-patient care (Ron et al., 2005).

Box 10.2: *Health care as a primary concern*

A 30-year-old working mother is likely to be more concerned about having health care for her family than having a pension in 30 years' time, even if she was guaranteed employment during the entire period until retirement, and even if the value of that pension would be guaranteed and not subject to inflation and decreasing purchasing power. Individuals will be particularly concerned if they have to face unpredictable financial burdens over their life span, over which they have no control of the type, volume of service or the cost, at the time of illness. For social security administrations, introducing health-care benefits could therefore be attractive to their existing – and potential new – members, and enhance compliance in contribution payments, as members would want to be sure that they are and remain covered.

Another added value is the potential positive effect on work injury programmes for salaried workers, which are the most common form of social security benefit, and exist in almost all countries. Access to health care for non-work related reasons is likely to change the burden of demand to receive health services in such schemes, and reduce abuse of the work-related benefits. So far, there has been negligible attention to the value of expanding coverage to non-work related illness and accidents for the insured.

Perhaps the most significant added value of including health care is the impact on health, along with the productivity and development that come with good health. Adults who are ill reach a stage where their productivity is negatively affected – they have more sickness absenteeism, more disability claims and eventually stop working, which means that they also stop contributing. Children who die before they reach school age will significantly deplete the work-force in the next generation. Schoolchildren who cannot concentrate on studies because of poor nutrition will not go on to higher education and qualification for the skills needed in developing countries. And all these will deplete the extension of coverage of the social security system, while creating new demands on cash sickness benefits and disability allowances, as well as on unemployment benefits where these exist. If the added value is recognized, the pressure for health-care coverage could eventually enable the introduction of legislative mechanisms for compulsory rather than voluntary affiliation of the informal economy population, regardless of progress of the formalization of the labour force.

Review of the third failure: The third failure listed above relates to the limitation of coverage in compulsory social health insurance systems to workers, and excludes the legal dependants of active and retired workers as in China, Mongolia, Thailand and Viet Nam. China has followed an individual approach in both urban and rural social security reforms, and has only

recently introduced affiliation for "non-working" residents in urban areas. Mongolia is a particularly interesting case of a country which started essentially with universal coverage and now has lower coverage and fewer benefits. The Mongolian Citizens' Health Insurance Programme was implemented by law in 1994 (Bayarsaikhan et al., 2005). The scheme covered individual workers, at a time when almost all workers were active and retired state employees. Full government subsidy covered vulnerable groups (such as children under 16, pensioners, parents with children under 2 years old and social welfare beneficiaries). Benefits were initially limited to hospital care but later expanded to a comprehensive range of health services, with cost control achieved mainly through a sound primary health-care base and referral system.

Subsequent economic crises led to difficulties in subsidizing the vulnerable individuals while the informal economy grew as the transition to private enterprise left many workers without coverage. The administration of the health insurance scheme was ill-prepared to enable non-salaried workers to continue membership, even if these disenfranchised individuals could afford to continue without the part paid by employers. Coverage fell to around 70 per cent and it has taken another decade to reach the current 80 per cent. In 2005, about 65 per cent of those insured were subsidized by government, 20 per cent made payroll contributions, and 15 per cent made flat rate contributions. To deal with the government's budgetary constraints, benefits were reduced to only hospital in-patient care. The use of hospital care is again high, indicating misuse of the system as in the early years, while the important primary health-care base, with its cost control function, has been lost. Studies demonstrated that a relatively small increase in the employers' and workers' contributions could replace the government subsidy for dependent children without any negative impact on labour costs (WHO, 2000) yet subsequent amendments to the law have failed to introduce family coverage.

In Viet Nam the combination of low compliance in the private salaried sector, the exclusion of dependants and the failure to reach the non-salaried sector has hampered a significant increase in coverage. The Health Insurance Decree of 1992 stipulated mandatory coverage for active and retired workers, while dependants were encouraged to enrol on a voluntary basis with a fairly low premium for each individual. Recent legislation failed to change this component despite indications that voluntary membership was unstable, had a high drop-out rate, and a far higher expenditure per insured person due to adverse selection. If all dependants were included through an acceptable increase in contribution rates, coverage would be almost tripled, given family size in Viet Nam, and could reach over 70 per cent for contributing members. As will be noted later, Viet Nam has already provided for the very low-income population, through a Health Care Fund for the Poor which purchases regular health insurance cards for this population (WHO, 2008).

Thailand too introduced mandatory social security, including health-care benefits from the start, only for salaried workers in the private sector, through the Social Security Act of 1991 (Ron et al., 2005). This contributory insurance scheme followed the establishment of social health protection for other populations through the National Social Welfare Scheme for low-income households in 1975, the Civil Service Medical Benefit Scheme for government employees in 1978 (both funded by general taxation revenues) and the Voluntary Health Card Scheme started in 1983 for rural families. The Universal Coverage Scheme was introduced in October 2001 as a popular initiative to enable access for the entire population. This scheme used general tax revenues to provide access to health care to the populations previously covered by the Social Welfare and the Voluntary Health Card Schemes, as well as the dependants of workers covered by the social security system, regardless of the income of these insured workers. The move allowed Thailand to reach universal coverage, with around 86 per cent of the total funded by government and only 14 per cent covered by a contributory social security scheme. However, this situation raises questions regarding the use of state subsidies for dependants of high wage earners, particularly in a period of renewed economic crisis.

A related issue is the limitation of the number of dependants who can be covered within the family unit, sometimes introduced as a population control mechanism. The National Social Security Law passed in Indonesia in 2004 limited the number of persons covered in a family to five, which usually meant only three children, at a time when a significant proportion of families had four and more children (Hidayat et al., 2004). Coverage of other family members requires additional contributions for each member, borne in full in the case of salaried workers, that is, without any employer participation. Apart from the potential for adverse selection in the registration of the covered family members, the limitation is contradictory to the objectives of universal coverage. A similar situation is found in Tanzania, where the National Health Insurance Fund limits family coverage to four children. Fortunately, only a few countries have adopted this individual approach, which fails to recognize that parents generally work to support their families and not only themselves.

2. Mechanisms to accelerate coverage

2.1 The inclusion of health care in existing social security schemes

The earliest social security schemes (established mainly in Europe and Central and South America) included health care from the start (Ron et al., 1990). However, the schemes established from around the 1960s and particularly in newly independent states of Africa and Asia, were less likely to include health care, and tended to set up separate institutions for work injury programmes and for income-replacement benefits, such as retirement and invalidity pensions. The formal sector social security schemes now face a double challenge: adding health care as a benefit and extending coverage to the self-employed and informal economy workers. The added value of health care in a broad social security scheme was discussed above. Despite the advantages, few schemes are taking on this challenge and we see more countries going to separate schemes for health care despite the duplication of administrative effort and the loss of opportunity to extend the social protection concept to the broadest coverage of contingencies through the life span.

The trend towards separate systems may be linked to the current source of government concern and the actors involved. The government agencies mandated to deal with social security and health are often separate, with the first under Ministries of Labour and the second under Ministries of Health. Ministries of Health generally developed an interest in social health insurance as a financing mechanism at a later stage, and were motivated more by financing opportunities than by the principles of social protection (Carrin and James, 2005). This interest in social health protection intensified as the Poverty Reduction Strategy Papers requested by the international development partners over the last decade increasingly included social health insurance as a poverty reduction tool, with responsibility for implementation placed on Ministries of Health (Claeson et al., 2001).

The pressure on Ministries of Health increased when government budgets no longer enabled free health care and new user charges failed to bring in the necessary revenues without seriously comprising equity in access to health care. Expectation of the stable revenue from heath insurance even led some Ministries of Health to take health care out of the social security system, as in the Philippines, and set up a separate national health insurance scheme under that Ministry. This strategy comes with a higher cost of administration as it means two parallel agencies dealing with registration and contribution collection. There may also be a negative impact on the potential to extend coverage in all branches of social security for the population (ILO, 2001). Once health needs are dealt with, it is unlikely that the self-employed and informal economy population will seek mechanisms to assure income in old age and disability without employers or the state to share the contribution burden.

2.2 Extension to the informal sector in existing schemes

In the short run, more effort is needed to encourage formal sector schemes which have health care to extend membership to the informal economy population. There is significant progress in this direction in some countries, even without a parallel process of formalization of the informal economy workers. The initiatives come with the realization that not all informal economy workers are poor, a significant proportion have regular income throughout the year, many are willing to pay affordable and fair contributions rather than deal with high expenditures at the time of use of health care and many belong to informal economy associations. The National Health Insurance Fund in Kenya recently launched a scheme for the 100,000 households affiliated with the Kenya Women Finance Trust, a specialized microfinance organization (Mbogo, 2008).

In middle-income countries, such as Egypt, economic crises have sparked initiatives to cover the informal economy, since the increase in poverty among this population due to paying for health care poses a significant threat. The economic crisis in Mexico led to a 2003 health reform that established the Seguro Popular universal health insurance scheme (Parry and Humphreys, 2009). About 45 per cent of the 103 million people have access to health insurance through social security for the salaried sector and by 2010 the entire population is expected to be covered through this extension to the informal economy and social assistance for the indigent population (Knaul and Frenk, 2005).

PhilHealth, the national health insurance scheme in the Philippines has focused efforts to extend coverage to informal economy workers through cooperatives and civil society associations, which can undertake registration and contribution collection for the group, thereby reducing the burden of dealing with individuals. Another important step is the accreditation of existing community-based health insurance schemes and their absorption into PhilHealth, as required by the National Health Insurance Act.

2.3 Promotion of controlled and regulated growth of community-based schemes

So far, formal sector social security schemes in most low- and middle-income countries have not been able to meet the challenge of extension to the informal economy. These are generally countries in which the majority of workers are self-employed or in the informal economy, and taxation systems are weak and do not allow for adequate revenue collection to ensure tax-based funding for universal coverage (Jacobs et al., 2008). While the lower-income population may spend less on health care (but a higher proportion of their income), most of this money usually goes to the unregulated private sector, whether for over-the-counter drugs or to private practitioners (Ekman, 2004).

An alternative policy launched in some of these countries has been to promote the extension of coverage through community-based or micro-health insurance or mutual schemes. Some countries have begun a process of parallel development of compulsory social health insurance for the formal labour sector and voluntary community-based health insurance for the informal sector (Coheur et al., 2007). In this approach, the voluntary community-based schemes are seen as an interim mechanism to protect the target population, increase awareness about an affordable pre-payment for health care, and bring revenues to the providers through negotiated contractual arrangements (Ron et al., 2005).

Parallel development is now underway in a number of countries, such as Indonesia, Ghana, Laos, and Rwanda, among others.

Laos: A first step in the development of social safety nets in Laos was made through the Social Security Decree implemented by the Ministry of Labour and Social Welfare in 2001, with the inclusion of health care for salaried workers in the private sector. In the same year, the Ministry of Health launched voluntary community-based health insurance for the informal economy population in both rural and urban areas, with ministerial regulations guiding the establishment of new sites, provider contracts and benefits. The network has now grown to 17 sites in the capital city and six provinces, and accelerated extension is underway with upgrading of the legislative tool to a Decree. In 2006, the civil servants health-care benefits scheme was reformed. By the end of 2008, close to 230,000 persons were covered by the three contributory schemes. The next stage will be coverage of the very low-income families, financed mainly through government revenues from expanded hydro-power projects and other taxation revenues. The schemes covering all these populations have the same benefits, provider payment method and basic information system to facilitate the implementation of a road map to universal coverage through a national scheme covering the entire population, with the very low income population covered through social assistance.

Rwanda: Rwanda launched the parallel development of a number of schemes that together constitute the Social Health Insurance System (Musango et al., 2006). The three major schemes are the Rwandaise Health Care Insurance (La Rwandwaise d'assurance maladie) for the salaried sector workers and their dependants, the Military Medical Insurance, and the community health insurance schemes, health mutual funds (Mutuelles de santé) for the informal sector. The network of Mutuelles is funded by a relatively low monthly flat rate contribution per person, matched by government, which also provides technical support. By mid-2008, 85 per cent of Rwandans countrywide were insured with Mutuelles de santé, and 6 per cent by the other schemes so that around 90 per cent of the Rwandan population were covered (Logie et al., 2008).

Ghana: Ghana passed a National Health Insurance Act in 2003, to replace the "cash and carry" system of user charges applied in 1992. The Act set up District Mutual Health Insurance Schemes to provide financial intermediation services between their members and the health-care providers. The 145 District Mutual Health Insurance Schemes operating in the country by mid-2008 are controlled by a National Health Insurance Authority, which provides subsidies and technical support to these schemes for their operation.

Parallel development requires government commitment, resources and legislative tools based on a declared policy of eventual linkage of all the schemes to achieve universal coverage. Voluntary non-profit community-based schemes need contribution rates which are affordable for the majority of the target population and a benefit package which includes both often used primary health care and rarely used hospital-based services. These can be achieved with low administrative costs and effective cost control through regulations which enable innovative and shared systems to register populations and collect contributions, negotiated contracts with providers with payment systems that are population-based (such as capitation) rather than volume-based (such as fee-for-service), and maximal pooling through mergers at district, provincial and eventually national level.

The process can be accelerated when formal sector social security schemes show readiness to be involved, by sharing their administrative experience and tools and eventually adopting the community-based schemes. In Ghana and Rwanda, the informal economy populations constitute the majority of insured persons, yet the development of schemes for these sectors was undoubtedly prompted and assisted by the experience of the formal sector social security schemes. Eventual merging is important not only to expand the principle of solidarity between low- and higher- income populations, but also to maximize the pooling of risks and strengthen the purchasing power in the provision of health-care benefits, all of which are necessary to reach universal coverage.

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Without appropriate commitment and technical support to all these functions, the growth in coverage by community-based health insurance is likely to be slow and sporadic, with a multitude of small schemes often competing for the same target population and lacking power to negotiate with providers for appropriate costs and quality. Criticism of community-based schemes has generally neglected to examine the existence of a regulatory framework and has focused on unstable membership and financial viability, linked to weak administrative capacity, high administrative costs and inadequate popularity due to limited benefits (Ekman, 2004). This criticism can undermine rather than support a process which can prevent poverty among low-income populations and create grass-roots pressure for broader social health protection.

2.4 Use of social assistance funds to purchase health insurance for the low-income and vulnerable populations

The previous approach to enabling access to health care for the poor was to identify the poorest and exempt them from user charges in public health services. Exemptions presented not only a stigma issue but these patients were often underserved, as the provider received no remuneration for the care given (Bitrán and Giedion, 2003). In recent years, the trend has been to transfer social assistance funds to the social health insurance schemes to purchase health insurance membership for the population identified as unable to contribute themselves.

A few countries have focused support on specific vulnerable populations, mainly the elderly.

Bolivia passed legislation on health insurance for the elderly in 2006, through municipal

Box 10.3*: Integrate social insurance and social assistance in health-care coverage*

Several national social health insurance schemes, such as in Columbia, Mexico, the Philippines and Viet Nam, now use social assistance funds to purchase health insurance for indigent families. Stigma and discrimination are reduced when the poor seek health care with the same health insurance card as contributing members, and again, solidarity and purchasing power are increased. An additional factor in the integration of both contributing and subsidized low-income populations is related to the quality of care. Recipients of free care limit expression of dissatisfaction with the health services, while people with higher incomes and higher education tend to be more vocal in expressing both satisfaction and dissatisfaction, particularly if their sharing in the cost of services is through a pre-payment mechanism.

funding and earmarked taxes on carbon emissions (ISSA, 2009). In the Maldives, state-funded health insurance for the population over 65 years of age has now come into effect (SSW, 2009). The move is an expansion of the social health insurance scheme introduced in August 2008, under which government employees and those on the "Absolute Poverty List" were eligible for fully or partially state-funded medical care. This is part of a broad approach to social protection of this population, as the government's long-term aim is to have universal health care by 2010. In addition to health care, the elderly in Maldives will receive a monthly allowance, depending on their income, to ensure a minimum income.

2.5 Family coverage

Perhaps the simplest and fairest mechanism to extend coverage is to assure coverage of the legal dependants, particularly children under the age of 18, of the contributors. The definitions of legal dependant and household members will certainly vary from country to country, but these can be defined and contribution rates or amounts can be set to avoid discrimination against large families. The limitation of family size in social health insurance is an inappropriate mechanism to control population growth, and as long as the individual approach continues in voluntary affiliation, there is likely to be adverse selection, with those considered "healthy children" excluded.

3. Prerequisites to the extension of coverage

3.1 Policy formulation and legislation

The above mechanisms to extend coverage are essential parts of a process contributing towards significant increases in the number and mix of people with regular rather than ad hoc health protection. Yet the process will remain piecemeal unless there is policy formulation at the highest level, leading to legislative tools which clearly set out the statutory extent of coverage, eligibility, governance and financing by all the partners.

Policy formulation needs more than statements of the importance of social protection and inclusion of social health insurance mechanisms in poverty reduction strategy papers and political platforms. Master plans or road maps towards universal coverage need to be developed with the broadest involvement of stakeholders and endorsement at the highest political level, with access to health care without financial barriers recognized as a national priority.

The development of such a master plan in Cambodia in 2003 led to a process of development of social health insurance, basic regulation of the increasing number of community-based schemes, linkage of Equity Funds with community-based schemes and the drafting of legislation to cover salaried workers and their dependants in the public and private sectors. The plan has been the foundation for technical cooperation to develop understanding and capacity in the relevant government agencies and to establish the institutional frameworks (WHO, 2007). A second stage involves a decision on the type of legislation needed, to what extent coverage will be compulsory, whether voluntary enrolment will be encouraged in the first stage, how the non-economically active and vulnerable population will be covered, and a realistic time frame to reach universal coverage.

A similar process was crucial in the development of the National Health Insurance Plan in the Bahamas, and a law based on the document endorsed by Cabinet was passed unanimously in 2006. However, the passage of legislation per se does not guarantee full implementation within the time frame stipulated in the law. In the Bahamas, as in Kenya in 2004, new governments which came into power within several months after passage of the laws were not in a hurry to implement them and these laws have still not been applied. At least in Kenya new proposals for health insurance mechanisms are being discussed as a result of the interest generated by the parliamentary debates in the past (Mbogo, 2008; Muchuma, 2008).

3.2 Government commitment to increase spending on health

Government spending on health care is low in most low- and middle-income countries (WHO, 2001b). In some, it has increased substantially in recent years, as happened in

Cambodia and Viet Nam, mainly following changes in allocations for the military sector. However, the public health systems in these countries remain underfunded, as evidenced by the failure to introduce and maintain modern medical technology, shortages of most health-care professionals and low wages in the public health sector. Social health insurance, which implies affordable contribution rates at levels which do not have a negative impact on labour costs, is not an instant solution to fill this funding gap. Successful extension of coverage will not be maintained if the newly insured population remains dissatisfied with the services for which they have in effect pre-paid through the insurance mechanisms. Public health workers are not likely to make efforts to improve quality and increase credibility if they see no direct financial benefit and perceive health insurance as the cause of lost opportunities for extra income when an increasing proportion of the population is protected from paying formal and informal fees at the time of use.

Box 10.4: ***Supplying adequate health-care coverage***

Governments will need to continue increasing expenditure on health care, with focused allocation of resources to strengthen the infrastructure and training components as well as health-worker remuneration, and increased efficiency and accountability in the use of these resources. At the beginning of this paper, it was noted that social health insurance can be started without waiting for an adequate supply of health-care resources. However, the continued operation of this financing mechanism will depend on visible improvements and increased satisfaction by an increased population that has paid in advance for the care they may need.

How much health insurance revenue will flow to health providers first depends on coverage and high compliance in the payment of contributions. Efficient use of these funds and rational use of benefits are essential as contributions cannot be increased to cover deficits emanating from inappropriate use. It is suggested that when health insurance payments reach around 40 per cent of the revenue into the public provider system, this financing mechanism may be considered successful in developing countries in which the Ministry of Health is the major provider of services and basic salaries of health workers come from government sources. Providers then understand that revenue can be increased by broader coverage, and an improvement in provider behaviour and visible improvements in infrastructure are key to this increased coverage. It also becomes clear to the providers that the higher revenues should be achieved by coverage for a comprehensive range of services and not by high charges and high utilization rates for an insured minority of patients with limited benefits.

3.3 Optimal design of the social health protection schemes

There are guidelines and manuals on the development of social health insurance, but no precise textbooks. Countries and schemes can learn from each other but cannot copy exact design – each environment needs to consider the specific demographic, labour force, cultural, health system and health care needs of the population. On the other hand, there are basic principles and good practices that will determine the financial stability and attractiveness of compulsory and voluntary health insurance which now assist us in accelerating extension of coverage and achieving financial stability. The most pertinent among these are:

- a broad range of benefits, with a strong primary health-care base and opportunities for cost control through a referral system and appropriate health promotion and preventive services;

- provider payment systems that are population- rather than volume-based, do not require cash from the insured at the time of use, and are based on provider contracts with requirements for quality assurance;
- contribution levels which are affordable for the majority of the population, cover all family or household members and are increased only by regulation, with increases justified by changes in benefits and not health system or scheme inefficiencies;
- maximal pooling and unified schemes with efficient administration.

3.4 Information sharing

Social security schemes, including social health insurance schemes, are dynamic institutions facing endless challenges in demography, disease burden, health-care technologies, management and economic trends, among other issues. The acquisition of new knowledge is crucial and best gained when such institutions are given opportunities to share experiences, with the guidance of international organizations, such as the ISSA, with its capacity to analyse and synthesize new developments and trends. The merging of schemes in Japan and Korea benefited from participation in ISSA activities and documents which covered both risk pooling and financial sustainability. However, some of the schemes mentioned in the paper may not yet have had the opportunities for information sharing through the ISSA, but have depended more on sporadic technical advice rather than an exchange of knowledge and experience with like institutions. Awareness of the benefits of sharing information needs to be seriously strengthened.

4. Conclusion

Why should health protection be extended? We identified four major reasons at the beginning of this paper:

1. to reduce poverty and inequity;
2. to achieve maximal pooling of risks and funds;
3. to secure stable financing for health care;
4. to achieve public health goals, such as preventing both communicable and non-communicable chronic disease.

Universal coverage, or access to adequate health care without financial barriers for all the citizens or residents of a country cannot be launched through statutory social health insurance alone, as noted in the beginning of this paper. Some development partners claim that tax-financed health care is the optimal financing mechanism for all. A recent paper by the World Bank (Wagstaff et al., 2009) reviewed the transitions between tax-financed health care and social health insurance in the Organisation for Economic Co-operation and Development (OECD) countries over the period 1960–2006. The paper concludes that adopting social health insurance in preference to tax financing increases per capita health spending by 3–4 per cent, reduces the formal sector share of employment by 8–10 per cent, and reduces total employment by as much as 6 per cent.

At this time, the argument in favour of a tax-based health-care financing system does not apply in most low- and middle-income countries in which the tax base is weak, income tax from earners does not come from the majority of the working population and the process of employment formalization is at a standstill, either due to weak governance or repeated national and global economic crises. The findings for the OECD countries may also be biased by the changing demography in these countries, whereby the age pyramid has changed from a young population with a large number of productive workers contributing to the fund, to an ageing population with a reversed ratio of productive to dependent individuals, with increased

longevity now synonymous with high health-care expenditure over several decades after retirement.

The fact that the majority of the working population are not in the formal economy does not mean that they should not participate in financing their health care, which all members of society need. The majority understand that health care is no longer free and will be prepared to contribute to fair, progressive and administratively efficient prepayment mechanisms that will protect them from unpredictable and high payments at the time of use. Their willingness to pay will be greater when the institution already has established credibility and the registration and contribution collection mechanisms are in place to assure income replacement in times of other contingencies in the life span, as in the broad social security schemes. Several governments, such as those of Ghana, Laos and Rwanda, have taken on the health protection of this informal economy population as national programmes, which seek linkage with the formal sector social security schemes.

The trend for separate development of social health insurance by government health authorities rather than existing formal sector social security schemes under the government labour and welfare authorities was discussed above. This trend needs to be reversed, through the inclusion of health care as a benefit, extension to the informal economy and social assistance for the neediest families. The continuation of the establishment of separate health insurance schemes is likely to result in concentration of coverage on the low-income or near-poor populations, which will not attract the higher-income populations. Social security systems are among the most powerful organizations in any country – they have the political backing and the institutional structures to add health care to the range of benefits, and extend this benefit to the self-employed and informal economy. Through partnership with government, which needs to confirm its commitment to health and to cover those requiring social assistance, these institutions have the power to make universal coverage through social health protection a reality.

The ISSA has an important role to play in providing the forum for discussion and information sharing on the practical aspects of the extension of coverage, in which both the formal sector and the new informal schemes have the opportunity to interact and find ways to work together. Besides the administrative issues of efficient registration and contribution collection in diverse populations, particular areas of information exchange are the current approaches to cost control through enhanced health promotion and prevention and appropriate health-care provider payment mechanisms. The new global economic crisis, with its threats of loss of employment and income for many, should provide a stimulus to this process which recognizes the added value of equity in access to health care in the framework of social security.

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